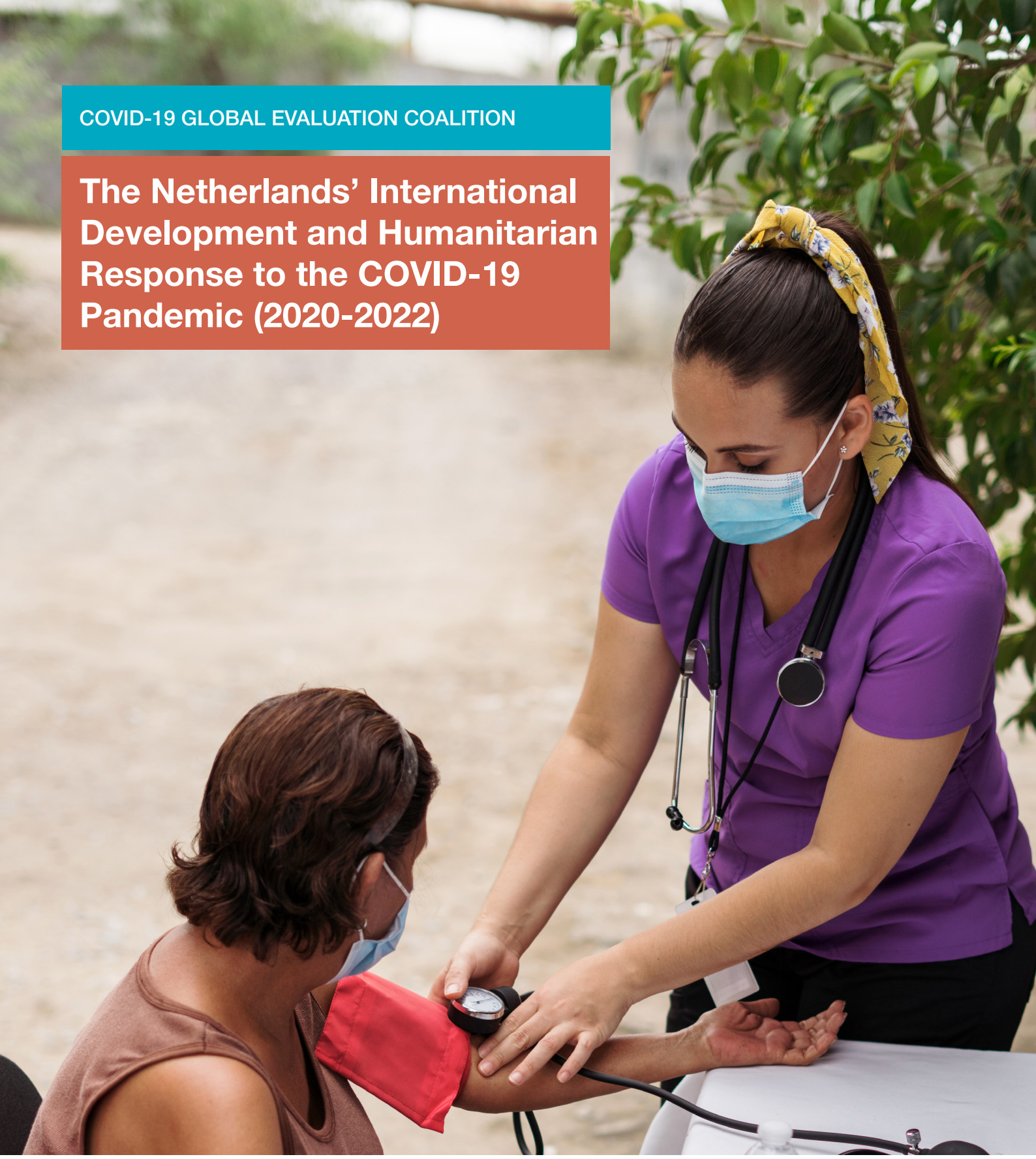
COVID-19 GLOBAL EVALUATION COALITION

The Netherlands' International Development and Humanitarian Response to the COVID-19 Pandemic (2020-2022)



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Foreword

The COVID-19 pandemic presented an unprecedented test of the global community's ability to respond swiftly, adapt to evolving needs, reallocate resources and co-ordinate effectively across borders and sectors. As governments, organisations and development actors worked to mitigate both the immediate effects of the pandemic and the broader socio-economic repercussions, the role of international development co-operation and humanitarian assistance in supporting national response efforts became crucial.

In 2022, the participants of the COVID-19 Global Evaluation Coalition (hereafter referred to as the "Coalition") launched the "Strategic Joint Evaluation of the Collective International Development and Humanitarian Assistance Response to the COVID-19 Pandemic" to take stock of and learn from this response. Conducted under the auspices of the Coalition and led by the Organisation for Economic Co-operation and Development's (OECD) Development Co-operation Directorate, this evaluation seeks to generate credible evidence, assess coherence and effectiveness, and draw lessons to strengthen future responses to global crises.

The Coalition was established in 2020 to provide actionable insights and foster accountability in international co-operation during the COVID-19 pandemic. Comprising more than 65 organisations, including evaluation units from OECD and non-OECD governments, UN agencies and multilateral institutions, – the Coalition leverages diverse experiences to create high-quality, timely evaluations and to feed evidence into decision making in near real time. Its collective efforts enable learning across stakeholders and ensure that the global development community can better deliver on its commitments. In line with the Coalition's values of credibility, usefulness and partnership, this strategic joint evaluation builds and complements other evaluations and reviews conducted on COVID-19 responses over the past four years. It brings together multiple actors to address the gap in evaluative evidence around the overall results of the collective pandemic response effort, offering a system-wide perspective.

This provider case study on the Netherlands was prepared by Miyabi Babasaki, Echica van Kelle and Marit van Zomeren (IOB) and Mayanka Vij (OECD). We are deeply grateful for the expertise, insights, and resources provided by all those involved in this collaborative undertaking, including the Netherlands and other OECD member states that provided funding for the Coalition project and the strategic joint evaluation.

This is one of a set of case studies of international support by individual providers, and of support in nine partner country studies, which together form a major source of evidence for the evaluation, along with a synthesis of evaluations, and a study of the philanthropic response. The final overarching report will be published in 2025, along with supporting policy briefs and thematic summaries.

The lessons emerging from this analysis – focused on the ways international partners work together and engage with local authorities and impacted communities – provide valuable insights to guide more relevant, coherent, effective and efficient international co-operation and, in turn, to support humanitarian and sustainable development progress.

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Abbreviations and acronyms

ACT-A	Access to COVID-19 Tools Accelerator
BHOS	Foreign Trade and Development Cooperation
C19RM	COVID-19 Response Mechanism
CBPF	Country-based Pooled Fund
CCRT	Catastrophe Containment and Relief Trust
CEPI	Coalition for Epidemic Preparedness Innovations
CERF	Central Emergency Response Fund
CFE	Contingency Fund for Emergencies
COVAX	COVID-19 Vaccine Global Access
COVAX AMC	COVAX Advance Market Commitment
CRS	Creditor Reporting System
CSO	Civil society organisation
CTF	Corona Task Force
DAC	Development Assistance Committee (OECD)
DGGF	Dutch Good Growth Fund
DGIS	Directorate-General for International Cooperation
EU	European Union
FMO	Dutch Entrepreneurial Development Bank
Gavi	Gavi, the Vaccine Alliance
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
GNI	Gross national income
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICRC	International Committee of the Red Cross
ICST	International (In-Kind) COVID Support Task Force
IMF	International Monetary Fund

IOB	Policy and Operations Evaluation Department
LDC	Least developed country
LIC	Low-income country
LMIC	Lower middle-income country
M&E	Monitoring and evaluation
MENA	Middle East and North Africa
MFA	Ministry of Foreign Affairs
MHPSS	Mental health and psychosocial support
MIBZ	Management Information Foreign Affairs
MOPAN	Multilateral Organisation Performance Assessment Network
MPTF	COVID-19 Multi-Partner Trust Fund
MSME	Micro, small and medium-sized enterprise
NGO	Non-governmental organisation
OBJ.	Objective
ODA	Official development assistance
OECD	Organisation for Economic Co-operation and Development
PPE	Personal protective equipment
PRGT	Poverty Reduction and Growth Trust
SDG	Sustainable Development Goal
SPRP	Strategic Preparedness and Response Plan
SRHR	Sexual and reproductive health and rights
SU4SU	Surinamese for Suriname
UN	United Nations
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
MoH	Ministry of Health, Welfare and Sport
WASH	Water, sanitation and hygiene
WHO	World Health Organization

Executive summary

This case study of the Dutch development and humanitarian response to the COVID-19 pandemic from 2020-22 is being conducted jointly by the Organisation for Economic Co-operation and Development (OECD) and the Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs (MFA). The study answers six questions on the nature, relevance, coherence, efficiency and effectiveness of the response, and on lessons learned. In order to answer these questions, the evaluation team conducted 25 semi-structured interviews with key stakeholders and performed an extensive review of secondary data.

Description and objectives of the Dutch response

Between 2020 and 2022, the Netherlands provided EUR 541 million to combat COVID-19 globally. This primarily involved official development assistance (ODA) and some non-ODA financing by the MFA and the Ministry of Health, Welfare and Sport (MOH). The funding was used to achieve objectives on disease prevention; emergency assistance; socio-economic resilience; country readiness and health systems strengthening; and sustainable and inclusive recovery. In addition, the Development Assistance Committee (DAC) issued a joint statement containing commitments by members on the COVID-19 pandemic, such as the Netherlands. Among others, this included a commitment to support civil society organisations and protect ODA budgets.

While most of the Dutch COVID-19 aid was allocated through multilateral channels, the Netherlands also provided some bilateral in-kind assistance, which it does not typically do. This case study includes an up-close look at the bilateral aid to Suriname. It highlights this type of aid and supplements the overarching findings and conclusions.

Key findings and conclusions

Relevance

Key findings: The Netherlands' COVID-19 aid package was aligned with global needs and priorities. It adapted to the shifting nature of the pandemic, moving from an emphasis on emergency assistance in 2020 to strengthening health systems in 2022. While the response was partly shaped by explicit articulations of needs and external assessments of evolving priorities, political and practical considerations also played a part. Political considerations specifically influenced two areas: the prioritisation of COVAX once the first COVID-19 vaccines became available and which countries received exceptional bilateral vaccine donations.

Conclusion: This case study found clear evidence that the Dutch response was adaptive and endeavoured to remain relevant to partner needs throughout the pandemic period. Dutch support to Suriname was responsive to country needs, but no definite conclusion can be drawn regarding the degree to which the entire Dutch response met the recipients' needs.

Coherence

Key findings: The Dutch MFA established internal co-ordination structures that contributed to co-ordinated external communications and a coherent approach across the Dutch response. Interministerial co-ordination experienced some challenges due to ad hoc political decision making. The decision to primarily support multilateral organisations contributed to external coherence. In the cases where the Netherlands donated vaccines bilaterally, however, no evidence was found of co-ordination with other donors. In addition, political ad hoc decision making regarding bilateral vaccine donations was not based on equity principles, which contrasted with the decision to support multilateral initiatives.

Conclusion: Overall, the Netherlands' response was well aligned at the global level with that of its development and humanitarian partners, mainly as a result of the allocations through multilateral organisations and initiatives. The internal task forces at the MFA were important drivers of coherence. However, internal coherence regarding the equity objective was constrained by political decision making and domestic priorities.

Efficiency

Key findings: The Netherlands provided timely funding to respond to COVID-19 by disbursing funds soon after appeals were received. Political prioritisation of rapid support as well as the decision to select larger partners contributed to timeliness. Dutch in-kind vaccine donations, however, arrived late relative to the urgency of recipient countries' needs. This was due to the Netherlands' prioritisation of the Dutch population as well as extensive legal risk assessments. Furthermore, the Netherlands primarily provided unearmarked and basket or pooled funding, which enabled recipients to execute their COVID-19 responses flexibly. It also provided institutional flexibility to existing partners by allowing for various programme adjustments.

Conclusion: Overall, the Dutch response was timely and flexible, especially in terms of mobilising funding. The bilateral in-kind vaccine support was late due to legal issues and domestic priorities.

Effectiveness

Key findings: The Dutch response was structured around clear objectives and sub-goals that had good alignment with and therefore likely contributed to the overarching global goals. There was limited ex-post evidence on early results due to insufficient monitoring. However, investments in prevention measures abroad and heavy support for vaccine distribution through COVAX helped alleviate the global public health crisis. Action to address gaps in country capacities for vaccine rollouts is likely to have helped mitigate the spread of the coronavirus, although vaccine availability did not necessarily lead to widespread coverage in partner countries. Furthermore, the Netherlands maintained advocacy and funding for mental health and sexual and reproductive health and rights. While the Netherlands aimed to facilitate equitable vaccine distribution through investments and donations, aggressive procurement of domestic vaccines on the global market likely limited the results on this objective, and the Netherlands could have done more to increase equitable access.

Conclusion: This study found sufficient evidence to illustrate the extent to which the Dutch response contributed towards its objectives, using the findings on relevance, coherence and efficiency, even though there was limited ex-post evidence.

Lessons to be learned

Crisis response plan: The COVID-19 response was informed by relevant information, consultations and staff expertise. However, the evaluation team did not find institutionalised lessons from past crisis responses. In addition, the study found that different collaborating Dutch ministries were guided by different priorities. Combined with occasional ad hoc political decision making, this resulted in strategic uncertainty and incoherence in the Dutch response. In the future, an overarching crisis response plan based on lessons learned and with high-level political support could improve the Dutch MFA's crisis preparedness. The following three lessons could inform such a plan.

Equity: One of the objectives of the Dutch response was to improve equitable access to vaccines. This study found that the Netherlands could have done more in this area. An important lesson that emerged is the need to define, operationalise and monitor equity objectives. This could lead to more targeted and intentional decision making, promoting a more equitable response in the future.

Channels and partnerships: During the COVID-19 response, 80% of funding went to multilateral organisations, compared to 49% of regular ODA in the period 2016-22. This case study found that strategic decision making did not always drive the shift in funding towards multilateral organisations. Rather, the findings show that logistical reasons partly influenced this preference in the COVID-19 response. Mapping possibilities for rapid funding of non-multilateral actors, removing potential barriers and conducting a transparent stakeholder analysis may enable strategic funding decisions in future crises.

Monitoring and evaluation: This study found a notable lack of information regarding the outcomes of the Netherlands' COVID-19 response. Regarding the bilateral support, the MFA required minimal M&E because it was perceived as unrealistic to request M&E during the crisis. This data gap makes learning challenging and also poses challenges to accountability. Exploring ways to make M&E more feasible for partners in times of crisis could improve future accountability and facilitate learning to inform future crisis response plans.

1 Introduction

1.1. Background

The Strategic Joint Evaluation of the Collective International Development and Humanitarian Assistance Response to the COVID-19 Pandemic is a flagship project conducted under the auspices of the COVID-19 Global Evaluation Coalition. The Strategic Joint Evaluation will document the collective response to the COVID-19 pandemic, including efforts to support equitable access to vaccines. It is learning focused and aims to generate lessons and good practices to inform future co-operation and crisis preparedness for governments, communities and development partners. The COVID-19 Global Evaluation Coalition is a collaborative project of the independent or central evaluation units of governments, United Nations (UN) agencies and multilateral institutions and supported by the OECD.[1]

This provider case study on the Netherlands, conducted jointly by the OECD and the Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs (MFA), is one of ten examining the development co-operation and humanitarian assistance response to the COVID-19 pandemic at the bilateral provider level. The purpose of this case study, a key line of evidence for the Strategic Joint Evaluation, is to document overall response efforts and present findings and lessons on the relevance, coherence, effectiveness and efficiency of the Netherlands' development and humanitarian response to the pandemic. This case study also serves to address a gap in evaluative evidence on the responses of bilateral providers including OECD Development Assistance Committee (DAC) members and other official providers. Beyond serving as a learning opportunity for development partners, findings and lessons can inform national policy discussions around public health, crisis response and cross-government action.

The Netherlands is an important provider of official development assistance (ODA), ranking seventh among DAC members in terms of its ODA budget as a percent of gross national income (GNI) and eighth in terms of total volume (OECD, 2024[1]). The Netherlands was selected for the case study due to its sustained engagement with least developed countries (LDCs) and fragile contexts in Africa and the Middle East and its reliance on the multilateral system and non-governmental organisations (NGOs) as key partners for ODA delivery. The Netherlands' focus on policy coherence for sustainable development makes this case study a useful addition to the broader evaluation as it provides opportunities to explore how providers upheld this commitment during the pandemic.

Chapter 1 provides an overview of the Methodology and Limitations of this study. Chapter 2 describes the Netherlands' development co-operation and humanitarian assistance including Policy frameworks and it provides information on the Institutional set-up of the Netherlands (MFA). Chapter 3 describes The Netherlands' international COVID-19 response between 2020-22, including a timeline of the response. Chapter 4 discusses the Findings related to the research questions on the relevance, coherence, efficiency and effectiveness of the Dutch response (OECD, 2019[2]). Chapter 5 provides overarching Conclusions and lessons, drawing on the findings on the selected criteria, and discusses four recurring and cross-cutting themes across the case study, with practical recommendations for the Netherlands MFA.

1.2. Methodology

The case study was undertaken by one evaluator from the OECD Development Evaluation Unit in collaboration with three evaluators from the IOB. The study was conducted from October 2023 to July 2024 and answers six questions:

- Descriptive – How did the Netherlands respond to the COVID-19 pandemic internationally?
- Relevance – To what extent did Dutch COVID-19 support meet partner needs and priorities?
- Coherence – To what extent did the Dutch response align internally and with other actors to ensure coherent approaches globally?
- Efficiency – To what extent was funding timely and flexible?
- Effectiveness – What are the early results of the Netherlands' development and humanitarian response to the COVID-19 pandemic?
- Forward looking – What good practices, innovations and lessons learned emerged? How might they inform future crisis response?

The evaluation matrix used for this case study builds on these questions from a shared evaluation framework[2] and includes sub-questions and key indicators to capture the diversity and scope of the pandemic response across stakeholder types, geographies and response objectives. This matrix was validated by the Strategic Joint Evaluation's Steering Group and is used across each country case study. The key findings and lessons from this study will be integrated into the overall evaluation report for the Strategic Joint Evaluation.

Three of the six questions listed above were modified to align with the nature of the Dutch response to the pandemic. The original question on relevance (*to what extent did Dutch COVID-19 support meet partner country needs and priorities?*) was broadened in scope to include all types of partners (including multilateral organisations and NGOs) since only a minimal portion of the Dutch support was allocated directly to partner countries. The original question on coherence (*to what extent are responses aligning to ensure coherent approaches at global, regional and country levels?*) was broadened to include an analysis of the internal coherence of the Dutch response. Finally, the evaluation team expanded the original question on efficiency (*to what extent were funding and programming decisions and interventions timely and informed?*) to reflect on issues around flexibility and timeliness.

To reflect on the bilateral aspect of the Dutch development and humanitarian COVID-19 response, the team conducted an up-close review of the Dutch support to Suriname. This example was selected for two main reasons. First, the support to Suriname included different components such as in-kind support and technical assistance, which allowed for an analysis of these different kinds of support offered by the Netherlands in different phases of the pandemic. Second, Suriname was one of the first countries to receive in-kind support from the Netherlands and received donations throughout the evaluation phase. These donations were also among the first to be co-ordinated by multiple ministries, giving the evaluation team the opportunity to analyse the interdepartmental co-ordination and the decision-making process throughout 2020-22. While the Suriname example is not necessarily representative of other countries that received Dutch support, additional interviews with policy officers who were involved in support to other countries allowed for some general findings regarding bilateral support.

The evaluation team conducted semi-structured interviews with 25 key stakeholders representing, among others, Dutch ministries and embassies, NGOs, diplomats and multilateral organisations. Eight of these were interviewed for the up-close study of Suriname. While a few interviews were conducted in person, most were conducted virtually and subsequently transcribed for documentation and reference purposes. Secondary data collection involved reviewing internal documents from the archives of the Netherlands

MFA and publicly available material, including letters to the Dutch parliament as well as project and evaluation reports of key recipients of the Netherlands' COVID-19 funding.

The team used two financial data sources to triangulate findings and strengthen the quantitative ODA analysis: ODA statistics from the OECD Creditor Reporting System (CRS) Aid Activity database and actual disbursement data received from the Dutch MFA.[3] The CRS database provided insights into general trends in Dutch ODA figures (The Netherlands' development co-operation and humanitarian assistance landscape), ensuring consistency and comparability across different provider case studies. The MFA's Management Information Foreign Affairs (MIBZ) financial database allowed for a deeper, more detailed and more complete exploration of the data, including insights on 2022 figures and non-ODA allocations. It is important to note that these databases provided slightly different amounts, with the CRS database recording commitments and the MFA data recording actual disbursements.

A framework matrix method was used to analyse the qualitative data using the case study's evaluation matrix. This case- and theme-based approach to qualitative data analysis (Macfarlan, 2024[3]) was used to summarise and analyse the rich data, allowing for adequate interpretation and triangulation of findings. This led to the identification of key findings for each research question, presented in Chapter 4. As there was limited information on early results, the findings under relevance (section 4.1), coherence (section 4.2) and efficiency (section 4.3) were used as prerequisite factors for effectiveness (section 4.4). Moreover, an overview of the extracted objectives (Figure 3.1) was used as a tool for understanding the contribution to early results for the Dutch objectives based on policy assumptions.

A draft report was shared with the relevant MFA policy departments as well as with IOB and OECD peer reviewers for additional validation.

1.3. Limitations

Time limits constrained the data collection and review period and the number of sources and respondents consulted. As such, the findings cannot fully capture the experiences and opinions of all stakeholders involved in the Netherlands' response to the COVID-19 pandemic. In particular, the close-up on the Netherlands' bilateral donations to Suriname includes limited perspectives from the Surinamese healthcare sector, national government and communities due in part to limited access to the relevant actors within the time available. In addition, most interviewees were individuals directly involved with the Dutch response. This could lead to response bias and an overestimation of effects. Throughout this study, the limited inclusion of end users may have, for instance, resulted in a limited understanding of local needs and the relevance of the response. The team tried to mitigate this limitation by including representatives from the non-governmental sector.

The team also encountered some instances of recall bias where interviewees could not always recollect details from the pandemic period. The potential impact of these biases was mitigated by relying on multiple data sources to triangulate findings.

