

Main Report

**INTER-AGENCY
HUMANITARIAN EVALUATION
of the COVID-19 Humanitarian
Response**



2022



INTER-AGENCY HUMANITARIAN EVALUATION of the COVID-19 Humanitarian Response

Management and implementation of the evaluation

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Acronyms

AAP	Accountability to Affected Populations
ACAPS	Assessment Capacity Project
ADWG	Age and Disability Working Group
AHF	Afghanistan Humanitarian Fund
ALNAP	Active Learning Network for Accountability and Performance
AoR	Area of Responsibility
CAR	Central African Republic
CASS	<i>Cellule d'Analyse en Sciences Sociales (Social Sciences Analysis Cell)</i>
CBO	Community-Based Organization
CBPF	Country-Based Pooled Fund
CCI	Cross-cutting issues
CEPI	Coalition for Epidemic Preparedness Innovations
CERF	Central Emergency Response Fund
CSO	Civil Society Organization
COVAX	COVID-19 Vaccines Global Access
CP	Child Protection
CVA	Cash and Voucher Assistance
DRC	Democratic Republic of the Congo
EDG	Emergency Director's Group
ERC	Emergency Relief Coordinator
ERP	Emergency Response Preparedness
ESSN	Emergency Social Safety Net
EVD	Ebola Virus Disease
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
FTS	Financial Tracking Service
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GCCG	Global Cluster Coordination Group
GHC	Global Health Cluster
GHO	Global Humanitarian Overview
GHRP	Global Humanitarian Response Plan
GIMAC	Global Information Management, Assessment and Analysis Cell
GOARN	Global Outbreak Alert and Response Network
GPMB	Global Preparedness Monitoring Board
HB	Humanitarian Buffer
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HNO	Humanitarian Needs Overview
HPC	Humanitarian Program Cycle
HRP	Humanitarian Response Plan
IAHE	Inter-Agency Humanitarian Evaluation
IASC	Inter-Agency Standing Committee
ICC	Inter-Cluster Coordination
ICU	Intensive Care Unit

ICVA	International Council of Voluntary Agencies
IDPs	Internally Displaced Persons
IFRC	International Federation of the Red Cross and Red Crescent Societies
IHR	International Health Regulations
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
IPC	Integrated Phase Classification
JEE	Joint External Evaluation
JRP	Joint Response Plan
LMIC	Low- and Middle-Income Countries
L/NA	Local/National Actors
MPTF	Multi-Partner Trust Fund
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OPAG	Operational Policy & Advocacy Group
PHEIC	Public Health Emergency of International Concern
PiN	People in Need
PIP	Pandemic Influenza Preparedness
PPE	Personal Protective Equipment
PSEA	Protection from Sexual Exploitation and Abuse
RA	Reserve Allocation
RC	Resident Coordinator
RCO	Regional Coordinator's Office
RCCE	Risk Communication & Community Engagement
RRP	Refugee Response Plan
SARI ITCs	Severe Acute Respiratory Infection Isolation and Treatment Centres
SARS	Severe Acute Respiratory Syndrome
SARS- CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SDG	Sustainable Development Goal
SEA	Sexual Exploitation and Abuse
SERP	Socio-Economic Recovery Plan
SPRP	Strategic Preparedness & Response Plan
SRF	Solidarity Response Fund
SRH	Sexual and Reproductive Health
STAG-IH	Strategic and Technical Advisory Board on Infectious Hazards with Pandemic and Epidemic Potential
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UN Habitat	United Nations Human Settlements Programme
UNHAS	United Nations Humanitarian Air Service
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNSDCF	UN Sustainable Development Cooperation Framework
UK	United Kingdom
US	United States

WFP World Food Programme

WHO World Health Organization

Context of the COVID-19 response

The development of the global pandemic architecture

1. After the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS)/H1N1, significant progress was made towards strengthening pandemic preparedness. Most notably, the International Health Regulations (IHR) were agreed, providing an overarching legal framework to define the rights and obligations of countries in handling public health events and emergencies with the potential to cross borders.¹ The Global Outbreak Alert and Response Network (GOARN)² had already been established back in 2000, but its global toolkit was expanded with the concept of the Public Health Emergency Operations Centre Network, which became a reference for best practice.³ The SARS outbreak also resulted in the adoption of the concept of a '*public health emergency of international concern (PHEIC)*'⁴ within the revised International Health Regulations, which was agreed to in 2005.
2. Despite these advances, the inadequacies of pandemic preparedness and response were laid bare during the Ebola outbreak in West Africa in 2014-16. The pandemic reached PHEIC status, overwhelmed national and regional capacities, and presented incontrovertible evidence of gaps in epidemic/pandemic preparedness and response, alongside the significant impact on affected communities. The performance of the formal system was largely deemed to be inadequate and there were urgent discussions about reform. Despite widespread concerns that the global health system was not fit-for-purpose and sustained advocacy on the importance of strengthening the global health system, that reform was never fully achieved.⁵ After the international threat had passed, there was a lack of sufficient support to develop a radically changed set of instruments.
3. That is not to say that progress in strengthening pandemic preparedness completely stalled. In 2016, the Joint External Evaluation (JEE) Process was developed as a voluntary, independent process to assess national public health preparedness capacities under the IHR. This mechanism for country-level assessment was intended to assist in developing national action plans⁶ and provided the baseline for global preparedness of states.⁷ Over 100 JEEs were conducted between 2016 and 2019,⁸ many by African

¹ https://www.who.int/health-topics/international-health-regulations#tab=tab_1

² GOARN is a WHO network of over 250 technical institutions and networks globally that respond to acute public health events with the deployment of staff and resources to affected countries.

³ Shuaib FM, Musa PF, Muhammad A, Musa E, Nyanti S, Mkanda P, Mahoney F, Corkum M, Durojaiye M, Nganda GW, Sani SU, Dieng B, Banda R, Ali Pate M. Containment of Ebola and Polio in Low-Resource Settings Using Principles and Practices of Emergency Operations Centers in Public Health. *J Public Health Manag Pract*. 2017 Jan/Feb;23(1):3-10. doi: 10.1097/PHH.000000000000447. PMID: 27488940.

⁴ A PHEIC is defined in the IHR (2005) as, "an extraordinary event which is determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response". This definition implies a situation that is: (i) serious, sudden, unusual or unexpected; (ii) carries implications for public health beyond the affected State's national border; and (iii) may require immediate international action. See <https://www.who.int/news-room/questions-and-answers/item/emergencies-international-health-regulations-and-emergency-committees>.

⁵ The Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (2019) From "never again" to the "new normal": What does the 2018–2019 Ebola outbreak in the Democratic Republic of the Congo tell us about the state of global epidemic and pandemic preparedness and response?

⁶ McPhee, E., Gronvall, G.K. & Sell, T.K. Analysis of sectoral participation in the development of Joint External Evaluations. *BMC