Finally, analysing the effectiveness of the Dutch response was challenging. It was difficult to draw causal linkages between the Dutch response and reported results for two reasons. First, the Dutch COVID-19 aid package was predominantly channelled through multilateral organisations, pooled funds, multi-party trust funds or NGOs. In many cases, the first-degree recipients of Dutch funding were regranting or intermediary organisations and/or funds. Some but not all of the responses of these first-degree recipients have been evaluated. This analysis relies on the findings of independent evaluations when available. For unevaluated entities, the analysis is based on self-reported results data and annual reports, with variations in source, content, scope, method of collection and completeness. Pooled funding likewise complicates attribution and contribution because it is difficult or impossible to disentangle Dutch support from that of other actors.

Second, the bilateral COVID-19 support provided by the Netherlands did not include specific requirements for monitoring and evaluation (M&E). This was also the case for monitoring of the assistance to Suriname, making it difficult to assess its relevance and effectiveness. The crisis demanded considerable improvisation and flexibility from MFA and Ministry of Health, Welfare and Sport (MoH) staff to respond to bilateral requests for assistance. Response wide, policy officers agreed at the time that the unprecedented nature of this crisis made comprehensive monitoring unrealistic, and the IOB supported this. From March 2020, the Dutch MFA used a so-called COVID-19 marker to track any funding related to the pandemic. Internal documentation, such as funding agreements and contracts, suggests that the Dutch government relied on the M&E systems of the recipients. While this is common practice, it adds complexity to identifying and evaluating results of support provided.

2 The Netherlands' development co-operation and humanitarian assistance landscape

This chapter describes the Netherlands' development co-operation and humanitarian assistance policy frameworks as well as the institutional set-up of the Dutch MFA. It also provides an overview of pre-COVID-19 ODA financing and supports readers in contextualising the COVID-19 response against how the Netherlands typically provides development co-operation and humanitarian assistance.

2.1. Policy frameworks

The Netherlands Foreign Trade and Development Cooperation policy, Investing in Global Prospects, ran from 2018-21. This policy set four main objectives:

- preventing conflict and instability
- reducing poverty and social inequality
- promoting sustainable and inclusive growth and climate action worldwide
- enhancing the Netherlands' international earning capacity.

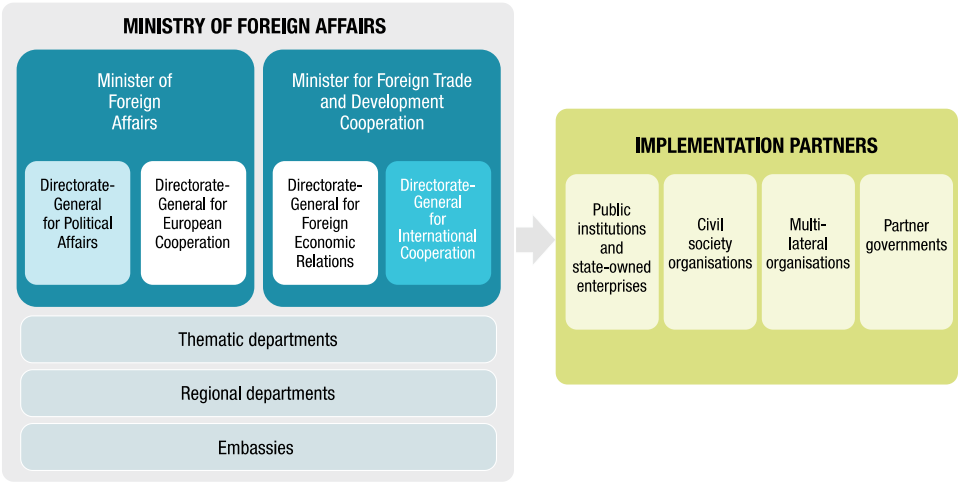
The policy had a cross-cutting focus on gender equality and the empowerment of women and girls. The West African Sahel, the Horn of Africa, and the Middle East and North Africa (MENA) were listed as focus regions for development co-operation in the period (Government of the Netherlands, 2018[4]).

In 2022, a new policy was introduced – Do What We Do Best – that sought to make foreign trade and development co-operation policy more cohesive and focused. This policy set out six methods to achieve maximum development impact: a focused approach for greater impact, leveraging development co-operation for private finance, investing in the global development system, increasingly working through the European Union (EU), localising development co-operation and listening to young people, and prioritising fragile regions (i.e. the Sahel, Horn of Africa and MENA) (Government of the Netherlands, 2022[5]).

2.2. Institutional set-up

The MFA holds the Dutch development co-operation portfolios, which are overseen by the minister for foreign trade and development cooperation (BHOS) (OECD, 2023[6]). Figure 2.1 presents the institutional set-up underpinning Dutch development co-operation and humanitarian assistance.

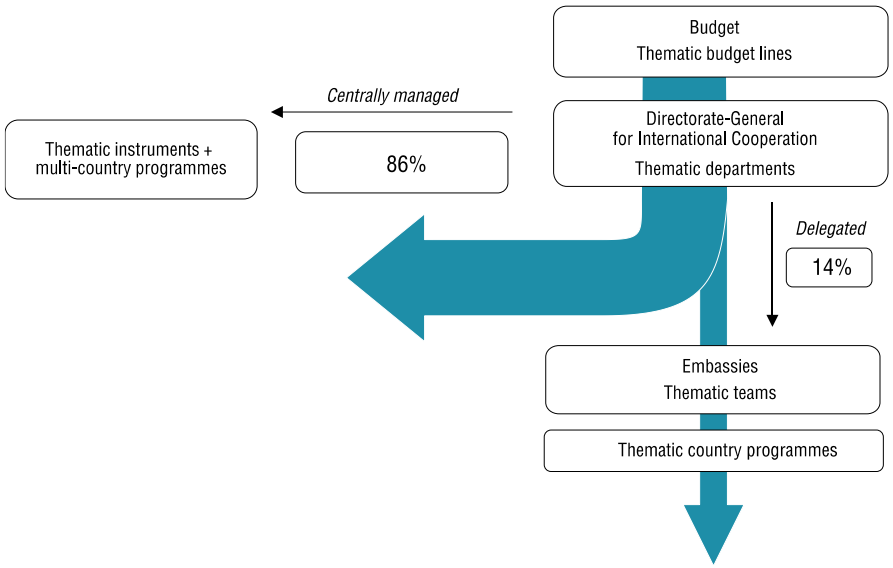
Figure 2.1. The Netherlands' development co-operation system



Source: authors' own design based on OECD (2023[6]), *OECD Development Co-operation Peer Reviews: Netherlands 2023*, https://doi.org/10.1787/67b0a326-en.

The Dutch development co-operation budget, programming and institutional set-up are organised thematically rather than geographically. Five thematic budget lines under the development co-operation and trade budget constitute a large portion of Dutch ODA, which is managed by the Directorate-General for International Cooperation (DGIS). ODA programming is highly centralised within the MFA, and thematic departments at headquarters decide on the bulk of programmes. Resources managed by embassies (delegated financing) represent only 14% of Dutch ODA (Figure 2.2) (OECD, 2023[6]).

Figure 2.2. Flow of development co-operation and trade budget to headquarters and embassies



Note: The thematic budget lines refer to four of the five the thematic budget articles that are managed by thematic departments within DGIS. These are peace, security and stability; sustainable economic development, trade and investment; sustainable development, food security, water and climate; and social progress. The fifth thematic budget article, strengthened frameworks for development, encompasses contributions to multilateral organisations.
Source: authors' own edit based on OECD (2023[6]), *OECD Development Co-operation Peer Reviews: Netherlands 2023*, https://doi.org/10.1787/67b0a326-en.

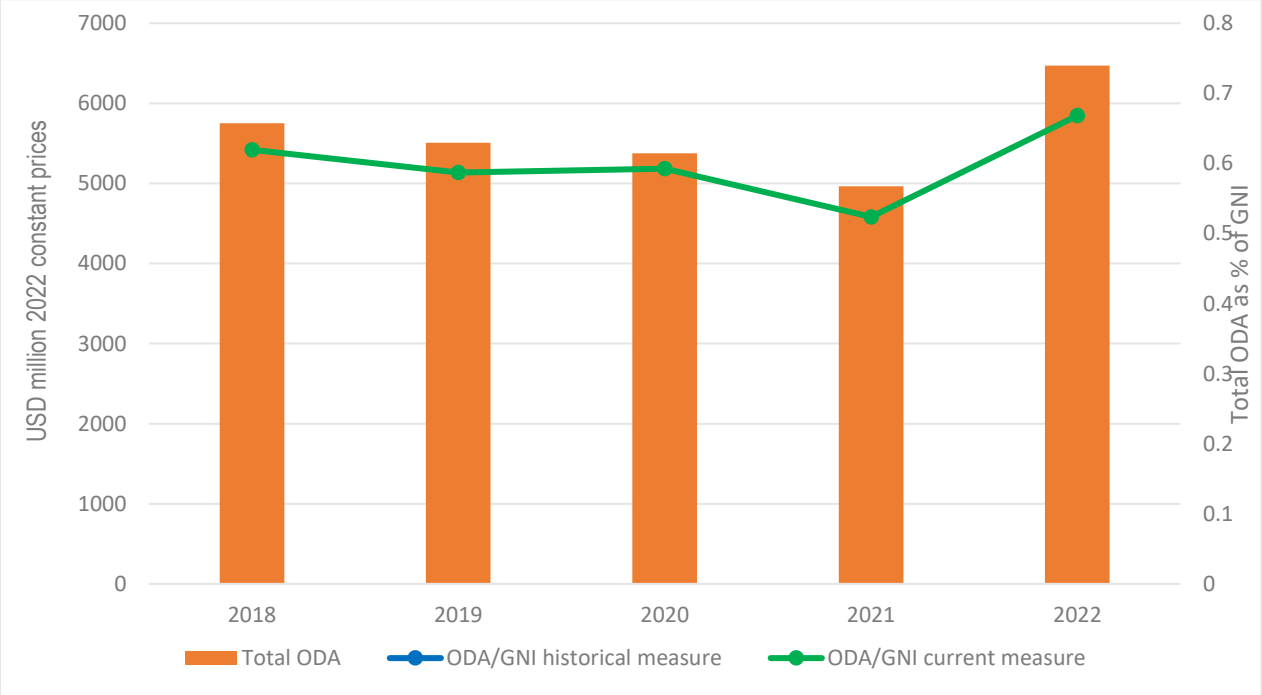
Dutch ODA has a maximum that is adjusted based on developments in GNI. While growth and decline in GNI are not directly reflected into the ODA budget lines, there is a buffer article that can mitigate GNI fluctuations and be used for additional allocations (House of Representatives of the Netherlands, 2023[7]; Advisory Council on International Affairs, 2024[8]). To complement this article in case of changing needs, the Netherlands uses an approach in exceptional circumstances whereby it effectively borrows money from future years through an administrative shift between the current and future budgets (i.e. a cash shift) to smooth fluctuations. Although useful to meet unexpected needs, this approach can prove problematic when several shocks occur at the same time or in quick succession (OECD, 2021[9]).

The recent Peer Review of the Netherlands (OECD, 2023[6]) and the OECD Development Co-operation Profile of the Netherlands (OECD, 2023[10]) provide detailed insights on the Netherlands' development co-operation policy and systems and on Dutch ODA.

2.3. ODA overview

In 2020, the Netherlands provided EUR 4.9 billion of ODA in total, representing 0.59% of its GNI. In 2021, total ODA decreased to EUR 4.4 billion, representing 0.52% of GNI. In 2022, total ODA amounted to EUR 6.5 billion, representing 0.67% of GNI (Figure 2.3). For consistency with other provider case studies, financial data for the years 2016-22 are used in this section. The data presented in Figure 2.3, however, are from 2018-22 because the calculations before 2018 were conducted using different methods, making comparison with the more recent years unrealistic.

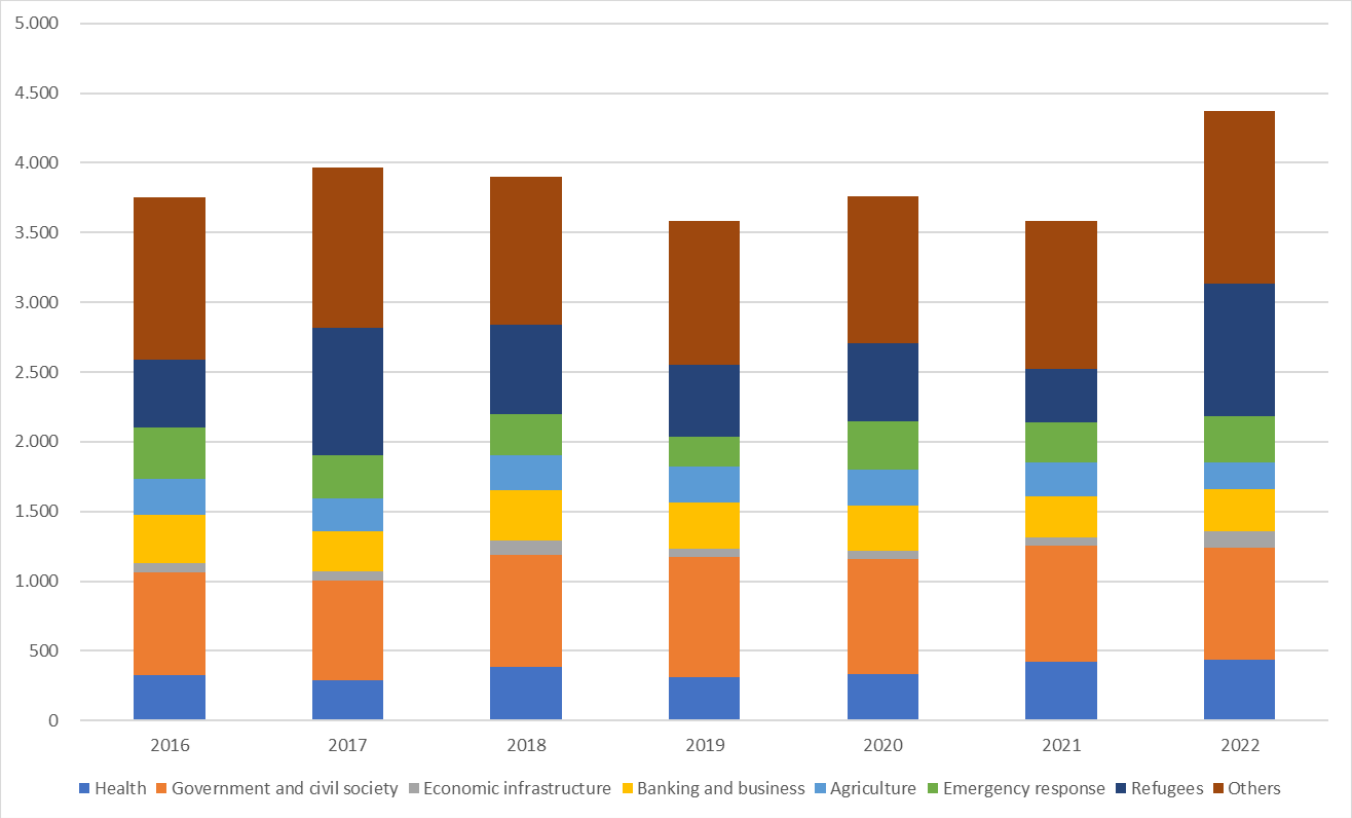
Figure 2.3. The Netherlands' total ODA as a percentage of GNI, 2018-22



Note: The figure shows total (grant equivalent) ODA contributions in USD millions, 2022 constant prices.
Source: OECD (2024[11]), *Creditor Reporting System (CRS)* (database), https://stats.oecd.org/Index.aspx?DataSetCode=crs1.

Between 2018-22, the Netherlands' bilateral ODA primarily targeted the government and civil society sectors as well as refugees within its own territory, although their shares of the total fluctuated significantly over the years. Furthermore, during the COVID-19 pandemic, ODA targeting the health sector, which had declined, surged again as health became one of the Netherlands' top priorities, particularly in 2020. Figure 2.4 depicts this shift.

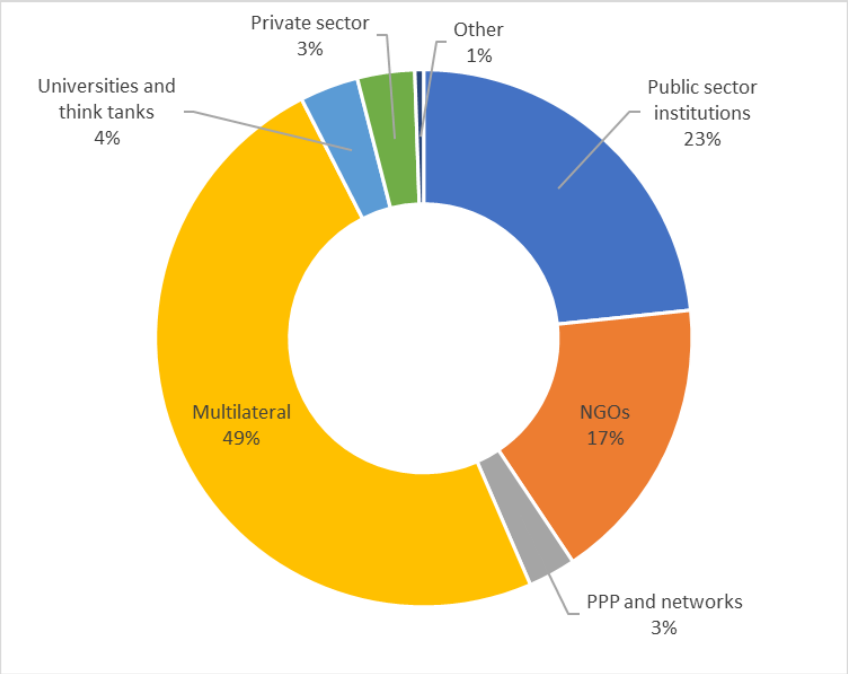
Figure 2.4. The Netherlands' ODA allocation by sector, 2016-22



Note: The figure shows the major sectors targeted over 2016-22 and disbursements in USD millions, 2022 prices. Allocations to "others", shown in brown, mainly refer to administrative costs.
Source: OECD (2024[11]), *Creditor Reporting System (CRS)* database, https://stats.oecd.org/Index.aspx?DataSetCode=crs1.

Apart from ODA channelled through multilateral organisations, funding primarily was allocated to the public sector and NGOs over 2016-22 (Figure 2.5).

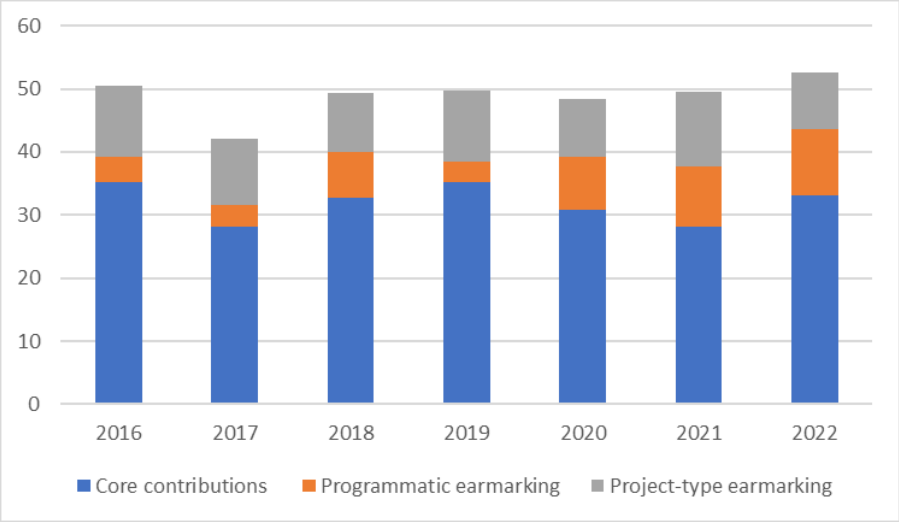
Figure 2.5. Total Netherlands ODA by channel, 2016-22



Note: The figure shows percentages of total (grant equivalent) ODA contributions in USD millions, 2022 prices. PPP = public-private partnerships.
Source: OECD (2024[11]), *Creditor Reporting System (CRS)* database, https://stats.oecd.org/Index.aspx?DataSetCode=crs1.

The Netherlands relies significantly on the multilateral system: between 2020-22, it channelled EUR 3 billion on average each year through multilateral partners. Between 2016-22, approximately half of total ODA was channelled to or through multilateral partners (Figure 2.6).

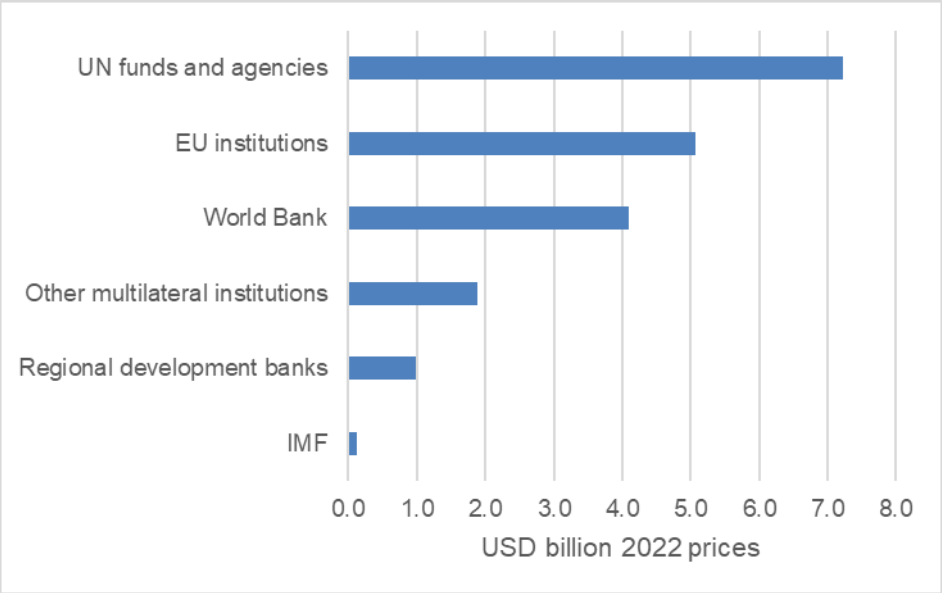
Figure 2.6. Netherlands' contributions to multilateral organisations as a share of total ODA, 2016-22



Note: The figure shows the percentages of total Dutch ODA channelled to or through multilateral organisations.
Source: OECD (2024[11]), *Creditor Reporting System* (CRS) database, https://stats.oecd.org/Index.aspx?DataSetCode=crs1.

Between 2016-22, the Netherlands' top multilateral partners were UN funds and agencies, followed by EU institutions and the World Bank (Figure 2.7)

Figure 2.7. Top multilateral recipients of the Netherlands' ODA, 2016-22



Note: Total (grant equivalent) ODA contributions in USD millions, 2022 prices. IMF = International Monetary Fund.
Source: OECD (2024[11]), Creditor Reporting System (CRS) database, https://stats.oecd.org/Index.aspx?DataSetCode=crs1.

3 The Netherlands' international COVID-19 response

3.1. Response overview

On 30 January 2020, the World Health Organization (WHO) declared COVID-19 a public health emergency of international concern, and on 11 March 2020, it declared COVID-19 a pandemic (World Health Organization, 2024[12]). The Netherlands' international response included development co-operation and humanitarian assistance, non-ODA resources to key multilateral organisations, in-kind assistance, and global advocacy for a holistic and equitable response.

Between 2020 and 2022, the Netherlands provided EUR 541 million to combat COVID-19 globally. In 2020, an initial EUR 265 million was allocated, followed by EUR 157 million in 2021 and EUR 119 million in 2022.[4] This assistance was additional to existing development and humanitarian aid and, according to official parliamentary documents, did not impact regular programming.

Beyond development co-operation and humanitarian assistance, the Netherlands contributed to the global COVID-19 response via various departments within the MFA as well as the Netherlands MoH. This involved non-ODA financing from the MoH; EUR 14 million supporting the WHO Strategic Preparedness and Response Plan[5] (SPRP); and EUR 50 million to the Coalition for Epidemic Preparedness Innovations (CEPI) for accelerated investments in COVID-19 vaccine development (House of Representatives of the Netherlands, 2020[13]; House of Representatives of the Netherlands, 2022[14]). Financial data received from the Dutch MFA show that the MFA's non-ODA assignments and subsidies to the pandemic response amounted to EUR 9 million over three years (Table 3.1).

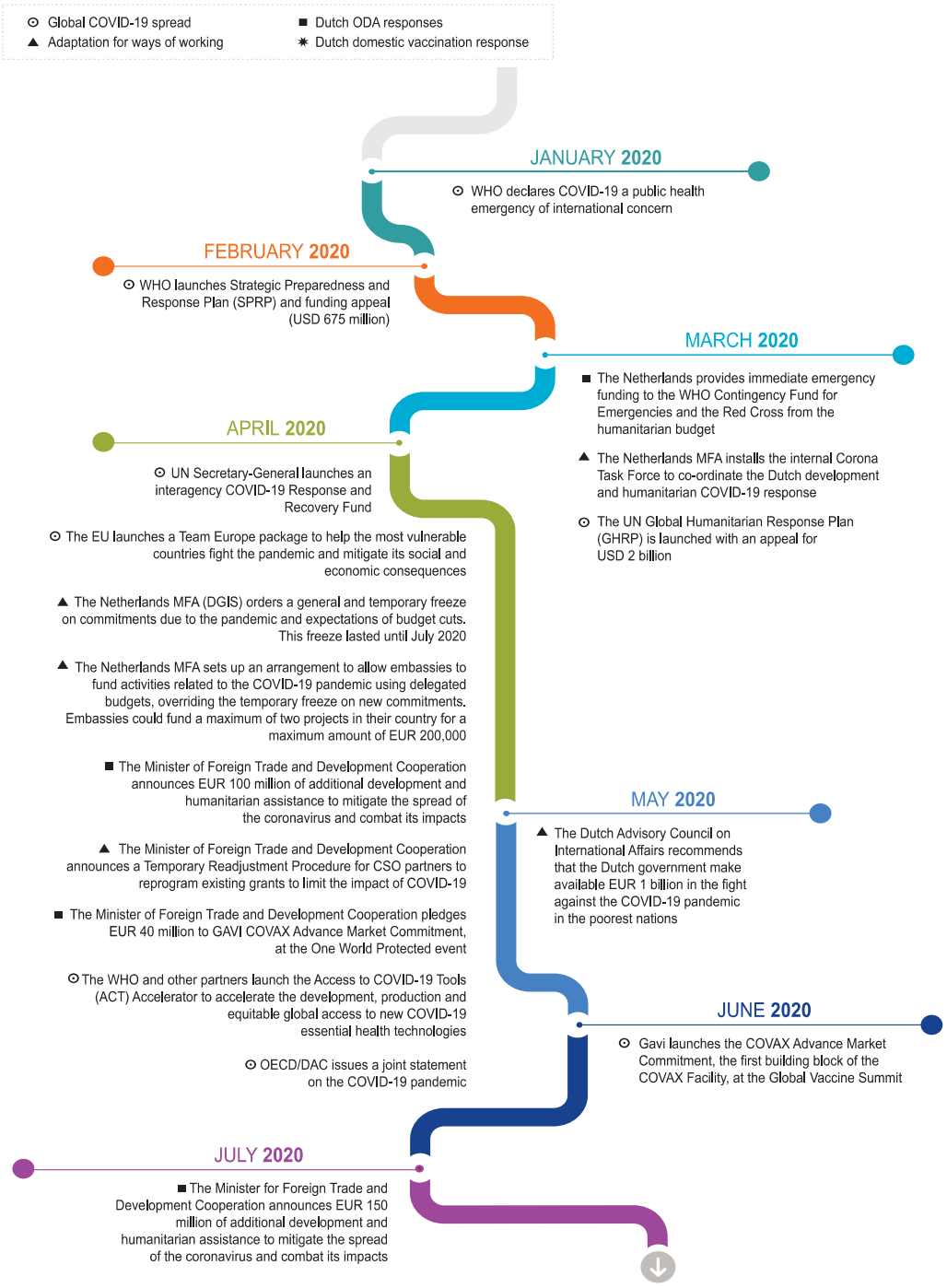
The Dutch MoH also introduced the Get One Give One initiative whereby the Netherlands strived to donate at least as many vaccine doses as it used domestically (House of Representatives of the Netherlands, 2021[15]). The MFA's preferred route for donating excess vaccines procured on the global market was through the COVID-19 Vaccines Global Access (COVAX) facility, operated through Gavi, the Vaccine Alliance[6] (Gavi). COVAX only accepted doses that the Netherlands had purchased but had not yet physically received. Doses that had already been delivered to the Netherlands and were at risk of not being utilised before expiration were donated bilaterally.

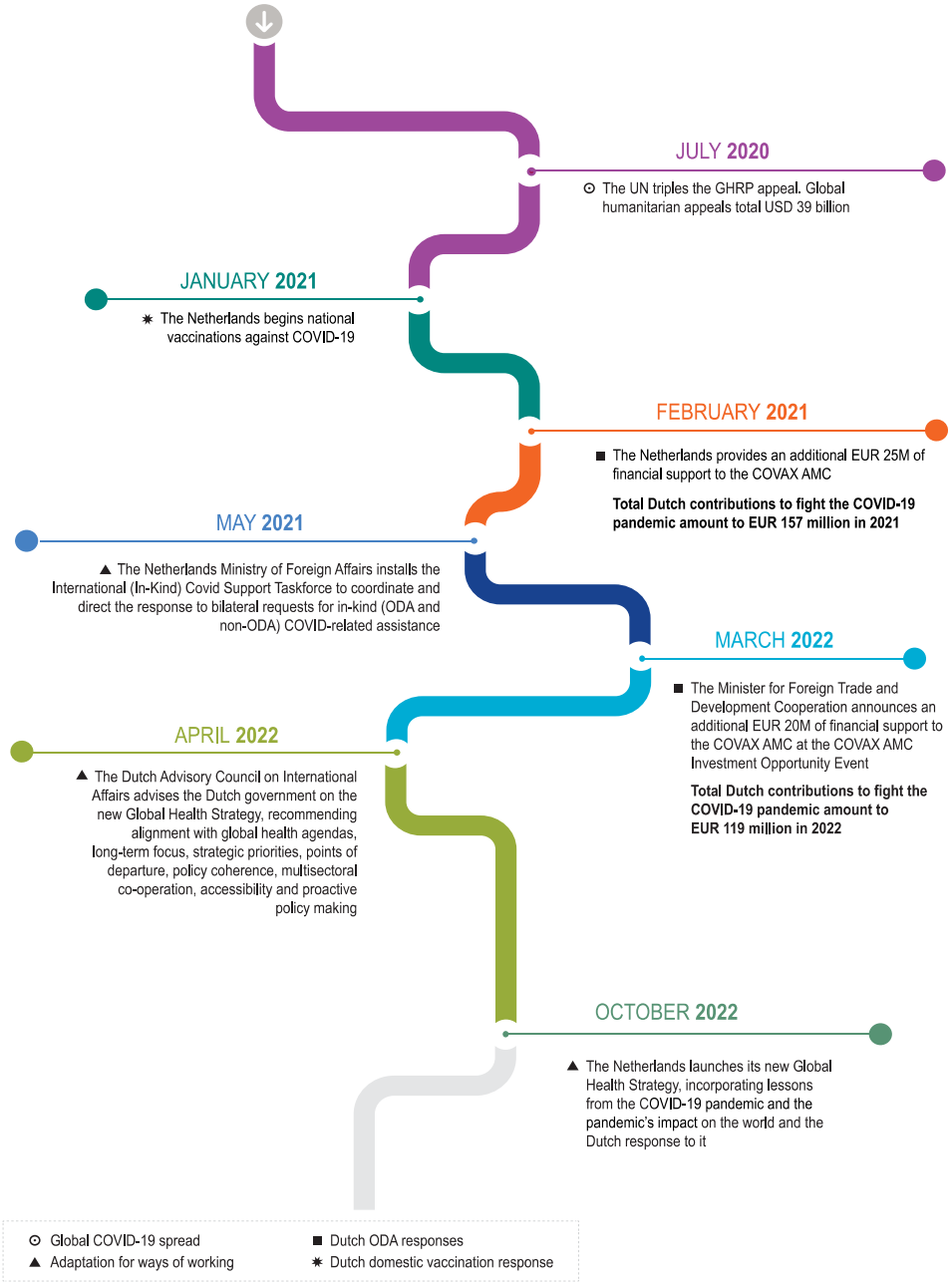
Although it received requests for COVID-19 assistance from several countries, including for instance in-kind donations of medication and personal protective equipment (PPE), the Netherlands maintained a position of responding to bilateral requests only in exceptional circumstances. Between 2020-22, in collaboration with other national ministries (the MoH and the ministries of Economic Affairs and Climate Policy, Justice and Security, and Defence), the Netherlands MFA donated COVID-19 vaccines to eight countries (Belize, Cabo Verde, Indonesia, Namibia, Nicaragua, Suriname, Ukraine and Viet Nam). By the end of December 2022, the Netherlands had donated a total of 22.5 million doses, of which 6.4 million had been donated bilaterally (Netherlands Court of Audit, 2024[16]). Finally, the Netherlands continued its advocacy for its priority topics such as mental health and psychosocial support (MHPSS) within the

humanitarian sector and coherence and alignment of responses within the EU, especially concerning COVID-19 vaccines.

A detailed timeline of the Netherlands' development and humanitarian response to the pandemic is depicted in Infographic 3.1.

Infographic 3.1. Timeline of the Dutch development and humanitarian response to the pandemic





Source: Authors based on data reviewed for this provider case study.

3.2. Objectives of the response

The Netherlands' COVID-19 response sought to achieve three objectives, according to the parliamentary letter of 10 July 2020 (House of Representatives of the Netherlands, 2020[17]).

The first objective (OBJ. 1) was to enhance prevention measures with the aim of mitigating the spread of the coronavirus and improving health outcomes. This involved facilitating better access to water, sanitation and hygiene (WASH) for local communities and governments and increasing testing capacities and vaccination research and development, especially for the most vulnerable countries and populations. Once vaccines were available, these became the primary method to curb the spread of the coronavirus globally. This objective also included responding to specific bilateral support requests for medical equipment, contributing to the North Atlantic Treaty Organization and supporting allies in need of COVID-19 protection.

The second objective (OBJ. 2) was to provide humanitarian assistance mainly through food aid for children and access to education. This included an emphasis on MHPSS and efforts to minimise the impact of COVID-19 on education in fragile contexts.

The third objective (OBJ. 3) was to increase socioeconomic resilience in low- and middle-income countries. This involved contributing to reducing shortages of food and medicine, strengthening social safety nets for the most vulnerable, mitigating job losses in micro, small and medium-sized enterprises (MSMEs), and supporting the continuity of public basic services through efforts focused on debt relief for vulnerable countries (House of Representatives of the Netherlands, 2020[17]).

In addition to these three initial objectives, the evaluation team extracted two additional objectives of the Dutch response. These objectives are corroborated by various documents and have been validated through interviews and triangulated financial data.

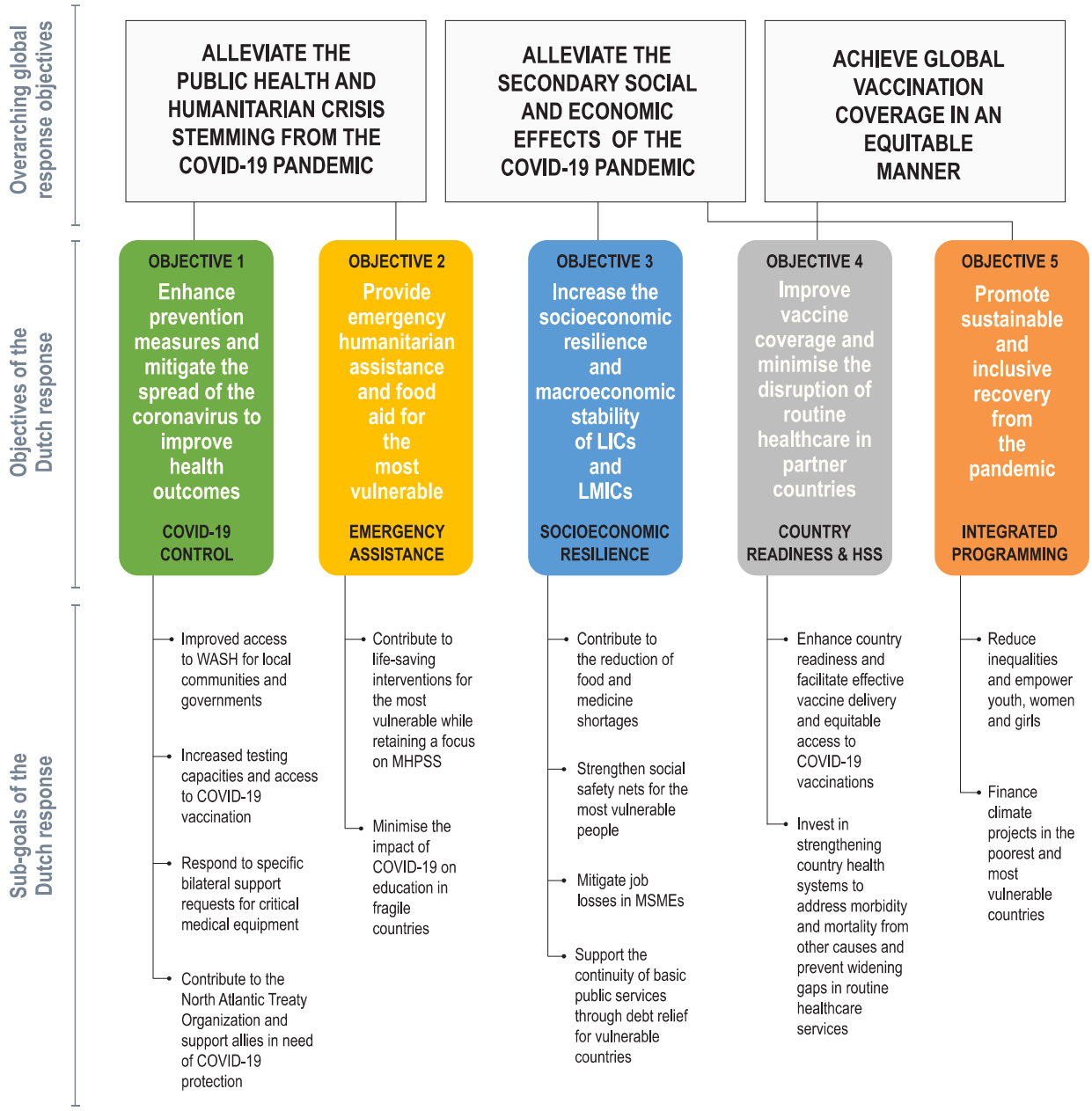
Thus, the fourth objective (OBJ. 4) of the response was to enhance country readiness and invest in strengthening country health systems to facilitate the rollouts of COVID-19 vaccination campaigns (once vaccines were available) and to minimise the disruption of essential healthcare in partner countries. Supplementary to OBJ. 1, this approach aimed to prevent healthcare services gaps from getting wider by addressing morbidity and mortality from other causes such as HIV/AIDS, tuberculosis and malaria and by maintaining a focus on sexual and reproductive health and rights (SRHR).

A fifth and final objective (OBJ. 5) emerged as the pandemic was progressing and the public health emergency showed signs of subsiding. The Dutch response evolved into promoting sustainable and inclusive recovery from the pandemic, with a focus on countering increases in inequality through empowering youth, women and girls and financing climate projects in the poorest and most vulnerable countries (House of Representatives of the Netherlands, 2020[13]).

Based on these five objectives as well as the underlying rationales and three overarching goals of the collective response to the COVID-19 pandemic (as described in the Strategic Joint Evaluation matrix), the evaluation team constructed an overview of the extracted objectives underpinning the Dutch response to the pandemic (Figure 3.1).

Additionally, in April 2020, the DAC issued a joint statement including commitments by members on the COVID-19 pandemic (OECD DAC, 2020[18]). These commitments were to mitigate the socioeconomic impact of the pandemic in poor and fragile contexts; address the immediate public health and humanitarian crisis; support civil society organisations (CSOs) in their role as key actors in tackling the pandemic and its consequences; protect ODA budgets and mobilise additional development funding that would be necessary for the response; and provide a strong, co-ordinated, inclusive and coherent development response.

Figure 3.1. Overview of the extracted objectives underpinning the Dutch response



Note: HSS = health systems strengthening.

Sources: Authors' elaboration based on House of Representatives of the Netherlands (2020[17]), "Bijlage Onderbouwing en Evaluatie van het voorstel (CW3.1)" [Attachment Substantiation and Evaluation of the proposal (CW3.1)], https://zoek.officielebekendmakingen.nl/blg-944804.pdf, and other data reviewed for this provider case study.

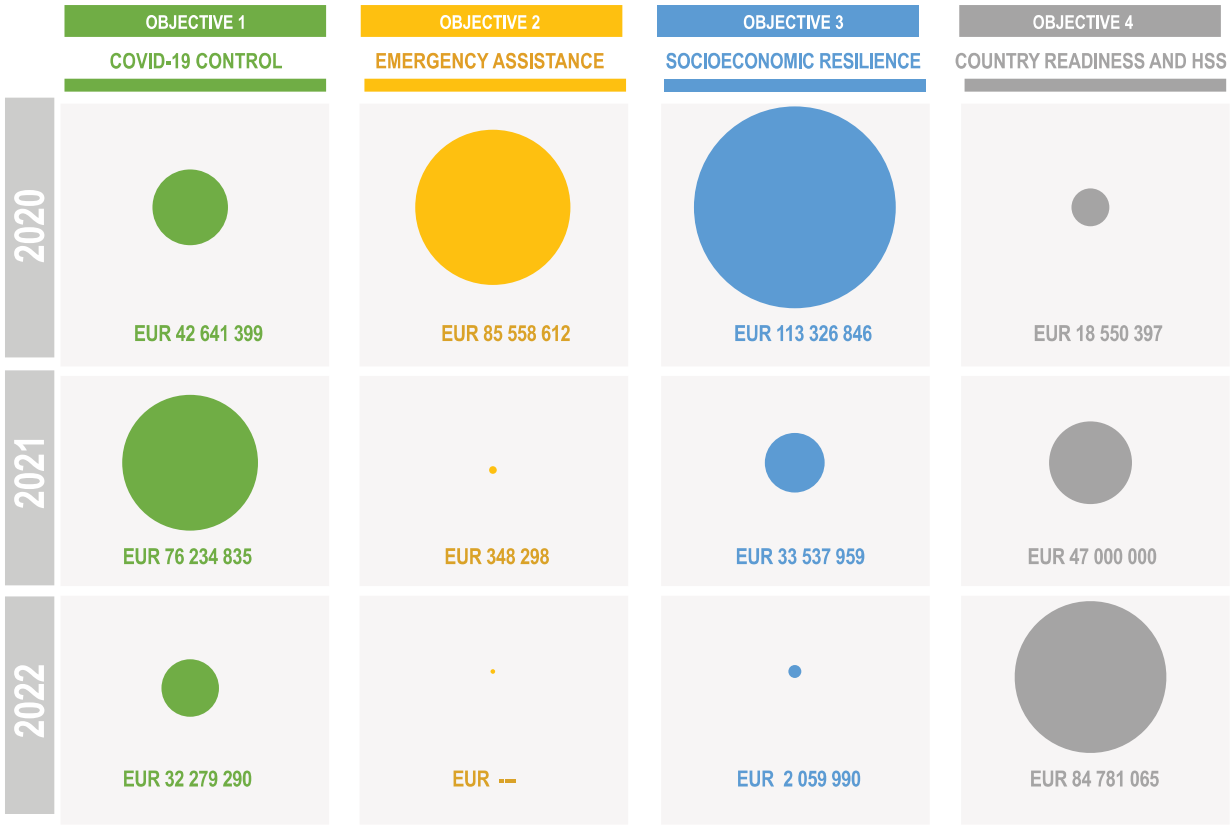
House of Representatives of the Netherlands (2020[13]), "Hulp, handel en investeringen; Brief regering; Kabinetsreactie op briefadvies nr. 34 'Nederland en de wereldwijde aanpak van COVID-19 van de AIV' [Government response to advisory letter 34, The Netherlands and the global approach to COVID-19]", Kamerstuk 33625, nr. 320, https://zoek.officielebekendmakingen.nl/kst-33625-320.pdf.

Minister for Foreign Trade and Development Cooperation (2021[19]), "Investeren in Perspectief; Brief regering; Impact COVID-19 op armoede en ongelijkheid [Investing in Global Prospects; Letter to Parliament; Impact COVID-19 on poverty and inequality], Kamerstuk 25 295, nr. 149, https://www.tweedekamer.nl/kamerstukken/detail?id=2021Z22660&did=2021D48064

3.3. Evolution of the Dutch COVID-19 aid package

The overview of extracted objectives allows for an overview of the Netherlands' COVID-19 aid package allocations, including an approximate financial allocation overview for four of the objectives (Figure 3.2). The fifth objective (promoting sustainable and inclusive recovery from the pandemic) is not included as it entailed integrated programming into ongoing programmes and allocations and had no specific financial allocations under the COVID-19 aid package. Figure 3.2 also illustrates the yearly evolution of the Dutch response, highlighting how the response adjusted to the shifting nature of the pandemic and corresponding global needs.

Figure 3.2. Overview of the Netherlands' COVID-19 aid package allocations by objective, 2020-22



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: Authors' calculations based on internal disbursement data provided by the MFA and its MIBZ database.

In 2020, much of the Netherlands' efforts were directed towards delivering emergency humanitarian aid (OBJ. 2) (Figure 3.2). These included supplements to the Central Emergency Response Fund (CERF), Country-based Pooled Funds (CBPFs) and the International Committee of the Red Cross (ICRC). Additionally, contributions were made to mitigate the pandemic's impact on education in fragile contexts through the Education Cannot Wait initiative. The Netherlands allocated funds to the International Monetary Fund's (IMF) Catastrophe Containment and Relief Trust (CCRT) and its Poverty Reduction and Growth Trust (PRGT) subsidy account; the Dutch Good Growth Fund (DGGF); the UN Secretary-General's COVID-19 Response and Recovery Trust Fund; and the COVID-19 Multi-Partner Trust Fund (MPTF) with

the aim of reinforcing socioeconomic resilience through debt relief in low- and middle-income countries (OBJ. 3). It also provided smaller supplements to ongoing initiatives such as the Health Insurance Fund established by PharmAccess. Prevention measures included contributions to improve access to WASH services, to the WHO Contingency Fund for Emergencies (CFE) and to expedite vaccine development by supporting the Foundation for Innovative New Diagnostics. The Netherlands also contributed to the WHO Access to COVID-19 Tools Accelerator (ACT-A) mechanism, providing 1.2% of the USD 24.2 billion mobilised for ACT-A between April 2020 and March 2023; the Netherlands' contribution amounted to 29% of its computed fair share[7] to ACT-A for the 2020-21 period (OBJ. 1). To expand country capacity to respond to the health emergency, the Netherlands invested in the WHO SPRP and the Global Financing Facility (GFF) (OBJ. 4).

In 2021, once the first vaccines were available, there was a shift in focus of Dutch COVID-19 aid allocation away from providing emergency humanitarian assistance and towards vaccines as the primary COVID-19 control approach (OBJ. 1). The COVAX Facility, operated through Gavi, received the largest share of funding under this objective. Also in 2021, the Netherlands increased investments in strengthening country readiness to ensure effective vaccine delivery while maintaining attention on other diseases such as HIV/AIDS, tuberculosis and malaria as well as on SRHR (OBJ. 4). Contributions to the GFF, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), and the WHO SPRP furthered the health systems strengthening and country readiness objective. The Netherlands sustained its commitment to supporting economic recovery and resilience in low- and middle-income countries by continuing investments in the IMF's CCRT and PRGT subsidy account in 2021 (OBJ. 3).

Finally, in 2022, the Netherlands maintained focus on furthering access to vaccinations through COVAX (OBJ. 1) and strengthening country health systems to ensure the widespread rollout of vaccines without neglecting other causes of morbidity and mortality (OBJ. 4). Gavi (COVAX), the GFF, the Global Fund and the SPRP remained the primary recipients of Dutch COVID-19 response funding.

The Netherlands' ambitions around COVID-19 control, equitable access to vaccines and country readiness (OBJ. 1 and OBJ. 4) warrant reflection on relevant global multilateral agreements – in particular, the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement among members of the World Trade Organization (WTO), introduced in Box 3.1. Though not a subject of primary research, Box 4.2 in Chapter 4 discusses lessons learned around TRIPS from the HIV/AIDS pandemic and the Dutch position on TRIPS during the COVID-19 pandemic, as these related to issues of coherence.

Box 3.1. International negotiations on Trade-Related Aspects of Intellectual Property Rights (TRIPS)

In October 2020, India and South Africa proposed a comprehensive waiver of copyright, patent, industrial design and undisclosed information provisions of the TRIPS Agreement. This waiver was to ensure that intellectual property rights do not hinder the timely availability of affordable medical products or the expansion of necessary research, development, manufacturing and supply to combat COVID-19. The TRIPS waiver was supported by 99 countries but faced opposition from the EU representing member states including the Netherlands, as well as the United Kingdom, United States and other WTO members (Kohler, Wong and Tailor, 2022[20]).

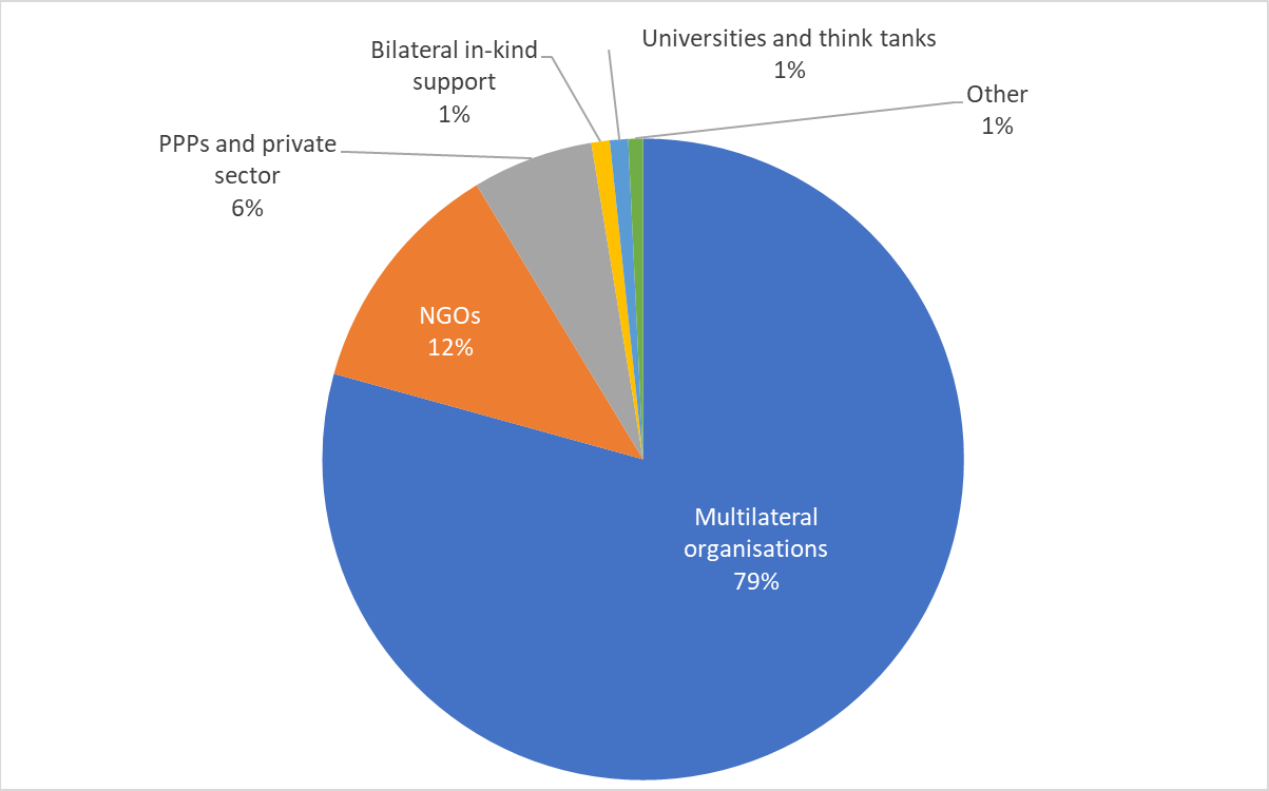
Negotiations on various TRIPS waiver proposals began in 2021 between the EU, India, South Africa and the United States at the ministerial and technical level. The final agreement, announced in 2022, differed from the original proposal by India and South Africa and was limited to patents on vaccines and the use of protected clinical trial data for regulatory approval (Amin and Kesselheim, 2022[21]).

Source: Kohler, Wong and Tailor (2022[20]), "Improving access to COVID-19 vaccines: An analysis of TRIPS waiver discourse among WTO members, civil society organizations, and pharmaceutical industry stakeholders", https://www.hhrjournal.org/wp-content/uploads/sites/2469/2022/12/kohler.pdf; Amin and Kesselheim (2022[21]), "A global intellectual property waiver is still needed to address the inequities of COVID-19 and future pandemic preparedness", https://journals.sagepub.com/doi/10.1177/00469580221124821.

3.4. Financial allocation overview of the Dutch COVID-19 aid package

The Netherlands channelled 79% of its total COVID-19 aid package through multilateral organisations. NGOs were the second-most utilised channel of delivery followed by the private sector and public-private partnerships (Figure 3.3). This was in line with its regular practice of channelling ODA primarily through multilateral organisations and NGOs, as illustrated in Figure 2.5. However, compared with the delivery channels for regular ODA over 2016-22, a significantly larger share of the COVID-19 aid was allocated to multilateral organisations (79% versus 49%) and a lower share was allocated to NGOs (12% versus 17%).

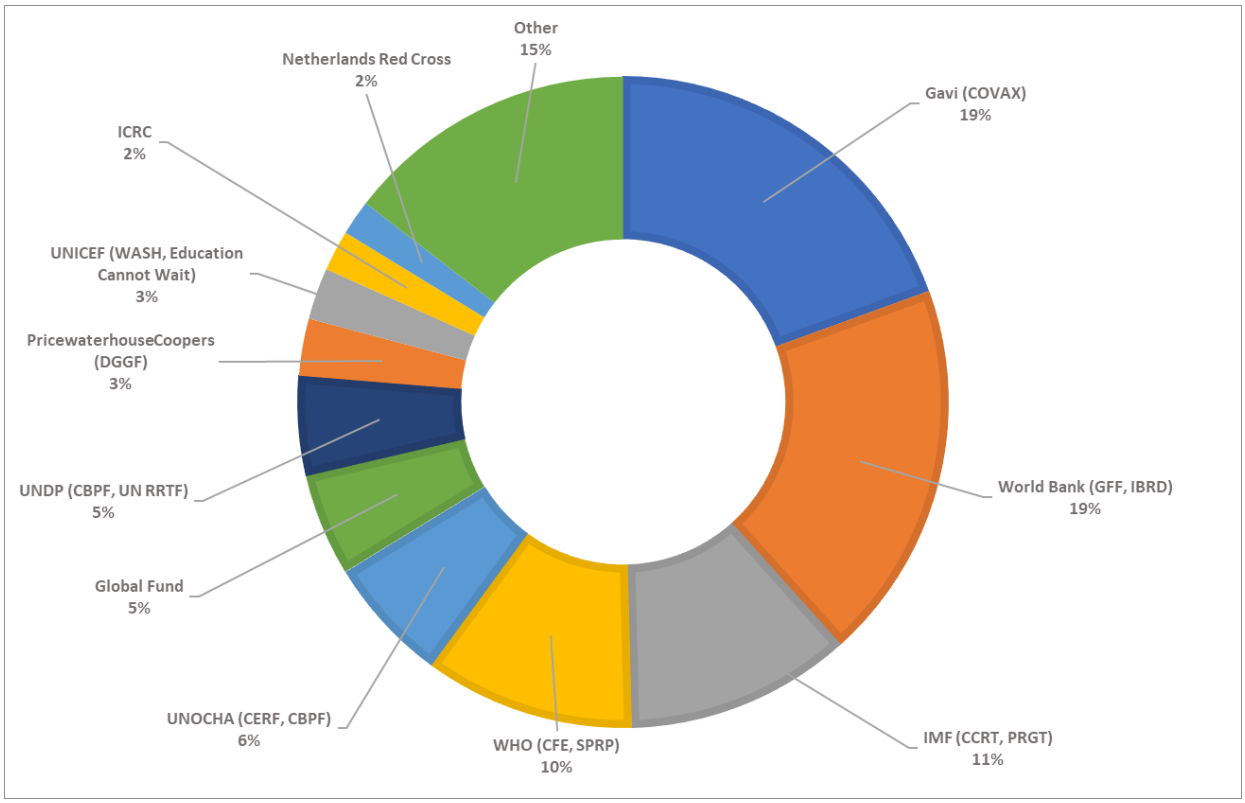
Figure 3.3. The Netherlands' COVID-19 aid package by channel



Note: The data 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. PPP = public-private partnerships.
Source: Authors' calculations based on internal disbursement data provided by the Dutch MFA and its MIBZ database.

Five organisations accounted for 82%, or EUR 358.78 million, of the Dutch COVID-19 aid package channelled through the multilateral system over 2020-22: Gavi (COVAX); the World Bank (GFF); the IMF (CCRT and PRGT); the WHO (SPRP); and the UN Office for the Coordination of Humanitarian Affairs (UNOCHA), which oversees the CERF (Figure 3.4). Moreover, 7 of the 11 largest recipients of the Netherlands' COVID-19 aid package were multilateral organisations, a further indication of its reliance on the multilateral system.

Figure 3.4. Top recipients of the Netherlands' COVID-19 aid package



Note: The data 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. UNICEF = United Nations Children's Fund; IBRD = International Bank for Reconstruction and Development.
Source: Authors' calculations based on internal disbursement data provided by the Dutch MFA and its MIBZ database.

The MFA's non-ODA contributions to the COVID-19 response amounted to EUR 9 million. Of this, EUR 8 million was allocated towards enhancing prevention measures by providing bilateral support and in-kind assistance (Table 3.1).

Table 3.1. MFA non-ODA contributions to fight COVID-19

Contributions to enhance prevention measures to mitigate the spread of the coronavirus and improve health outcomes (in EUR)	
COVID-19 aid to Greece	1 523 052
COVID-19 aid to Tunisia	807 199
COVID-19 aid to South Africa	745 588
COVID-19 aid to Iran	711 143
Procurement of COVID-19 testing kits	500 000
COVID-19 aid to Morocco	500 000
COVID-19 aid to Brazil	498 800
COVID-19 aid to Suriname	418 213
COVID-19 aid to Viet Nam	400 000
COVID-19 aid to Montenegro	321 000
COVID-19 aid to Sri Lanka	294 767
COVID-19 vaccinations to Indonesia	290 170
COVID-19 aid to Kosovo	250 000
COVID-19 aid to Armenia	207 113
COVID-19 aid to Moldova	200 000
COVID-19 aid to India	189 792
COVID-19 aid to Kyrgyzstan	100 000
COVID-19 aid to Romania	50 000
COVID-19 aid to Peru	50 000
COVID-19 aid for Roma communities	50 000
COVID-19 aid to Ukraine	39 425
COVID-19 vaccinations to Cabo Verde	35 379
COVID-19 PPE CIM Mover China (People's Republic of) and Montenegro	34 612
Meeting on counterterrorism post COVID	11 489
Contributions to provide emergency relief and food aid (in EUR)	
COVID-19 ICRC in Iraq	442 925
COVID-19 UN Women in Moldova	198 472
COVID-19 UNICEF in Kosovo	99 468

Note: The data 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.
Source: Authors' calculations based on internal disbursement data, provided by the Dutch MFA and its MIBZ database.

Approximately 10% of the Dutch ODA related to COVID-19 was allocated to specific countries, with the top ten recipients receiving nearly 91% of the country allocations. Another 5% of COVID-19-related ODA was allocated regionally, to Africa, and the remaining 85% was not specified geographically (Table 3.2).

Table 3.2. Geographical allocation of the Netherlands' COVID-19 aid package

Recipients	COVID-19-related ODA (in euros)
Ethiopia	15 297 381
Sudan	7 430 000
Mozambique	5 699 990
Yemen	5 600 000
Syrian Arab Republic	5 300 000
Suriname	4 101 316
Lebanon	3 838 555
South Sudan	1 531 922
Iraq	1 063 525
Somalia	1 000 000
Other countries	4 875 476
Regional allocation (Africa)	25 100 029
Unallocated	451 506 198
Total COVID-19-related ODA	532 344 392

Note: The data 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.
Source: Authors' calculations based on internal disbursement data provided by the Dutch MFA and its MIBZ database.

3.5. Up close: The Dutch bilateral support to Suriname

The Netherlands provided a relatively small amount of bilateral support to individual countries. This section focuses on an example of such support – to Suriname – and describes what this bilateral support entailed, the different stakeholders involved in this support and the factors that informed the decision-making processes. This up-close study, highlighting the bilateral assistance component of the Dutch COVID-19 response, supplements the overarching findings and conclusions. Chapter 4 presents the findings of this in-depth examination.

Context

Suriname and the Netherlands have a strong societal connectedness, with a large diaspora community in the Netherlands. In addition to their language, they also share a 300 year old intricate history, largely shaped by their colonial past (House of Representatives of the Netherlands, 2020[22]). Suriname gained independence from the Kingdom of the Netherlands in 1975. In 2022, Suriname had a population of about 600 000 people (World Bank, 2024[23]), and in that same year, about 362 000 people of Surinamese descent[8] lived in the Netherlands, indicating the large size of the diaspora community in the Netherlands (Central Bureau of Statistics, 2022[24]). While the two countries' bilateral relationship had been strained during Desi Bouterse's presidency from 2010-20, the election of a new government under President Chan Santhoki in July 2020 incentivised efforts in both countries to rebuild and strengthen bilateral ties (House of Representatives of the Netherlands, 2011[25]; House of Representatives of the Netherlands, 2020[22]; Government of the Netherlands, 2020[26]).

At the onset of the COVID-19 pandemic, Suriname faced several challenges in containing the spread of the virus. The Surinamese National Preparedness and Response Plan for COVID-19 identified three of these: protecting its hinterland, managing the potential spread of the virus during the May 2020 elections and monitoring its borders (Asin Oostburg, 2020[27]). The plan noted that Suriname's rapid response, young population and low population density were considered advantageous in combatting the virus. In the beginning of June 2020, however, the pandemic had a greater impact on Suriname than had been

anticipated in the response plan, which led the government to formally request assistance from the Netherlands. This support was granted.

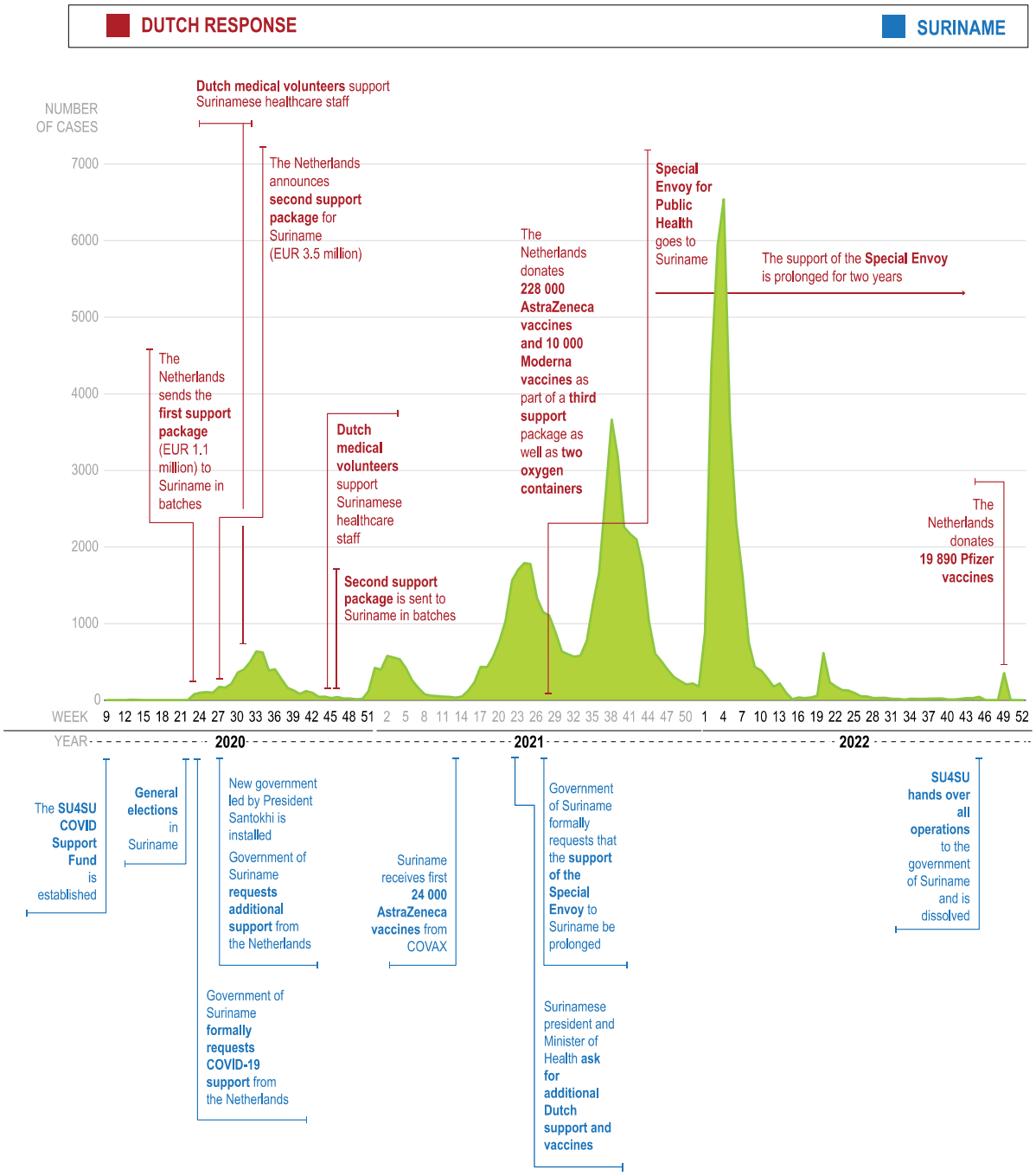
In interviews, Surinamese and Dutch representatives pointed to a lack of sufficient Surinamese government staff to co-ordinate external support during the electoral process and the government transition. At the same time, Suriname was facing an economic crisis that limited its ability to procure necessary medical supplies to respond to the pandemic (House of Representatives of the Netherlands, 2020[22]). The lack of staff and the implications of the economic crisis that the government had to deal with prompted a collective of private sector companies to establish the Surinamese for Suriname COVID support fund (SU4SU), which initially focused on financing the healthcare sector. The SU4SU later expanded its role, drawing on its logistics expertise and warehouse resources to complement Dutch assistance efforts in Suriname, according to internal documentation and interviews.[9]

Details of the Dutch response

In March 2020, while President Bouterse still led the Surinamese government, the Dutch embassy in Suriname shared concerns about the potential effects of the pandemic in the country with the Dutch MFA, seeking opportunities to support Suriname regardless of the challenging bilateral relationship. This request did not lead to Dutch support. In June 2020, following a surge in COVID-19 infections, the newly elected Surinamese government shared its first formal request for support from the Dutch government, underlining the heightened pressure on the healthcare system and listing required medical supplies (Asin Oostburg, 2020[27]). The government of the Netherlands approved this request. The political priority of strengthening bilateral ties, according to interviewees and internal documentation, was a key driver of the quick response. Other reasons for the approval were historical relations, the social connections that posed further risk of the virus spreading due to the intensive travel movement between the countries and humanitarian concerns. The initial support package, disbursed in June and July, included donations of medical products and PPE from the MFA and MoH, according to internal documentation.

Prior to this formal request from the Surinamese government, requests for technical support and donations had already been shared with Dutch colleagues through the SU4SU and through the Surinamese healthcare sector's personal and professional networks, according to interviews (Radboud University Medical Center, 2020[28]). Dutch hospitals sent volunteer medical staff – nurses, doctors and specialists – to Suriname on three-month rotations. The MFA facilitated these initiatives, covering travel and visa expenses, and the SU4SU contributed by paying for the medical volunteers' accommodations in Suriname, according to internal documentation and interviews. Concurrently, social solidarity between the Netherlands and Suriname manifested in various initiatives created by people of Surinamese descent and other Dutch citizens in the Netherlands, including a televised fundraising event (NOS Nieuws, 2020[29]). Figure 3.5 illustrates the progression of COVID-19 cases in Suriname alongside the timing of Dutch support initiatives.

Figure 3.5. Timeline of the Dutch response in Suriname



Note: The number of cases along the left axis in the top panel of the figure refers to the number of COVID-19 cases in Suriname. The progression of COVID-19 cases in Suriname is represented in green.
Source: Authors and Mathieu et al. (2020[30]), *Coronavirus (COVID-19) Cases* (database), https://ourworldindata.org/covid-cases; authors based on data reviewed for this case study

On 21 August 2020, the Netherlands MFA announced a second support package of EUR 3.5 million to combat COVID-19 in response to a request from the Surinamese government just eight days earlier. The contents of the package were determined based on a formal needs list from Surinamese authorities, advice

from medical experts and product availability and were fully financed by the Dutch MFA, according to internal documentation and interviews. Non-governmental actors in both countries – medical professionals and experts and private sector representatives from the SU4SU – were instrumental to determining needs and co-ordinating and distributing donations and technical assistance.

In March 2021, Suriname received 24 000 AstraZeneca vaccines from COVAX out of the 79 200 doses allocated (Pan American Health Organization, 2021[31]). In April of that year, Suriname requested the Netherlands to donate vaccines (Netherlands Court of Audit, 2024[16]). Interviewees representing both Dutch and Surinamese perspectives emphasised that the number of vaccines received via COVAX was insufficient and arrived in a fragmented manner. Suriname was unable to procure the remaining vaccines necessary, and despite donations from other countries, a gap persisted between available and required doses, a concern shared in internal communications within the Dutch MFA and between both countries.

Between May and June 2021, Suriname faced a third wave of COVID-19 cases, increasing the need for vaccines. During a visit to the Netherlands in June 2021, the Surinamese president and minister of health requested the Netherlands to donate additional vaccines. The Netherlands pledged to donate 600 000 vaccines in total, including AstraZeneca and Moderna vaccines, and these were partially delivered in the third batch of donations in June (Government of the Netherlands, 2021[32]; Netherlands Court of Audit, 2024[16]). Starting in July 2021, a Special Envoy from the MoH was deployed to Suriname for three months with the task of supporting the government of Suriname in co-ordinating the COVID-19 response and the vaccination campaign and strengthening the public health system.[10] The Special Envoy also advised the Dutch government on Suriname's health-related needs, according to interviews (Government of the Netherlands, 2021[33]). Additionally, the Netherlands Ministry of Defence, in collaboration with the MFA and the MoH, donated two oxygen containers to Suriname and sent five staff members who provided training for Surinamese medical staff to increase oxygen production capacity (Netherlands Ministry of Defence, 2021[34]).

In November 2021, the general Dutch stance was to direct countries that requested vaccine donations to COVAX. However, the Netherlands' donations to Suriname continued, justified in part to the parliament by the need to protect the Dutch population from COVID-19 in light of the intensive travel movement between the two countries due to their strong societal connectedness (Ministry of Health, Welfare and Sport; Minister for Foreign Trade and Development Cooperation, 2021[35]; House of Representatives of the Netherlands, 2021[15]). Internal documents stressed the importance of follow-up donations to maximise the effectiveness of the first batches of support to Suriname. Due to the risk of AstraZeneca vaccines in the Netherlands expiring, the Netherlands had donated vaccines to four countries including Suriname by December 2021 (House of Representatives of the Netherlands, 2022[36]).

At the end of the three-month assistance period of the Special Envoy, the Surinamese president requested the Netherlands to extend the Special Envoy's role in implementing the pandemic response plan and strengthening the healthcare sector. This request was granted, and the Special Envoy continued his work until the end of 2023.[11] Throughout his tenure, the Special Envoy played an important role in Dutch assistance, providing updates on the national situation and identifying needs for vaccines and medical supplies, according to internal documentation and communications. In December 2022, the Netherlands donated 19 890 Pfizer vaccines to Suriname, bringing the total bilateral vaccine donations to Suriname to 257 890 (Netherlands Court of Audit, 2024[16]), well below the pledged amount (Ministry of Health of Suriname, 2022[37]). In its audit of vaccine procurement, the Netherlands Court of Audit (2024[16]) noted this discrepancy without identifying its cause.

4 Findings

This chapter discusses the findings of this study related to the research questions on the relevance, coherence, efficiency and effectiveness of the total Dutch development and humanitarian response to the COVID-19 pandemic between 2020-22 and outlines the evidence and analysis behind each finding. It also presents the findings for each of the research questions on the Netherlands' bilateral pandemic support to Suriname.

4.1. Relevance of the Dutch development and humanitarian COVID-19 response

This section presents the findings regarding the research question on relevance: *To what extent did Dutch COVID-19 support meet partner needs and priorities?* It explores the extent to which the entire Dutch humanitarian and development response to the COVID-19 pandemic aligned with global needs and priorities and what considerations informed this response. It also reflects on the findings of the up-close study on the Netherlands' bilateral pandemic support to Suriname.

The Netherlands' COVID-19 aid package was aligned with global needs and priorities. It adapted to the shifting nature of the pandemic, reflecting changing needs and the evolving impacts on countries.

The global impact of the COVID-19 pandemic was widespread and left no country unaffected. Immediate health-related effects included high mortality rates worldwide and significant strains on healthcare systems. The pandemic also resulted in economic contractions and substantial loss of employment and income-generating activities globally. Beyond these primary effects, the pandemic had far-reaching secondary impacts on macroeconomic stability, education, gender-based violence, food security, conflict and fragility. These consequences led to setbacks in progress towards achieving the Sustainable Development Goals, plunging millions into extreme poverty and exacerbating existing inequalities (Yuan et al., 2023[38]).

As detailed in Chapter 3, the Dutch COVID-19 response targeted the pandemic's impacts through interventions to prevent the spread of the coronavirus including by providing humanitarian assistance, reinforcing country health systems to sustain essential healthcare, and supporting effective vaccination rollouts and socioeconomic resilience. Figure 3.2 illustrates the Netherlands' investment prioritisation and how the response evolved over the three-year period, which together show that the response aligned with global needs.

Bilateral in-kind assistance was provided to several countries to address the impacts of the pandemic. This included technical assistance, medicines, PPE and COVID-19 vaccinations. Although part of it was financed through non-ODA sources, the in-kind assistance highlights how the Netherlands responded to specific and emerging[12] needs and priorities. The Netherlands' support to Suriname, elaborated in the up-close study in section Up close: The Dutch bilateral support to Suriname, further illustrates how the Dutch assistance responded to requests and was largely contextually relevant. Relevant findings are discussed in the up-close look at Suriname in this section.

While the Dutch COVID-19 response was partly shaped by explicit articulations of needs and secondary assessments of evolving priorities, political and practical considerations also played a part.

The Netherlands delivered the bulk of its COVID-19 response through the multilateral channel. Interviews with involved policy officers revealed that these decisions and funding allocations were primarily informed by needs assessments by key multilateral organisations. The MFA relied on research by these institutions, whose extensive in-country presence was a source of valuable information. These data also underpinned the various multilateral appeals for funding that the Netherlands explicitly responded to (per internal documentation).

According to interviews with MFA policy officers and Dutch NGOs, the MFA also consulted NGOs to ascertain the impact of the pandemic on their operations and on their partners. For instance, the most pressing needs of NGOs were to have both the flexibility to adapt pre-determined budgets to respond to the impacts of the pandemic and more time to close ongoing programmes. Where requested, the MFA granted no-cost extensions to CSOs implementing existing programmes and through the MFA's temporary readjustment procedure (Box 4.3), which enabled a high degree of flexibility in the NGO response. The Netherlands also relied on its embassies and missions abroad – its eyes and ears on the ground – for insights into countries' needs and priorities related to healthcare infrastructure, supply shortages and vaccine readiness.

However, Dutch support was not entirely needs driven. Interviews and internal communications suggest that political and practical considerations were strong drivers of the direction of the response. Political considerations specifically influenced two areas: which countries received exceptional bilateral vaccine donations and the prioritisation of COVAX once the first COVID-19 vaccines became available. Practical considerations included staff capacity and know-how, institutional arrangements, and financial constraints. Finally, the extent to which lessons from previous health crises and programming informed the response remains unclear. Some policy officers mentioned that they used lessons they remembered from other epidemics (such as HIV/AIDS and Ebola) in their advising role to the political level but that their advice was not always followed. No formalised lessons were found, and not formalising these lessons also shows that institutionalisation of this knowledge is lacking.

Although it did so during the COVID-19 crisis, the Netherlands MFA does not usually provide in-kind development or humanitarian assistance. The ministry instead generally relies on channelling ODA through the multilateral system and NGOs. Interviews and internal data show that in consequence, there was limited staff and logistical capacity to deliver this bilateral in-kind assistance during the COVID-19 response, leading to challenges that are further discussed in section 4.4 on the effectiveness of the Dutch development and humanitarian COVID-19 response. Additionally, a study by the Netherlands Court of Audit (2024[16]) found that in tripartite agreements concerning vaccine donations between the recipient country, the Netherlands MoH and the MFA, the MFA was required to finance significant parts of the arrangement – something the MFA had not been intending to do. Interviewees said there were challenges around executing these agreements, citing high transaction costs[13] and financial requirements as leading causes of friction. These practical considerations acted as further impetus for the Netherlands to channel much of the COVID-19 support through trusted multilateral partners, where such systems were well established. (This is discussed further in section 4.3 on the efficiency of the Dutch COVID-19 response.)

The Netherlands donated COVID-19 vaccinations to Indonesia and Suriname bilaterally due to both countries' historical and current political and societal ties with the Netherlands. Domestic political and media pressure influenced the Netherlands' decision to bilaterally donate vaccines to Namibia (Box 4.1). Practical limitations around donating surplus vaccines through COVAX[14] and the urgency of avoiding vaccine expirations and wastage, explored further in the up-close discussion of Suriname in this section,

also played a part in these decisions. Nonetheless, the Dutch response mostly aligned with global needs despite the underlying political and practical incentives and can therefore be considered relevant.

While officially the Netherlands funded COVAX in order to contribute to global herd immunity and for vaccine equity reasons, interviewees and internal communications indicate that high political prioritisation and visibility were also reasons for this funding. Prioritising support for health systems, preventing disruptions in critical healthcare services including maternal and childcare, and managing diseases were recognised as key functions of development finance during the pandemic (OECD, 2020[39]). MFA policy officers reported navigating situations where their advice around retaining such a holistic health response was given less importance at political levels than vaccine-related support. Some policy officers suggested that vaccines presented the Dutch government with a tangible way to channel its COVID-19 response package, serving as an easy solution to a complex problem. Funding allocations confirm the prioritisation of COVAX. However, the more visible and politicised bilateral donations remained limited to eight countries. MFA policy officers mentioned that they needed to internally advocate for a holistic health response with high-level policy makers to secure such a focus and that the efforts were ultimately successful.

Up close: Relevance of Dutch support to Suriname

The bilateral support provided to Suriname responded to the country's needs to combat the direct effects of the COVID-19 pandemic. Therefore, the Dutch bilateral response in Suriname can be considered relevant overall. Nevertheless, the study did find some issues that limited its relevance somewhat.

The support was tailored to formal requests from the Surinamese government, including lists of necessary supplies, as well as to requests from the Surinamese medical sector. The work of the Special Envoy from July 2021 onwards helped align Dutch support to Suriname's situation, needs and priorities, enhancing the relevance of this support. However, internal documentation and interviews with MFA and MoH staff show that other Dutch political considerations – such as the risk of vaccine expiration, strengthening bilateral ties and societal connectedness – had a stronger influence on decision making than did the urgent needs in Suriname. Nonetheless, given the absence of monitoring, this study cannot determine if the Dutch support reached end users, such as vulnerable groups, and if so, which ones. Nor could it determine whether the Dutch support promoted equitable access to vaccines and medical supplies within Suriname. Staff from the Dutch MFA and MoH indicated that the imperative to promote equitable access and reach vulnerable populations did not drive decision making regarding bilateral donations to Suriname and other countries.

Box 4.1. Bilateral vaccine donations to Namibia

The Netherlands donated 75 000 COVID-19 vaccinations to Namibia on 6 August 2021 (Government of the Netherlands, 2021[40]), although the Dutch government had not initially designated Namibia as a potential recipient. Media and domestic pressures influenced the pandemic response.

As early as 2020, the Netherlands procured excess vaccinations as part of agreements reached with vaccine manufacturers. These doses were purchased with the understanding, at the time contracts were signed, that in case of a surplus, doses would be donated to countries facing vaccine shortages, although the channels for donating these supplies had not yet been determined. As the domestic vaccination campaign in the Netherlands gained momentum, concerns around the AstraZeneca vaccine's lower rate of efficacy reduced demand for it, resulting in a surplus. General practitioners around the country reported that large numbers of unutilised doses of AstraZeneca were about to expire in their own stocks while developing countries were facing acute shortages (RTL Nieuws, 2021[41]).

Two doctors brought significant media attention to the issue (NRC, 2021[42]) and initiated a lobbying campaign aimed at the Dutch MoH, leveraging their personal connections with Namibian authorities. The MoH noted serious challenges in the doctors' proposed solution, which included Dutch doses being shipped to and administered in Namibia. Due to pressing shortages, Namibia was reportedly willing to accept donations, including vaccinations in packaging that had already been opened in the Netherlands (NRC, 2021[43]). This solution potentially posed health risks to people getting vaccinated and subsequent legal risks for the Netherlands.

Eventually, the MoH decided on a one-time donation of 75 000 doses from its own stock of unopened vaccines that had not yet been distributed to medical practitioners in the Netherlands. This support was relevant considering that Namibia had the highest infection and death rate in Africa at the time (NRC, 2021[43]). However, the decision was driven by public and media pressure and not by an explicit bilateral request for support or a needs assessment.

Source: Government of the Netherlands (2021[40]), "75.000 vaccines naar Namibie [75.000 vaccines to Namibia]", https://www.rijksoverheid.nl/actueel/nieuws/2021/08/06/75.000-vaccins-naar-namibie; RTL Nieuws (2021[41]), "Haagse huisarts prikt met Nederlandse restvaccins in Namibië: 'Mensen zijn dolblij' [General practitioner from the Hague administers Dutch remaining vaccines in Namibia: 'People are overjoyed'], https://www.rtl.nl/nieuws/buitenland/artikel/5248103/nederlandse-huisarts-namibie-astrazeneca-vaccins-prikken; NRC (2021[42]), "Artsen boos omdat vaccins worden vernietigd [Doctors angry because vaccines are being destroyed]", https://www.nrc.nl/nieuws/2021/08/25/artsen-boos-omdat-vaccins-worden-vernietigd-a4056016; NRC (2021[43]), "Hoe 75000 Nederlandse coronavaccins naar Namibie kwamen [How 75,000 Dutch corona vaccines came to Namibia]", https://www.nrc.nl/nieuws/2021/11/05/hoe-75000-nederlandse-coronavaccins-naar-namibie-kwamen-a4064417?t=1706524345.

4.2. Coherence of the Dutch development and humanitarian COVID-19 response

This section presents the findings related to the research question on coherence: *To what extent did the Dutch response align internally and with other actors to ensure coherent approaches globally?* It describes the extent to which aspects of the Dutch COVID-19 response were coherent with other interventions and objectives of the Dutch government in response to the pandemic (internal coherence) and with the responses of partner country governments and those of other donors (external coherence). The section also discusses how the Netherlands' response was co-ordinated within and across the separate departments and ministries of the Dutch government.

The Dutch MFA established internal co-ordination structures, among them the Corona Task Force (CTF) and the International (In-Kind) COVID Support Task Force (ICST), that contributed to co-ordinated external communications and a coherent approach across the response. Overall, interviewees stated that co-operation at the technical level was conducive to coherence, although lack of clarity around the channels of communication led to an increased workload for MFA staff.

The Dutch humanitarian and development response to COVID-19 required interministerial co-ordination (mainly in the case of bilateral donations) in addition to extensive co-ordination between many different departments within the MFA.[15] The two distinct co-ordination structures established within the MFA to co-ordinate the response, the CTF and the ICST, had different mandates, with the ICST handling requests regarding non-ODA support such as in-kind donations. MoH officials said they occasionally found that it was unclear when the CTF was leading, when specific MFA departments took over and how the CTF mandate differed from that of the ICST, which resulted in confusion over which communication channels to follow and whom to contact. However, several interviewees from the departments and from NGOs mentioned that while there were some challenges, overall the interministerial co-ordination and co-operation were good.

Corona Task Force

The CTF at the MFA, set up in March 2020 with an initial focus on Africa, was the primary task force responsible for co-ordinating the Netherlands' development and humanitarian response to the pandemic. The CTF was established at the request of the minister for BHOS and involved ten departments[16] within the MFA. It served as the primary point of contact for the minister for BHOS and the director-general or the deputy of the DGIS and held meetings to discuss progress.

The CTF played a crucial advisory role for the minister and other MFA officials. It functioned as a central hub within the MFA, ensuring a timely flow of information on relevant developments, donor reactions, security implications, and spillover effects on priority topics such as migration, climate change and gender equality. The responsibilities of the task force included drafting weekly situation reports on COVID-19 that covered virus development, economic impact, multilateral activities, and implications for Dutch development and humanitarian initiatives. Additionally, the CTF assessed COVID-19-related funding requests and co-ordinated with UN agencies, the EU and NGOs. The CTF also facilitated parliamentary communications and served as a so-called linking pin between departments, embassies and missions abroad, and international organisations.

While the CTF played an essential role in internal co-ordination at the MFA, MoH officials noted that changes in its scope of responsibilities sometimes caused confusion – for example when there were delays in involving the right individuals, which resulted in reduced time for task completion.

International (In-Kind) COVID Support Task Force

In May 2021, 14 months after the CTF was established, the MFA set up the ICST in recognition that bilateral in-kind support was not yet centrally co-ordinated and in anticipation of increased bilateral vaccine donations resulting from a national surplus. The ICST managed ODA and non-ODA support. The MoH supplemented this task force's budget mainly through in-kind donations. The ICST, led by a co-ordinator, was responsible for interministerial[17] co-ordination of the bilateral support and conducted practical assessments. The ICST was comprised of representatives from thematic[18] and regional departments within the MFA, which promoted synergies among three directors-general within the MFA.[19]

The ICST also was responsible for advising the BHOS minister and the minister of foreign affairs on in-kind donations in response to bilateral requests for support. It used an assessment framework to determine which countries would exceptionally receive support from the Netherlands via bilateral channels. It is important to note that in almost all cases, the use of the assessment framework to determine responses

to bilateral requests for support ended in the denial of countries' requests and their referral to multilateral organisations. In cases where the Netherlands honoured a request, the ICST facilitated implementation in collaboration with relevant ministries. According to interviewees who were part of the ICST, their responsibilities as ICST members also included co-ordination with global initiatives such as ACT-A and COVAX to promote complementarity and alignment with international processes. However, interview data collected in the course of following up on this point regarding bilateral donations were contradictory, and no evidence of co-ordination was found. Once a country's request for support was granted, the regional departments then took the lead, serving as the primary point of contact for other ministries, the Dutch embassy and the counterparts. The regional departments were also responsible for the practical organisation of the support.

As was the case for the CTF, interviewees from other ministries faced difficulties in determining the appropriate communication channels at the ICST for bilateral vaccine donations. The MFA and MoH received separate requests for specific support and were responsible for donating products they owned, such as vaccines procured by the MoH and medication and PPE procured by the MFA. The MFA was responsible for the budget needed for transportation, while the ICST managed formal processing and logistics unless specific departments were in the lead, as was the case for Suriname. These difficulties in determining the appropriate communication channels occasionally increased work pressure on MFA policy officers, especially when decisions by other departments required rapid organisation of in-kind support facilitation.

External coherence

The decision to primarily support multilateral organisations contributed to external coherence. In the cases where the Netherlands donated vaccines bilaterally, however, no evidence was found of co-ordination with other donors.

One of the main considerations behind the decision to primarily work through multilateral organisations in the response to COVID-19 was to ensure a co-ordinated and coherent response aligned with the response of the international community. The minister for BHOS also emphasised this point in conversations with the WHO, the EU, the UN and financial organisations (House of Representatives of the Netherlands, 2020[13]). The Dutch response aimed to safeguard international co-ordination, and thus external coherence, through this strategy rather than by setting up bilateral initiatives that would require additional co-ordination to ensure alignment and coherence (per interview data, internal documentation and communications).

For the bilateral donations, the team found no evidence of Dutch policy officers co-ordinating the donations with other donors. The up-close look at Suriname touches on external coherence and also concludes that there was a lack of co-ordination with other donors regarding donations. On the other hand, there was co-ordination with Surinamese partners as well as with the Surinamese government. In-country co-ordination was left to the Surinamese government.

Internal coherence

Overall, the Dutch international COVID-19 response was internally coherent. However, political ad hoc decision making regarding bilateral vaccine donations in at least four of the eight countries that received donations was not based on equity principles. It should be noted that this contrasted with the decision to support multilateral initiatives such as COVAX, which was based on the principle of equity. In addition, prioritising the procurement of excess amounts of vaccines for the Dutch domestic vaccination campaigns while supplies for the global market were scarce was inconsistent with the Netherlands' stated objective of increasing equitable access to vaccines.

The two main task forces each had a distinct mission, although there was some overlap. The ICST aimed to promote internal coherence in Dutch foreign policy and as noted, served as a central hub for bilateral support requests, a role it took over from the CTF. MFA policy officers viewed both of these task forces as key contributors to internal coherence, which the evaluation team considered to be good, thanks to this co-ordinated approach. Furthermore, the objectives of the Dutch humanitarian and development response to COVID-19 were well aligned, and the team found no inconsistencies between them. However, a degree of lack of coherence was found between the Dutch national response and the humanitarian and development response.

While there were differences between the two involved ministries in terms of political priorities, particularly regarding vaccine donations, these did not result in a lack of internal coherence within the Dutch bilateral support to Suriname (see Up close: Relevance of Dutch support to Suriname). But they also did not contribute to the objective of increasing equitable access to vaccines. Initially, the MoH prioritised protecting the Dutch population from COVID-19 by focusing on the domestic response but later also acknowledged the national (health) security interest of the Netherlands in global immunisation. This was one of the arguments that led to bilateral vaccine donations once the Netherlands had surplus vaccines, especially from 2021 onwards when the Minister of Health, Welfare and Sport grew interested in seeking ways to implement bilateral donations (Netherlands Court of Audit, 2024[16]). This viewpoint diverged from the MFA's preference for COVAX, which distributed based on its need-based allocation system. As the Namibia example shows (Box 4.1), pressure from the media helped convince the Netherlands' health minister to donate vaccines, while MFA and MoH interviewees explained that in the week prior to that decision, the MFA and MoH had agreed to donate only through COVAX. A similar scenario allegedly played out around bilateral donations to Cabo Verde. According to interviews with MFA and MoH officials, societal pressure appeared to lead the health minister to make the decision to donate vaccines bilaterally. However, at certain moments, the ministers of the MFA and other members of the Dutch cabinet also recognised the advantages of vaccine donations for achieving certain diplomatic objectives, leading to the decision to donate bilaterally. For instance, the MFA perceived that in-kind donations could potentially strengthen bilateral relationships, as elaborated in the up-close look at bilateral support to Suriname in Up close: The Dutch bilateral support to Suriname. MFA and MoH officers acknowledged the abovementioned coherence issues and indicated that embassy counterparts shared their concerns.

Interviews with MFA and MoH staff confirm that in the cases of Cabo Verde, Indonesia, Namibia and Suriname, the Dutch objective of increasing equitable vaccine access was not driving the decision making. The absence of a needs assessment to inform these bilateral donations makes it very likely that the donations did not go to the countries with the highest needs. Therefore, internal coherence was lacking as the approach to bilateral donations was not consistent with the donations to COVAX, which were allocated following needs assessments and aimed at ensuring equitable vaccine access globally.

Finally, the objective to contribute to equitable vaccine access warrants reflection regarding the Dutch position at the WTO on the proposed TRIPS waiver. While no primary data collection was carried out regarding this aspect, Box 4.2 provides a brief reflection on TRIPS and the COVID-19 response and how lessons learned from previous health crises might have informed the Dutch position, as was mentioned by some health experts within the MFA during interviews. The information in Box 4.2 does not influence the conclusions of this report, as primary data collection on this aspect was outside the scope of this research.

Box 4.2. The Netherlands' position on the TRIPS waiver to combat COVID-19

The TRIPS Agreement sets minimum standards in the international rules governing intellectual property (including patents on medicines), with over 150 WTO members agreeing to its general, common rules. There has been debate around the impact of the TRIPS Agreement on public health as it can limit competition and local manufacturing, increase drug prices, and create an imbalance between the private interests of the patent holder and the larger interests of society. This threat to equitable access and global health security was acknowledged in 2001 at the height of the HIV/AIDS pandemic, when WTO member countries agreed to redress that imbalance and restated the primacy of health over commercial interests. The WTO Doha Declaration reaffirmed countries' right to use TRIPS safeguards such as compulsory licences or parallel importation to overcome patent barriers and promote access to medicines (World Trade Organization, 2001[44]; Médecins Sans Frontières, 2018[45]).

An internal document of the MFA from 2015 outlines lessons documented by the Netherlands and other prominent actors in the global health landscape (e.g. Gavi, the WTO, the WHO, the Joint UN Programme on HIV/AIDS and EU providers) after navigating requests for TRIPS waivers from LDCs during the HIV/AIDS pandemic. Among these lessons were the importance of local production capacity, competition legislation and capacity building in developing countries; the need for new financing models, increased patent quality standards and stricter industry regulation; the effectiveness of voluntary licences compared with compulsory licensing under TRIPS; and the importance of the Netherlands' strong position to mobilise global efforts to eliminate agreements in regional trade agreements that go beyond TRIPS (the TRIPS+ phenomenon).

This partner case study of the Netherlands' COVID-19 response did not specifically research the extent to which lessons from the past were used during the COVID-19 pandemic in negotiations within the WTO on the waiver proposal by India and South Africa. However, MFA policy officers brought up the subject in interviews for this study and were critical of the extent to which such lessons were used in determining the development and humanitarian response to the COVID-19 pandemic. The Dutch cabinet advocated within the EU for a constructive approach to a limited waiver proposal targeting patents for COVID-19 vaccines but received only limited support from a few EU member states (House of Representatives of the Netherlands, 2021[46]). Meanwhile, in its regular internal situation reports, the Netherlands government also acknowledged the importance of the intellectual property system for private research investment and production scale-up. Eventually, the Netherlands opposed the proposal by India and South Africa (Kohler, Wong and Tailor, 2022[20]).

In 2022, global health was explicitly included in the coherence agenda of the Netherlands. This was driven by global inequity around access to vaccines, drugs and other health commodities during the COVID-19 pandemic. The revised coherence action plan focusses on promoting equal access to knowledge in the field of vaccine and drug production and envisions a Dutch contribution to increasing global access to vaccines and medicines by stimulating knowledge sharing and encouraging local production (House of Representatives of the Netherlands, 2022[47]).

The new Dutch Global Health Strategy states that Dutch policy may not undermine the global health efforts set out in the strategy, either in the Netherlands or in other countries (Government of the Netherlands, 2023[48]). The BHOS policy document, Do What We Do Best, also specifically mentions the importance of a global health strategy for tackling vaccine and health inequalities (Government of the Netherlands, 2022[5]). What is missing, however, is clarity on what these policies entail in terms

of TRIPS, technology transfers and knowledge sharing and how the economic interests of the Netherlands and pharmaceutical companies will be balanced against global health needs.

Source: World Trade Organization (2001[44]), *Declaration on the TRIPS Agreement and Public Health*, https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm; Médecins Sans Frontières (2018[45]), "TRIPS, TRIPS Plus, and Doha", https://msfaccess.org/spotlight-trips-trips-plus-and-doha; House of Representatives of the Netherlands (2021[46]), "Ministeriële Conferentie van de Wereldhandelsorganisatie (WTO)" [Ministerial conference of the World Trade Organization (WTO); Government Letter; Intellectual property and COVID-19 at the WTO], https://zoek.officielebekendmakingen.nl/kst-25074-197.pdf; Kohler, Wong and Tailor (2022[20]), "Improving access to COVID-19 vaccines: An analysis of TRIPS waiver discourse among WTO members, civil society organizations, and pharmaceutical industry stakeholders", https://www.hhrjournal.org/wp-content/uploads/sites/2469/2022/12/kohler.pdf; House of Representatives of the Netherlands (2022[47]), "Doen waar Nederland goed in is - Strategie voor Buitenlandse Handel en Ontwikkelingssamenwerking; Brief regering; Herziening actieplan beleidscoherentie voor ontwikkeling" [Do What We Do Best, Government letter; revision action plan policy coherence], https://zoek.officielebekendmakingen.nl/kst-36180-29.pdf; Government of the Netherlands (2023[48]), *Dutch Global Health Strategy 2023-2030*, https://www.government.nl/documents/publications/2023/03/29/dutch-global-health-strategy; Government of the Netherlands (2022[5]), *Do What We Do Best: Policy Document for Foreign Trade and Development Cooperation,* https://www.government.nl/documents/policy-notes/2022/10/10/policy-document-for-foreign-trade-and-development-cooperation-do-what-we-do-best.

Up close: Coherence of the Dutch COVID-19 response in Suriname

Dutch officials found the co-ordination of support to Suriname challenging due to conflicting and ad hoc Dutch political influences on the donation process, according to various interviews and confirmed in internal documentation of the Netherlands MFA. Informal communication played an important role in improving co-ordination.

The support to Suriname required significant co-ordination – within and among Dutch ministries, between the Dutch and Surinamese embassies, with Surinamese authorities, with the SU4SU, and with medical staff in both countries. At times, ad hoc Dutch political promises were made about donations, and fulfilling administrative and legal requirements such as customs documentation within the set timeframe posed challenges at the technical level. The different MFA and MoH donation strategies also increased the challenges at the technical level (section 4.3). Regular interdepartmental meetings were held during the preparation and execution of donations to Suriname, with the Western Hemisphere Department taking the lead within the MFA. Once the first request was granted, the CTF and later the ICST were not extensively involved due to clear ownership of support within the Western Hemisphere Department, which was leading the effort (section 4.4). Informal communication on a technical level among stakeholders (such as policy officers, embassy staff and non-governmental actors) facilitated quicker co-ordination and decision making at the formal political level and enabled faster implementation of political commitments. However, their occasional exclusion from communication lines led to frustration among Dutch policy officers, although overall the relationship with counterparts was deemed to be very good.

Overall, the internal coherence regarding Dutch support in Suriname was good. The Netherlands Court of Audit (2024[16]) report noted differences in the MFA and MoH's approach to bilateral vaccine donations, as confirmed by respondents from both ministries. Whereas the Minister of Health, Welfare and Sport was inclined to donate bilaterally based on political preference and a desire to assist Suriname, according to the audit report, MFA policy officers stressed distributing vaccines based on needs rather than political preferences. This discrepancy caused frustration at the technical level, where the agreed-upon policy to work primarily via COVAX was sometimes disregarded. While the reasoning behind making the donations differed, this did not lead to a lack of internal coherence regarding the eventual Dutch response within Suriname.

Maintaining external coherence with other donors in Suriname was not actively managed, and hence the extent to which there was external coherence remains unclear. However, the Dutch support likely aligned well with the Surinamese response. While ICST members reported efforts to co-ordinate bilateral donations with multilateral organisations such as Gavi in the receiving country, policy officers reported that co-ordination did not occur in Suriname. The responsibility for co-ordinating vaccine donations with other partners was instead placed on the Surinamese counterparts. This partner case study found no documentation to confirm co-ordination with multilateral organisations, and in interviews policy officers gave contradictory accounts. In the case of co-ordination with multilateral donors regarding vaccine donations, policy officers at the MoH pointed towards MFA officers and vice versa when asked who was responsible for this co-ordination. There were regular efforts to co-ordinate with the Surinamese government, particularly through medical volunteers and the Special Envoy. The fact that the Dutch support responded to direct requests from the Surinamese government and medical sector also contributed to external coherence.

4.3. Efficiency of the Dutch development and humanitarian COVID-19 response

This section presents the findings related to the research question on efficiency: *To what extent was funding timely and flexible?* There was little information on the extent to which the Dutch support achieved good value for money. Although the evaluation of COVAX did show that it was able to achieve lowest-in-market prices for vaccine doses for LICs and lower middle-income countries (LMICs) (Cooper et al., 2023[49]), no comparative cost-effectiveness analyses were identified. Therefore, the team analysed other aspects of efficiency such as timeliness of funding and in-kind vaccine donations, flexibility of funding, and flexibility of staffing. While the Netherlands mobilised timely and flexible funding, its in-kind vaccine donations were relatively late.

The Netherlands provided timely funding to respond to COVID-19 by disbursing funds soon after appeals were received. Political prioritisation of rapid support as well as the decision to select larger partners contributed to timeliness.

Across the Dutch response, the MFA generally announced financial commitments within a few weeks after appeals were announced and requests for funding were received. For example, the WHO released a global appeal for USD 675 million on 3 February 2020, and on 2 March 2020, the Dutch MFA committed an initial one-time contribution of EUR 1 million to the WHO CFE and followed up with additional commitments over subsequent weeks (per internal MFA documentation). Infographic 3.1 in Chapter 3 shows the timeline of these and other Dutch responses to the pandemic. Likewise, after receiving an official request for funding for the Dutch Relief Alliance (DRA) COVID-19 response on 21 April 2020, the MFA approved a contribution to the DRA on 1 May 2020 (per internal MFA documentation). However, the Netherlands Court of Audit (2024[16]) found that MoH funding for the CEPI was an exception as it took longer to materialise after internal hesitation. Standard practice and a legal requirement for the MFA is to respond to project proposals for grants within 13 weeks, with the possibility of extending the response period by another 13 weeks. During the pandemic, the responses were generally much quicker. Moreover, interviews with financial officers at the MFA confirmed that disbursement is generally immediately after commitment. Therefore, overall, this study concludes that the Dutch COVID-19 funding was timely.

Three main factors influenced the speed of the financial commitments, according to interviewees. First, as policy officers mentioned, there was a sense of urgency and political pressure to inform the parliament quickly that financial support would be provided. Second, according to interviewees, scaling up funding to existing partners, in particular larger multilateral organisations and pooled funds, would be quicker than drawing up separate contracts with other entities. Third, policy officers noted that they had assumed that smaller NGOs would not have been able to deploy the substantial amounts of funds as quickly as the

multilateral channel could. NGOs interviewed, however, expressed disappointment that they were not asked whether they would be able to deploy such funds rapidly as their partners experienced high financial needs during the pandemic.

Another policy assumption was that these multilateral actors would act fast because they could leverage their existing infrastructure and capabilities. However, that assumption is not necessarily correct. The global review of 99 documents by bilateral, multilateral, NGO, and research and other organisations found that responses were timely regarding budget support and technical assistance to partner countries, but that multilateral organisations struggled to deliver services in a timely way because of logistical issues (Schwensen and Scheibel Smed, 2023[50]).

Dutch in-kind vaccine donations arrived late relative to the urgency of recipient countries' needs due to the Netherlands' prioritisation of the Dutch population as well as legal issues.

The Netherlands was relatively late with in-kind vaccine donations. The first COVID vaccinations were administered in the Netherlands on 6 January 2021 (Infographic 3.1). Six months later, in June 2021, the Netherlands donated its first vaccines bilaterally to Suriname.

Donations to COVAX came even later. Beginning in December 2020, COVAX emphasised the importance of donating as soon as possible, and in mid-2021, COVAX leaders urged countries to donate immediately. Yet, the Netherlands only started to donate its doses through COVAX in late November 2021 (de Bengy Puyvallée and Storeng, 2022[51]). Altogether, the Netherlands aimed to donate 22 million doses to COVAX and 6 million doses bilaterally in 2021 (House of Representatives of the Netherlands, 2021[52]). However, this aim was not fully achieved, as the Netherlands only donated 4.2 million doses bilaterally in 2021 and delayed donating the remaining doses until 2022 (Ministry of Health, Welfare and Sport; Minister for Foreign Trade and Development Cooperation, 2021[35]).

There are several reasons for the delays between the vaccines becoming available in the Netherlands and the donation of these vaccines. First, the Dutch priority was always to ensure that sufficient vaccines were available for the Dutch population. Donations only started when there were surpluses (Netherlands Court of Audit, 2024, p. 60[16]). In addition, a part of the planned donations for 2021 was delayed to 2022 to enable booster campaigns in the Netherlands (Ministry of Health, Welfare and Sport; Minister for Foreign Trade and Development Cooperation, 2021[35]). Second, legal issues caused delays in donating via COVAX. The Netherlands, unlike some other countries, wished to donate via donation mandates, that is, agreements between Gavi, the vaccine manufacturer and a facilitating EU member state other than the Netherlands (House of Representatives of the Netherlands, 2021[52]). Diverse interviewees confirmed that the creation of these mandates involved lengthy and painful legal negotiations with the Netherlands. Moreover, pharmaceutical companies were reluctant to change agreements to make it easier for countries to donate, and lawyers at the MoH were particularly hesitant out of concern over Dutch legal accountability in case of problems with the vaccines (Netherlands Court of Audit, 2024[16]).

The Netherlands primarily provided unearmarked and basket or pooled funding, which enabled recipients to execute their COVID-19 responses flexibly.

The majority of Dutch COVID-19 funding (63.4%) was unearmarked, basket or pooled. Unearmarked funding is generally considered flexible as it allows recipients to allocate resources quickly and shift funding flows to respond to emerging and unpredictable crises (Gulrajani and Lundsgaarde, 2023[53]). Of a total of EUR 541 million in COVID-related funding from the Netherlands, EUR 117 million (21.6%) was categorised as unearmarked. The largest recipients of this unearmarked Dutch funding were the World Bank, the IMF, the WHO and the ICRC. Moreover, EUR 226 million (41.8%) of the total COVID-related funding was categorised as basket or pooled funding. While not unearmarked, an advantage of these types is that multiple donors support the same priorities without attaching individual requirements, thereby circumventing risks associated with fragmentation of the multilateral system (OECD, 2015[54]). This

category of funding included, for example, programmatic funding to COVAX, the GFF and the UN COVID-19 MPTF.

This approach is aligned with regular Dutch development co-operation, which relies on multilateral partners and includes core and pooled funding, although to a lesser extent than that of other donors (OECD, 2023[6]).

Evaluations have found that unearmarked and pooled funds indeed provided flexibility to partners (Schwensen and Scheibel Smed, 2023[50]). The Multilateral Organisation Performance Assessment Network (MOPAN) found for instance that the World Bank had delivered "flexible support" to "national health responses" (MOPAN, 2023[55]). Similarly, the IMF, which received EUR 25 million for the CCRT, was said to have had an "effective and agile response to a crisis like no other" (Independent Evaluation Office, 2023[56]). The 2023 evaluation of COVAX shows that the COVAX Facility design and business model evolved considerably amid a highly dynamic and uncertain environment (Cooper et al., 2023[49]). The UN COVID-19 MPTF, a pooled fund to which the Netherlands contributed EUR 15 million in 2020, provided flexible resources to support the UN's early response to COVID-19 (MOPAN, 2023[55]). The Global Fund, which received EUR 27 million for its COVID-19 Response Mechanism, was likewise evaluated positively in terms of flexibility as it allowed for reprogramming of existing grants and also set up a new financing facility specifically for COVID-19, together amounting to a total of over USD 4 billion (Pharos Global Health Advisors, 2022[57]).

The Netherlands provided institutional flexibility to existing partners by allowing for various programme adjustments.

The Netherlands showed considerable flexibility in its relationships with implementing partners.[20] Interviewees mentioned that the CTF encouraged budget holders to be flexible and to allow implementing partners to adapt programming and accept delays in implementation. Generally, NGOs only had to explain changes involving more than 10% of the grant budget, which had also been pre-pandemic policy. In addition, extra costs due to the pandemic could be covered by contingency lines built into existing budgets or, if there was no such budget line, could be covered from the approved budget after explicit approval of the adjustments by the MFA. The ministry did not track how many partnerships made use of these possibilities.

Moreover, through a special temporary readjustment procedure in 2020, the MFA supported NGOs to respond to the COVID-19 crisis (Box 4.3). This readjustment was restricted to existing partners under ongoing policy frameworks. Partners under more recent frameworks could account for COVID-19-related risks in their programmatic budgets. The MFA also allowed for adaptations in M&E for existing partnerships with NGOs: the MFA recognised the need for requirements to be modest during the pandemic, allowing for uncertainties and limitations in programming.

Overall, MFA policy officers reported taking an empathetic approach, regularly communicating with NGO partners and providing flexibilities where feasible. While NGOs based in the Netherlands acknowledged the MFA's efforts and felt supported, the evaluation team did not conduct interviews with NGO country offices and could not collect sufficient information on if and how support translated at the partner country level.

Box 4.3. The temporary procedure to allow reallocation of funding by NGOs

In April 2020, the MFA established a temporary procedure for NGO partners operating under certain existing subsidy relations[21] to mitigate the impact of the pandemic on their operations and partners. This initiative permitted NGOs to redirect committed budgets to address the pandemic's effects in developing countries. From 8 April 2020, the Netherlands allowed NGOs that were not able to fully implement subsidised activities because of the pandemic to use these funds for activities aimed at preventing further consequences of the COVID-19 pandemic (Government of the Netherlands, 2020[58]). Through an expedited funding procedure, an NGO could request a reduction of at least EUR 1 million of the funding amount already provided and submit a brief proposal for new COVID-19-related activities for at least EUR 1 million.[22] The minimum reallocation amount was set at EUR 1 million to lighten the administrative burden on MFA policy officers and NGO partners.

Only five partnerships made use of this procedure, and reallocations by NGOs amounted to EUR 5.9 million. NGOs that were eligible but did not use this procedure reported in interviews that the existing funding agreements already allowed them sufficient flexibility for reallocation or that they did not have (the minimum requirement of) EUR 1 million to reallocate as 2020 was the final year of their programme implementation. In conclusion, this option was not used much, and the amount concerned was small compared with the EUR 541 million that the Netherlands spent on COVID-19-related activities in 2020-21. However, this procedure signals the MFA's willingness to allow for reprogramming by partners in crisis beyond regular funding agreements.

Source: Government of the Netherlands (2020[58]), "Besluit van de minister voor Buitenlandse Handel en Ontwikkelingssamenwerking van 6 april 2020" [Decision of the Minister for Foreign Trade and Development Cooperation for the establishment of policy rules for subsidisation], https://zoek.officielebekendmakingen.nl/stcrt-2020-21245.html.

NGO partners interviewed mentioned that the flexibility extended during the pandemic period was crucial to their ability to sustain operations and support partner organisations in developing countries. Interviewees stated that the freedom to reallocate resources for the response to the pandemic was helpful. An IOB evaluation on SRHR showed that NGO partnerships generally postponed, adjusted or cancelled their planned activities during the pandemic. Sensitisation and awareness campaigns were done virtually (instead of in person), and budgets of cancelled activities were reallocated to scaling up remote ones. When in-person activities did take place, they were conducted in smaller groups or one on one. Most projects were adapted to include COVID-19 awareness raising in the activities as well as the provision of hygiene products (Policy and Operations Evaluation Department, 2023[59]).

There were flexible work arrangements as well as efforts to combat increased workload during the pandemic

The 2021 MFA employee satisfaction survey indicated that flexible working positively affected employees' work-life balance (per internal MFA documentation). The evaluation team also found several examples of efforts to reduce the workload and support well-being. For instance, when the CTF became burdensome for its members, regular responsibilities could be shifted to relevant staff not directly involved in the CTF to alleviate the members' workload, interviewees said. Interviewees also mentioned that members had the option to leave the CTF if they felt the workload was too heavy. Additionally, measures to reduce the administrative burden on MFA policy officers, for instance to prioritise existing partners and setting a minimum amount for reallocation of EUR 1 million (Box 4.3), demonstrated a ministry-wide commitment to staff well-being and workload management, particularly in a system with high demands around project management (OECD, 2023[6]).

Up close: Efficiency of the Dutch COVID-19 response in Suriname

Overall, the donations of medical supplies (apart from vaccines) and technical support to Suriname were timely as disbursements were made within a few weeks after official requests from the Surinamese government. Vaccine donations, however, were late.

Political agreements, often publicised by both governments' communication channels, incentivised timely implementation. However, the first shipment of Dutch support, containing medical supplies, arrived after a significant increase in COVID-19 cases in Suriname. MFA officials explained that delays sometimes occurred due to the need to await formal requests from Suriname. Surinamese interviewees stated that administrative and legal requirements on the Dutch side caused additional delays. According to interviewees from the SU4SU, the involvement of the SU4SU and the Dutch embassy in Paramaribo improved efficiency on the side of Surinamese customs. The collaboration with reputable, key private actors and good working relationships with custom authorities expedited administrative processing, allowing Dutch policy officers and SU4SU counterparts to fulfil administrative obligations soon after donation completion, thereby enhancing speed.

The donations of the vaccines, however, were late, especially considering how the pandemic developed in Suriname (Figure 3.5) and by comparison with the Dutch vaccination campaign. According to the Netherlands Court of Audit (2024[16]), Suriname first requested vaccines in April 2021, but these were not pledged until May and only donated in June. By that time, Suriname was already experiencing its largest wave of new infections (World Health Organization, 2023[60]). In contrast, the Netherlands began administering vaccines in the Netherlands in January 2021, but focus was on ensuring availability for the domestic campaign due to vaccine availability setbacks and political pressure (Netherlands Court of Audit, 2024[16]).

4.4. Effectiveness of the Dutch development and humanitarian COVID-19 response

This section presents findings related to the research question on effectiveness: *What are the early results of the Netherlands' development and humanitarian response to the COVID-19 pandemic?* As only very limited information is available on early results that can be attributed to the Dutch response, this section reflects on how the Netherlands contributed to the three overarching global response objectives: alleviating the public health and humanitarian crisis, mitigating the secondary impacts of the pandemic, and achieving greater and more equitable vaccination coverage globally. These three objectives correspond to the outcome-level indicators described in the overarching evaluation matrix of the Strategic Joint Evaluation. The reflection then links these overarching objectives to the five Dutch response objectives to illustrate the Dutch contribution to these objectives.

The Dutch development and humanitarian response to the COVID-19 pandemic was structured around clear objectives and sub-goals that had good alignment with and therefore likely contributed to the overarching goals.

The selection of partners that the Netherlands worked with in its response to the pandemic was mainly based on their suitability to achieve the five Dutch objectives. For instance, CBPFs were selected for quick country-level disbursement of humanitarian assistance, COVAX for vaccine delivery, the IMF for macroeconomic stability, and the GFF for a focus on health systems and reproductive, maternal, newborn, child, and adolescent health and nutrition. These choices were grounded in established working relationships and the assumption that these partners would be effective due to their vast networks, expertise and mandates. Even though interviewees mentioned that decision making during the pandemic

was rushed, the final allocations on the output level were found to be reasonably in line with the Dutch response objectives. The allocations were also in line with the overarching impact-level objectives. The underlying assumption that these financial allocations would ultimately contribute to achieving these outcome- and impact-level objectives cannot be verified due to lack of data regarding early results. However, based on the overview of extracted objectives, the alignment of the response with Dutch goals and pockets of evidence discussed in this section, it is likely that the Netherlands contributed to the overarching goals.

Bilateral in-kind donations were also aligned with the five objectives of the Dutch response, particularly with OBJ. 1 on COVID-19 control. Although the evaluation team did not assess every instance of bilateral assistance, from the data reviewed for the up-close look at Suriname the team found that the Netherlands had an additional political objective driving the response – strengthening bilateral ties. It is likely that the Netherlands had the same objective for other countries that received Dutch bilateral assistance during the pandemic.

The Netherlands' investments in prevention measures abroad and heavy support for vaccine distribution through COVAX helped alleviate the global public health crisis between 2020-22 (OBJ. 1). Action to address gaps in country capacities for vaccine rollouts is likely to have helped mitigate the spread of the coronavirus (OBJ. 4), although vaccine availability did not necessarily lead to widespread coverage in partner countries.

The Netherlands invested in advancing global understanding of the novel coronavirus and strengthening prevention measures in other countries to cushion the impact of the pandemic on their populations and health systems. The assumption that prevention measures would help cushion the impact of the pandemic can be validated. Bilateral in-kind assistance and Dutch investments in the ACT-A mechanism's diagnostics, vaccines and therapeutics pillars are likely to have reduced the health impact on people and health systems by expanding access to COVID-19 tests and treatments and accelerating the development of a new vaccine. The ACT-A two-year impact report highlights how investing in diagnostics enabled capacity building by ACT-A partners, particularly in Southern Africa, to expand the use of next-generation sequencing for genomic surveillance. This enabled early detection of the Omicron variant, which ultimately saved lives (World Health Organization, 2022[61]).

The COVAX Facility was the largest recipient of Dutch COVID-19 funding. By December 2022, the Netherlands had donated 22.5 million doses – 6.4 million of these donated bilaterally and 16.1 million through COVAX (Netherlands Court of Audit, 2024[16]). It had also provided EUR 103 million in funding to the COVAX Advance Market Commitment (AMC). The assumptions driving Dutch investments in COVAX, i.e. that COVAX would increase the access of low- and middle-income countries to vaccines and thereby lead to high vaccination coverage in partner countries, can only partially be validated. The review by Cooper et al. (2023[49]) found that the COVAX Facility and COVAX AMC made a substantial contribution to the supply of vaccines to participating countries. However, the mere availability of vaccines did not guarantee their widespread coverage. The review also noted that gaps in country capacity and readiness for vaccine rollouts were important factors that hampered greater coverage (Cooper et al., 2023[49]).

Interviews and internal documentation reveal an early recognition within the MFA of the importance of country readiness for better vaccination coverage (OBJ. 1 and OBJ. 4). Therefore, the MFA invested in the WHO SPRP with the explicit objective of strengthening in-country vaccination campaigns (House of Representatives of the Netherlands, 2020[13]). Based on data gathered from partner country case studies under the Strategic Joint Evaluation, the role of the WHO in providing strategic, technical and operational assistance in vaccination campaigns was highly valued by partner country governments and widely acknowledged by other local actors. The formative review of the COVAX Facility, in which the WHO was a foundational alliance partner, further confirmed this (Cooper et al., 2023[49]), with respondents from recipient countries expressing appreciation for the support from Gavi and Gavi partners in strengthening

country readiness for vaccine rollouts. Through its contribution, the Netherlands helped the WHO respond effectively and provide crucial expertise during the pandemic. These investments were in line with the Netherlands' fourth objective, making it likely that the response contributed to achieving improved vaccine coverage and minimised disruptions of routine healthcare in partner countries.

The Netherlands prioritised essential healthcare services during the pandemic, maintaining advocacy and funding for mental health, sexual and reproductive health, and other diseases (OBJ. 4).

The Netherlands strived to maintain a focus on essential healthcare services during the pandemic and avoid additional morbidity and mortality from other diseases. It aimed for retaining global attention on other health issues during the pandemic period. This was achieved through funding and advocacy. In 2020, the Netherlands was the largest contributor to the WHO CFE with a contribution that was almost triple the size of its contribution in 2019. While this funding was partly used to provide technical advice to governments of countries impacted by COVID-19 and for the procurement of protective equipment, it also enabled responses to other health emergencies such as infectious disease outbreaks (World Health Organization, 2021[62]).

At the same time, regular Dutch SRHR programming continued with a budget allocation of EUR 972 million between 2020-21; in 2022, the MFA allocated EUR 579 million to global health and SRHR (Ministry of Foreign Affairs, 2024[63]).

A primary component of advocacy for essential healthcare is MHPSS. An evaluation by the IOB found the Netherlands' humanitarian diplomacy around MHPSS to be proactive, constructive and at times influential, with the most relevant outcome being the successful lobbying for inclusion of MHPSS in the UN Global Humanitarian Response Plan to the COVID-19 Pandemic (Policy and Operations Evaluation Department, 2023[64]). Working through the multilateral system to put development issues on the international agenda and building multilateral solutions to address cross-cutting issues can help ensure a minimum level of coherence and further strategic alignment on global priorities (OECD, 2015[54]).

However, there is little evidence on whether attention to essential healthcare services led to improved availability of these services. An early-stage evaluation of the Global Fund's COVID-19 Response Mechanism (C19RM 1.0) found no evidence that its investments, or those of governments and other donors to the C19RM 1.0, helped moderate declines in health services or facilitated faster recovery post lockdowns (The Global Fund, 2023[65]). An evaluation of the Product Development Partnerships III Fund over 2015-21 could not verify whether the partnerships led to improved access to drugs, vaccines and diagnostics for vulnerable groups (Ecorys, 2021[66]). Moreover, the Netherlands funded the GFF on the assumption that it would strengthen health systems in LICs by training health personnel to bring COVID-19 care to marginalised communities (House of Representatives of the Netherlands, 2022[67]). This assumption also could not be validated as there has not been an independent evaluation of the GFF.

The Netherlands' principled, substantial and targeted funding to humanitarian partners was in line with its objective to alleviate the humanitarian crisis stemming from the pandemic (OBJ. 2). While there is limited evidence on early programme results, the speed of funding as well as the selected instruments facilitated the effectiveness of the Dutch humanitarian response.

The motivation behind the Dutch humanitarian response was to alleviate acute needs in fragile regions and countries that were exacerbated by the pandemic. Allocations from the COVID-19 aid package included substantial contributions to the DRA, UNOCHA's CERF and CBPFs. Regular humanitarian assistance in the period 2020-22 continued with a budget of EUR 1.33 billion (excluding EUR 90 million earmarked for COVID-19 in 2020) (Ministry of Foreign Affairs, 2024[63]).

In this context, the Dutch contribution to the CERF from its regular humanitarian and COVID-19 response budget was important. The CERF's response to the pandemic and other crises in 2020 was made possible by the unprecedented levels of funding it received in 2019 and 2020. In 2020, 2021 and 2022, the Netherlands was the second-largest donor to the CERF, contributing about EUR 250 million in total (United Nations Central Emergency Response Fund, 2024[68]). There has not been a formal evaluation or independent review of the overall CERF COVID-19 response. However, there has been an independent review of the CERF's allocation mechanism (Poole, 2021[69]).

In interviews, MFA policy officers emphasised the importance of speed in humanitarian response to increase effectiveness. Therefore, the Netherlands funded the CERF and the CBPFs due to their assumed ability to make rapid disbursement to frontline actors. This assumption was validated in the independent review of the CERF's NGO allocation mechanism (Poole, 2021[69]). During the pandemic, the CERF allocation was in most cases the first significant funding NGO partners received. The allocation strengthened the effectiveness of the response by ensuring coverage of key priorities and gaps and allowed NGOs to deliver programmes of meaningful impact and scale, including the setting up of critical services such as isolation and treatment centres (Poole, 2021[69]).

This validation is consistent with the findings of an evaluation of the COVID-19 humanitarian response carried out for the Inter-Agency Standing Committee, which found pooled funding was an important source of income for local and national NGOs during the pandemic that allowed them to respond and adapt to the pandemic as it evolved (KonTerra Group and Itad Ltd, 2022[70]). These findings are especially important in the context of the pandemic, when response strategies required frequent adjustments and adaptations.

While the Dutch financial allocations to such multi-donor funds were in line with the second objective of the Dutch COVID-19 response, the lack of independent evaluations and evidence on early results prevents the evaluation team from drawing conclusions on the effectiveness of the Dutch humanitarian response (OBJ. 2). Still, the choices made regarding channels and funds (including multi-donor trust funds and CBPFs) as well as the speed of funding facilitated the effectiveness of the Dutch humanitarian response. (See also the discussion on efficiency in Effectiveness of the Dutch development and humanitarian COVID-19 response).

The Netherlands contributed to mitigating the socioeconomic impacts of the pandemic through various initiatives, and while evidence from different allocations is mixed, there is clear evidence illustrating the effectiveness of its largest contribution via the IMF (OBJ. 3).

The Netherlands' contribution to mitigating the secondary social and economic effects of the pandemic included funds to reduce food and medicine shortages, strengthen social safety nets, mitigate job losses, and continue basic services by creating fiscal space in partner countries' budgets.

Evidence on the effectiveness of these funding allocations is mixed. While effectiveness concerns were raised regarding some initiatives, such as the DGGF Track 2,[23] contributions to the Medical Credit Fund (MCF) proved successful in supporting health facilities in Africa during the crisis.[24] However, the largest Dutch financial contribution towards mitigating the economic fallout from the pandemic was through the IMF CCRT, which offers debt service relief to the poorest countries and creates fiscal space in national budgets. This instrument was fit for purpose in light of the CCRT's history[25] and its experience dealing with needs in sudden-onset crises. An Independent Evaluation Office (2023[56]) evaluation of the IMF's COVID-19 response found that it fulfilled its role to close financing gaps, helped catalyse support from other sources and mitigated output losses (capital flows out of the private sector due to the pandemic). According to the evaluation, the IMF also took the requisite steps to alleviate debt burdens through debt relief and debt operations by providing cash flow relief to help meet obligations through the CCRT. As of April 2022, the IMF had provided about EUR 890 million in debt relief to 31 CCRT-eligible countries. Given the significance of the funding flows to the IMF to meet the socioeconomic objective and the strong evidence

suggesting its efficacy, it can be concluded that overall, the Netherlands effectively contributed to mitigating the socioeconomic impacts of the pandemic.

The Netherlands aimed to facilitate equitable vaccine distribution through investments in COVAX and bilateral donations. However, aggressive procurement of domestic vaccines on the global market likely limited the results on this objective, and the Netherlands could have done more to increase equitable access.

The Dutch government believed that a collective multilateral effort to increase vaccine coverage globally would especially benefit low- and middle-income countries, which typically might have lower access to vaccinations than middle- and high-income countries (per interviews and internal MFA data). This stance was apparent in its position on donating vaccinations primarily through COVAX, in its reliance on its vaccine allocation mechanism and algorithms to promote equitable access among countries, and in donating bilaterally only exceptionally.

The Netherlands' routing through COVAX contributed to increasing vaccine coverage in low- and middle-income countries and therefore facilitated inter-country vaccine equity. Cooper et al. (2023[49]), in their COVAX review, found that the COVAX Facility and COVAX AMC made a substantial contribution to the supply of vaccines to LICs. COVAX was the main source of vaccines for LICs and accounted for about 79% of doses delivered. The same review also found that by the end of 2021, the COVAX Facility had delivered enough doses to vaccinate more than 20% of the population with at least one dose in LICs and in COVAX AMC-participating LMICs. Countries that received Dutch vaccines through COVAX were Bangladesh, Belize, Cambodia, Egypt, Indonesia, Kenya, Lao People's Democratic Republic, Mauritania, Mexico, Pakistan, Papua New Guinea, Philippines, Tajikistan, Tunisia, Vanuatu and Yemen (Netherlands Court of Audit, 2024[16]). While equity was a leading principle for COVAX, the Cooper et al. (2023[49]) review also found that the equitable distribution of vaccines within countries was not clearly defined and that the in-country vaccine programmes were outside the scope of Gavi's responsibilities. Their evaluation does mention available evidence suggesting the prioritisation of high-risk groups.

The Netherlands could have contributed further to improving equitable vaccine access globally. There is a tension between the development and humanitarian objective towards the principle of equity, on one hand, and the national response, which prioritised the Dutch population, on the other. The aggressiveness, scale and overwhelming market power of high-income countries (including the Netherlands) in procurement of vaccines on the global market for their domestic populations inevitably contributed to pricing out low- and middle-income countries from purchasing vaccines themselves, undermining COVAX's allocation mechanism and the Netherlands' equity goals (Cooper et al., 2023, p. 30[49]). Moreover, while the number of donated vaccines in December 2021 aligned with the objectives for the Get One, Give One initiative, an increased demand for vaccines in the Netherlands ultimately hindered that initiative as donations were postponed. This mainly occurred around the time that Dutch domestic booster campaigns were picking up steam (Netherlands Court of Audit, 2024[16]).

Nevertheless, it is safe to assume that Dutch contributions led to increased coverage in developing countries, thereby improving inter-country equity, although no evidence was available regarding the facilitation of equitable access to vaccinations within countries. While the absence of evidence on in-country distribution and thus equity is partly due to the fact that in-country vaccine programmes were outside the scope of Gavi and COVAX and thus they did not monitor these programmes, other factors played a part. The Netherlands did not include detailed reporting requirements around the distribution and usage of donated vaccines when donating through COVAX or bilaterally. Also, vaccination campaigns and country coverage were often managed by national governments. The Netherlands did not monitor or track these data, and no related adaptations to the bilateral agreements were found by the evaluation team for this study. Countries received vaccine donations from several other providers, and it was not possible to disentangle the Dutch donations from national health data to determine the Dutch contribution to equitable

vaccine coverage in the countries. Section Coherence reflects further on the decision-making process behind bilateral donations and its impact on increasing equitable access to vaccines across and within countries. This reflection points to a lack of needs assessments to inform decision making and, in some instances, a lack of coherence in the Dutch response regarding bilateral donations. Therefore, the evaluation team concludes that the Netherlands may have only contributed to achieving this objective of equitable vaccination coverage to a limited degree and could have done more.

The Netherlands lived up to commitments made under the DAC joint statement on the COVID-19 pandemic regarding the protection of ODA budgets and mobilising private funding for development aid. As for the commitment to support CSOs in tackling the consequences of the pandemic, evidence shows that the Netherlands put in reasonable efforts.

The Netherlands protected its ODA budgets during the pandemic by providing an additional COVID-19 aid package between 2020-22 that did not impact regular development and humanitarian programmes.[26] This was done through a cash shift from future ODA budgets of EUR 464 million, with EUR 350 million added to the current budget to allow for continued financing of programmes that were already planned and to avoid disruptions and ODA cuts (House of Representatives of the Netherlands, 2020[13]). The Netherlands financed its response in partner countries using both ODA and non-ODA resources, with contributions from various ministries.

The Netherlands, alongside the United States, excluded from its ODA figures donations of excess in-kind vaccine and ancillary products originally procured for domestic markets. At DAC Working Party on Development Finance Statistics meetings, the Netherlands raised concerns about reporting vaccines as ODA, citing potential market distortions and the risk of encouraging over-purchasing, which could exacerbate shortages for low- and middle-income countries as was seen during the COVID-19 pandemic (per internal MFA documentation).

The Netherlands mobilised substantial private sector funding (OECD, 2023[71]),[27] which was partly used to supplement the COVID-19 response. For instance, the FMO and the US International Development Finance Corporation (2021[72]) co-financed and launched the DFC-MASSIF COVID-19 Response Co-Financing Facility in 2021. This USD 75 million facility aimed to enhance liquidity for financial intermediaries to support MSMEs affected by the COVID-19 pandemic and encourage new investments for economic sustainability in developing countries. Through MASSIF, the Dutch government[28] allocated USD 25 million for this COVID-19 facility. Additionally, the Netherlands used its position in various international financial institutions to advocate for an accelerated release of additional resources. The MFA reported that it advocated for assisting countries with loans for both immediate crisis response and for green, sustainable and inclusive recovery (House of Representatives of the Netherlands, 2021[73]).

Finally, the Netherlands supported CSOs, for instance via the temporary readjustment procedure for NGOs involved in ongoing partnerships during the COVID-19 crisis in 2020, as discussed in section 4.3 (efficiency). The findings show that the flexibility provided enabled CSO operations and thus supported their efforts in tackling the consequences of the pandemic. Moreover, the Netherlands reported using its position in international political fora to create enabling conditions for the functioning of civil society (House of Representatives of the Netherlands, 2021[74]) amid reports of shrinking civic space due to pandemic-related restrictions (Gros and Eisen, 2021[75]). While there is limited evidence on the effectiveness of this advocacy, the combination of financial support, flexibility and advocacy efforts shows that the Netherlands put in reasonable efforts to live up to the commitment of supporting CSOs.

Up close: Effectiveness of the Dutch COVID-19 response in Suriname

It is highly likely that Dutch donations played a significant role in mitigating the spread of COVID-19 and its immediate impacts in Suriname. Representatives from all stakeholders involved, including government

and non-governmental entities, as well as an internal evaluation by Dutch medical professionals who supported Suriname affirmed that the donated products and medical volunteers were utilised for and essential to protecting medical staff and treating patients. In addition, MFA policy officers emphasised in internal presentations that the effectiveness of both the initial and subsequent support packages was enhanced by following up with vaccine donations.

The timeliness of the assistance was important to this effectiveness. WHO data indicate that a total of 554 590 vaccine doses have been administered in Suriname, with 41% of the population receiving at least one dose and 8% receiving a booster shot (World Health Organization, 2023[60]). While the lack of monitoring makes it difficult to know if all 257 890 donated Dutch vaccines were administered, it is likely that they contributed to achieving this level of coverage. However, considering that the initial pledge was to donate 600 000 vaccines, the Dutch contribution could have been bigger. Internal sources and interview data do indicate that vaccine hesitancy may have resulted in unused Dutch doses in Suriname.

5 Conclusions and lessons learned

This chapter provides an overarching conclusion regarding the six main evaluation questions. It draws on the findings in Chapter 4 on the relevance, effectiveness, coherence and efficiency of the Dutch response to the pandemic. It then discusses in greater depth three cross-cutting themes – developing a strategic crisis response plan, reexamining the use of channels and partnerships, and strengthening M&E – that emerged from this study and presents practical, forward-looking lessons for the Netherlands MFA.

5.1. Conclusions from the findings on the evaluation questions

1. Descriptive: How did the Netherlands respond to the COVID-19 pandemic internationally?

The Netherlands allocated EUR 265 million to combat COVID-19 globally in 2020, followed by EUR 157 million in 2021, and EUR 119 million in 2022. The EUR 541 million COVID-19 aid package was supplementary to regular, ongoing development and humanitarian programming.

The Dutch response was driven by five objectives. The first was to enhance prevention measures, mitigate the spread of COVID-19 and improve health outcomes. The second was to provide humanitarian assistance. The third aimed to increase socioeconomic resilience in low- and middle-income countries. The fourth was to enhance country readiness, invest in strengthening country health systems and minimise the disruption of essential healthcare in partner countries and the fifth was to promote sustainable and inclusive recovery from the pandemic. As the pandemic evolved, the primary objectives shifted: the largest ODA allocations targeted socioeconomic resilience and emergency assistance in 2020, then COVID-19 control in 2021, and finally country readiness and health systems strengthening in 2022.

Multilateral organisations received 79% of the Dutch COVID-19 aid package. The package also included non-ODA bilateral support and in-kind assistance towards enhancing prevention measures, which amounted to EUR 8 million between 2020-22. Additionally, the Netherlands donated a total of 22.5 million vaccine doses by December 2022, 6.4 million of these bilaterally and 16.1 million through COVAX.

2. Relevance: To what extent did Dutch COVID-19 support meet partner needs and priorities?

The findings show that the allocations fit the specified objectives and contributed to the broader ongoing global efforts against the pandemic. The Netherlands' choice of partners, channels and internal decision-making mechanisms ensured that the objectives were operationalised in a way that took into account existing organisational capacity and capabilities of key partners.

The Dutch development and humanitarian response was broad and responsive to an array of negative pandemic impacts. The support enabled multilateral organisations and NGOs to execute responses in line with regional, national and local needs and priorities. In cases where the Netherlands provided bilateral support, the support was only partly needs based, with political and practical considerations also weighing

in. Still, the evolution of the response from emergency assistance to health systems strengthening, as evidenced by the financial allocation shifts between 2020-22, demonstrates the responsiveness of the Dutch COVID-19 aid package to the changing nature of the pandemic. The study found clear evidence that the Dutch response was adaptive and endeavoured to remain relevant to partner needs, as communicated by the partners, throughout the pandemic period. For the most part, the up-close look at Suriname shows that the Dutch support was responsive to country needs. But no definite conclusion can be drawn regarding the degree to which the entire Dutch response met the recipients' needs.

3. Coherence: To what extent did the Dutch response align internally and with other actors to ensure coherent approaches globally?

Overall, the Netherlands' response was well aligned at the global level with that of other development and humanitarian partners. The Dutch response was primarily allocated through multilateral organisations and initiatives, which resulted in an externally coherent response. Internally, the response was well co-ordinated. The MFA established distinct task forces with co-ordination mandates. These task forces were important drivers of coherence.

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 addition, the Netherlands' approach to vaccine procurement for domestic use negatively impacted the coherence of its response by contributing to increased vaccine inequity on the global market, an effect its development response explicitly tried to avoid.

4. Efficiency: To what extent was funding timely and flexible?

Overall, the Dutch COVID-19 response was timely and flexible, especially in terms of mobilisation of funding. The findings show that funds were quickly disbursed after appeals were issued and requests received. Moreover, the decision to primarily provide unearmarked and pooled funding granted flexibility to partners. There was also some evidence that the Netherlands allowed for necessary adjustments within existing programmatic funding. However, the bilateral in-kind vaccine support was late as the result of domestic priorities taking precedence and because of extensive legal risk assessments for donating vaccines bilaterally and through COVAX.

5. Effectiveness: What are the early results of the Netherlands' development and humanitarian response to the COVID-19 pandemic?

The other evaluation criteria (relevance, coherence and efficiency) influence whether the Dutch development and humanitarian response was effective. This study found sufficient evidence to illustrate the extent to which the Dutch response contributed towards the objectives, even though there was limited ex-post evidence on early results.

For example, the Netherlands contributed to global COVID-19 control through investments in ACT-A's diagnostics, vaccines and therapeutics pillars. These investments helped further vaccine research and development; increase global testing capacity; and improve country readiness for vaccine rollouts, strengthening national health systems. The reliance on COVAX and bilateral vaccine donations improved access to vaccines for low- and middle-income countries. However, the extent to which these investments led to a higher vaccine coverage in these countries could not be determined. Furthermore, the lack of coherence between the Dutch bilateral donations to countries mentioned in this study, on one hand, and the objective to increase equitable vaccine access on the other, led the evaluation team to conclude that (overall) the Netherlands has made only had limited contributions to this equity objective.

The Netherlands' financial contributions included, among others, the second-highest donation to UNOCHA's CERF. The Dutch response also addressed the socioeconomic impacts of the pandemic through the IMF, as noted in the independent evaluation of the IMF's COVID-19 response, and maintained focus on other diseases, leading to the inclusion of MHPSS in the Global Humanitarian Response Plan to the COVID-19 Pandemic. Moreover, the speed of fund disbursements during the pandemic contributed to rapid subsequent disbursements to frontline actors, which facilitated an effective humanitarian response to the pandemic.

Last, throughout the pandemic period, the Netherlands ensured that its COVID-19 aid package was additional to regular ongoing development co-operation and humanitarian assistance budgets. In doing so, the Netherlands successfully protected its ODA budget as it had committed to do in the DAC joint statement on the COVID-19 pandemic.

5.2. Looking forward: Cross-cutting themes and lessons

Forward looking: What good practices, innovations and lessons learned emerged? How might they inform future crisis response?

In the future, an overarching strategic crisis response plan based on lessons learned and with high-level political support could improve the Dutch MFA's crisis preparedness and minimise risks of institutional memory loss and strategic uncertainties following ad hoc political decision making.

The Dutch international development and humanitarian response to the pandemic required collaboration within and across various ministries including the MFA, the MoH, the Ministry of Economic Affairs and the Ministry of Defence and was, for the most part, timely. The study found strong examples of interministerial and intra-ministerial crisis co-ordination. Dedicated task forces structured and managed this co-ordination. Members of the task forces had clear roles and responsibilities, and the co-ordinators regularly engaged with high-level decision makers. However, these task forces have since been disbanded, and this study has not identified formal operational lessons for future crises that could have been drawn from this experience.

The COVID-19 response was also informed by relevant information, consultations and staff expertise. A clear example of this was the Netherlands' early recognition of the need to focus on health systems strengthening and preventing the de-prioritisation of other diseases. However, 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. This is especially concerning considering the risk of losing institutional memory due to high staff turnover and rotation, particularly among senior-level staff and in fragile contexts, as identified in the recent Peer Review of the Netherlands' development co-operation (OECD, 2023[6]).

The Netherlands' response to the pandemic faced additional challenges. For instance, the study found that different collaborating Dutch ministries were guided by different priorities. Combined with occasional ad hoc political decision making, this resulted in strategic uncertainty and incoherence in the Dutch response. The good practices identified in this case study could be reinforced and challenges minimised in future crisis responses if the MFA were to develop an overarching strategic crisis response plan. Such a plan could incorporate internal reflections on specific elements such as task force structures as well as on the overall pandemic response (e.g. what worked well and what did not). Formalising these learnings into a consistent approach would mitigate the risk of institutional memory loss, ensure high-level engagement during the crisis period, and minimise strategic and/or directional uncertainties in a crisis setting. Such a response plan 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 requirements. Finding a balance between strategic planning and a timely response could lead to benefits in terms of relevance, coherence, efficiency and effectiveness.

While it is impossible to anticipate every aspect of a crisis and crises themselves can vary in impact, scale and geography, some lessons can be generalised and contextualised based on the situation. If such a crisis response plan is developed, the process of developing it can in itself prove useful, stimulating important reflections around the necessary preconditions to ensure that the plan is effective and flexibly operationalised. Evaluations of past crisis responses and the lessons learned from successes and challenges can also stimulate these reflections and help improve preparedness and future response effectiveness.

The following three lessons on the cross-cutting themes of equity, channels and partnerships, and M&E could be part of or inform the strategic crisis response plan.

Equity: It is necessary to define, operationalise and monitor equity objectives to achieve a more equitable response in the future

The fourth objective of the Dutch response mentioned equity and was to contribute to global equity goals regarding access to vaccines. This study found that the approach of the Netherlands to work mainly through multilateral channels contributed to inter-country equity in that the Dutch contribution to COVAX mainly enhanced access to vaccines for low- and middle-income countries. However, a potential lesson emerging from the Dutch response is that to achieve equity, the concept needs to be operationalised and integrated throughout the response. Equity objectives are difficult to achieve within decision making, bilateral support and multilateral programming without active steering. The aggressive procurement of vaccines by the Netherlands, the lack of needs assessments informing bilateral donations, and the lack of monitoring that prevented any analysis of results – and thus lessons in this regard – all highlight that the Dutch response could have done more to contribute to increasing equitable access to medical products.

Equity differs from equality mainly in the sense that it requires clear analysis to determine which people are disadvantaged and what factors cause this disadvantage and inequality and, following the analysis, identification of what is needed to combat these inequalities (Solar and Irwin, 2010[76]). While the Dutch response had the objective of improving equitable access to vaccines, operationalisation of this objective and specifically the principle of equity could have contributed to more targeted and intentional decision making. Given shifting national and international priorities and the various (multilateral and bilateral) funds and programmes, a continuous focus on what is necessary to achieve equity could lead to a more effective response in this regard. This focus also should include analysis of in-country needs of receiving countries once the Dutch government decides to provide bilateral support for and steering on the importance of in-country equity in multilateral initiatives and funds. While it is understandable that in-country distribution and vaccination programmes were left to national governments during the COVID-19 crisis, it is unlikely that achieving global equity goals will be achieved without including the principles in conversations. The Netherlands could have done more in this regard by actively steering and emphasising their importance in such agreements.

Channels and partnerships: Mapping possibilities for rapid funding of non-multilateral actors, removing potential barriers and conducting a transparent stakeholder analysis may enable strategic funding decisions in future crises

The findings show that during the pandemic, there was a tendency at the MFA to fund multilateral organisations. In the period 2016-2022, 49% of regular Dutch ODA goes to multilateral organisations and 17% to NGOs. During the COVID-19 response, 79% went to multilateral organisations and only 12% to

NGOs. Allocations were in line with objectives, but the study found it was unclear whether the selected partners were the ones best placed to achieve the objectives at that particular time. The study did not always find that strategic decision making underlay this funding shift towards multilateral organisations. Rather, the findings show that logistical reasons partly influenced the preference for multilateral organisations, such as the experience that drawing up larger contracts with these organisations was less time-consuming than doing so with NGOs. At the same time, 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. Moreover, only 6% of the response went through the private sector, although this sector proved to be of vital importance in the response in Suriname. Altogether, these findings highlight a potential limitation in strategic funding decision making during crisis settings.

To enable strategic, evidence-based decision making in future crises, the MFA could start exploring possibilities for rapid funding for non-multilateral actors during crisis periods. It could, for instance, map the current funding process and possible limitations and explore how such barriers could be minimised during a crisis. Adopting lighter funding frameworks could minimise the barriers, as could conducting a transparent stakeholder analysis at the onset of a crisis. The MFA could include such provisions in the strategic crisis response plan to ensure their institutionalisation.

Monitoring and evaluation: Exploring ways for M&E to be more feasible and realistic for partners in times of crisis could improve future accountability and facilitate learning to inform future strategic crisis response plans

The study found a notable lack of information regarding the outcomes of the Netherlands' COVID-19 response. While quantitative short-term results of regular development co-operation and humanitarian assistance from 2020-22 were available, there was very little to no documentation on the results of the COVID-19 response package and bilateral aid. Given that much of the response funding flowed through the multilateral system, the Netherlands relied on the M&E systems of these institutions as well as those of MOPAN. The information coming from these sources was also limited, specifically on outcome level. This made it difficult to assess to what extent activities achieved their intended results. The lack of disaggregated data on country level further complicated reflections on equity, as discussed in the section on equity.

Regarding bilateral support, the MFA required minimal M&E because it was perceived as unrealistic to request M&E during the crisis, as discussed in section 1.3. To mitigate the lack of M&E, starting in March 2020, the Dutch MFA used the COVID-19 marker to track any funding related to the pandemic. However, these data did not provide any information on results and therefore did not allow for proper triangulation of interview data that contained certain biases, as mentioned in the discussion of limitations in Chapter 1.

This data gap makes learning challenging and also poses challenges to accountability. Exploring more feasible and realistic ways of M&E during a crisis could help fill this gap. For instance, Dutch policy officers stationed at embassies suggested logging some basic information on the crisis response and the processes surrounding Dutch bilateral support in the countries where they serve. These kind of data could be useful to mitigate instances of recall bias and ensure that lessons learned can be institutionalised and are not dependent on the memory of individual policy officers. Doing so could result in valuable input for a future strategic crisis response plan, as this study suggests.

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Notes

[1] For more information, see www.covid19-evaluation-coalition.org.

[2] Participants in the COVID-19 Global Evaluation Coalition developed the shared evaluation framework. It includes six overarching questions that examine, to varying degrees, the relevance, effectiveness, coherence, efficiency, impact and sustainability of the international development and humanitarian co-operation provided to ODA-eligible recipients across all three non-clinical dimensions of the pandemic: the direct health response, the secondary effects and building back better. The shared framework acts as a common frame against which individual governments can evaluate their responses and serves a critical comparison purpose.

[3] The MFA data include activities tagged as the CRS code 12264-COVID-19 control as well as activities with the word COVID in the activity or budget description. The data on actual disbursements are from the Management Information Foreign Affairs database (MIBZ).

[4] These figures represent actual disbursements and are based on internal data provided by the MFA and its MIBZ database.

[5] This amount represents 30% of the Dutch contribution to the SPRP. The other 70% qualifies as ODA and was provided by the MFA via the Minister for Foreign Trade and Development Cooperation.

[6] The COVAX Facility was one of four pillars under the Access to COVID-19 Tools Accelerator, a global initiative co-convened by nine leading global health organisations. The other three pillars were diagnostics, therapeutics and the health systems connector pillar that worked across the other three. See https://www.who.int/initiatives/act-accelerator/faq.

[7] To meet ACT-A's need for grant funding in 2020 and 2021, the ACT Facilitation Council Financial Working Group (now the Accelerator Facilitation Council Financial and Resource Mobilization Working Group) developed a fair share model for voluntary contributions from countries. This model considered a country's wealth (gross domestic product at market exchange rate) and economic openness, progressive contribution principles, and a risk buffer. For details on the methodology, see https://www.who.int/publications/m/item/consolidated-financing-framework-for-act-a-agency-in-country-needs.

[8] In this context, people of Surinamese descent are people born in Suriname. There were an additional 50 800 people who were born in the Netherlands and had one or both parents born in Suriname. See https://longreads.cbs.nl/integratie-en-samenleven-2022/.

[9] The SU4SU was dissolved in November 2022 and handed over its work to the Surinamese government.

[10] The Special Envoy was partly financed through the Makandra programme, which was carried out in close collaboration with the Surinamese government. This programme is demand driven and focused on bilateral governmental co-operation and the supply of technical assistance to Suriname. It had a total budget of EUR 6 million for the 2021-25 period. Other objectives of Makandra were strengthening the rule of law and supporting the government and government agencies to set up frameworks and requirements for sustainable development and economic growth. See https://zoek.officielebekendmakingen.nl/kst-20361-194.html (in Dutch).

[11] The MFA, the MoH and the Senior Civil Service (SCS) co-operated in financing the second phase of this technical support. The Special Envoy's salary was paid by the Top Management Group, a group within the SCS that includes secretaries-general, directors-general, inspectors-general and other equivalent positions. Financing was also provided through the Makandra programme.

[12] Interviewees mentioned the occasional ad hoc nature of such support. For instance, the Netherlands provided in-kind assistance to India during the wave of infections from the Delta variant that had a devastating impact on the country. For more information, see https://www.hindustantimes.com/videos/coronavirus-crisis/switzerland-netherlands-send-oxygen-concentrators-other-medical-aid-to-india-101620363233447.html.

[13] Insufficient staff capacity necessitated the recruitment of one full-time employee at the MFA to co-ordinate the bilateral support. Co-ordinating the bilateral agreements required extensive logistical arrangements and new agreements with private companies and other Dutch ministries, which underwent several rounds of due diligence and approvals. Engagement between the MFA and the MoH was also mentioned in interviews as challenging for both sides.

[14] In addition to COVAX donations, the Netherlands donated excess vaccine supplies that it had already received and were at risk of expiring before they could be used. These donations had to be done bilaterally due to legal and operational challenges associated with donating doses physically present in the donating country through COVAX.

[15] A third structure that had no clear links to the Dutch development and humanitarian response was the Crisis Coordination Structure**.** The MFA activated this structure (which could be set up on an ad hoc basis within the National Crisis Structure mechanism) in 2020 to address the challenges posed by the COVID-19 pandemic. Multiple MFA directorates collaborated under this mechanism, which was overseen by a central crisis co-ordinator. The character of the pandemic required a focus on informing and repatriating Dutch citizens abroad, a responsibility managed through expansion of the crisis structure for consular affairs. Additionally, the Crisis Coordination Structure assumed responsibility for ensuring the safety and well-being of embassy personnel, including Dutch and local employees, as well as staff within the MFA. See https://www.rijksoverheid.nl/ministeries/ministerie-van-buitenlandse-zaken/organisatie/het-ministerie-van-buitenlandse-zaken-in-crisissituaties#anker-6-veiligheid-van-eigen-personeel (in Dutch).

[16] These departments were the Multilateral Organisations and Human Rights Department, Sub-Saharan Africa Department, Sustainable Economic Development Department (DDE), Social Development Department (DSO), Inclusive Green Growth Department (IGG), Stabilisation and Humanitarian Aid Department (DSH), European Integration Department (DIE), Financial and Economic Affairs Department (FEZ), and the Office for International Cooperation.

[17] The Netherlands' bilateral in-kind donations required co-ordination between the MFA, the MoH, and the ministries of finance, justice and security, and defence.

[18] The thematic departments represented on the ICST were the DIE (coherence with EU); the DSO (development co-operation, coherence with COVAX and other development support); the DSH (expertise centre for EU civil protection), the FEZ (budget), the Communications Department; the Shared Service Organization 3W (logistics); the Legal Affairs Department; and the Financial Service Organization (purchasing).

[19] The three were the director-general for international cooperation, director-general for political affairs and director-general for European cooperation.

[20] Institutional flexibility in this section refers to the degree of adaptation that the Netherlands allowed recipient organisations in implementation within the existing funding agreement.

[21] Organisations receiving subsidies under articles 2.5, 4.2, 5.1, 6.1, 6.2, 6.4, 7.1, 7.2, 8.1 and 10.2 of the Subsidieregeling Ministerie van Buitenlandse Zaken 2006 (policy rules for subsidisation Ministry of Foreign

Affairs 2006) were eligible. These included, among others, partnerships on food security, water, safety and rule of law, human rights, SRHR, gender, climate, and private sector development.

[22] The assessment of redirection requests considered factors such as synergy with actions of other actors; the applicant's sphere of influence and capacities; feasibility of proposals; alignment with local contexts; and potential for rapid deployment, upscaling and result achievement. See https://zoek.officielebekendmakingen.nl/stcrt-2020-21245.pdf (in Dutch).

[23] In 2020, the MFA provided contributions to the DGGF Track 2 with the aim of increasing opportunities for emergency financing for local small and medium-sized enterprises in developing countries. Track 2 is a fund of funds that invests in investment funds and financial institutions in DGGF countries; it was the eighth-largest recipient of Dutch COVID-19 funding. The goal was to prevent acute bankruptcies during the crisis and the loss of employment. However, an earlier pandemic evaluation of the DGGF found that the Track 2 target on job creation was unrealistic and subject to optimism bias in non-crisis periods (https://www.itad.com/project/evaluation-of-the-dutch-good-growth-fund/), and thus the target was even less realistic during the pandemic.

[24] The Netherlands funded the MCF of PharmAccess, which funded health clinics in African countries. An independent evaluation found this support to be particularly effective in filling gaps in funding, as the MCF enabled public entities to respond to the COVID-19 pandemic. In several countries, it was the only fund that provided loans in the initial pandemic period. See https://www.government.nl/documents/reports/2022/02/28/evaluation-report-2016-2021-health-insurance-fund.

[25] In 2015, a debt relief trust originally set up to help Haiti respond to an earthquake was transformed into the CCRT, initially to help some West African countries tackle the Ebola pandemic and subsequently to help other LICs affected by public health disasters. See https://ieo.imf.org/en/Evaluations/Completed/2023-0313-imfs-emergency-response-to-the-covid-19-pandemic.

[26] On 11 May 2020, the Netherlands Advisory Council on International Affairs recommended allocating EUR 1 billion to combat COVID-19 globally and urged that this funding be additional to existing development and humanitarian budgets; see https://www.adviesraadinternationalevraagstukken.nl/documenten/publicaties/2020/05/11/nederland-en-de-wereldwijde-aanpak-van-covid-19 (in Dutch). In response, the minister for BHOS announced an additional EUR 150 million of ODA support; see https://zoek.officielebekendmakingen.nl/kst-33625-320.pdf (in Dutch). This new funding brought the total COVID-19 aid package to EUR 265 million in 2020.

[27] Between 2018-20, the FMO ranked as the fifth-largest mobiliser of private finance for sustainable development among OECD DAC bilateral providers. Using a combination of instruments such as credit lines and loans, the Netherlands mobilised USD 600 million on average per year, including finance for sustainable development.

[28] The MASSIF fund is managed by the FMO on behalf of the Dutch government. The fund provides access to financial services for MSMEs with a focus on women and youth entrepreneurs. See https://www.fmo.nl/partner-with-us/massif.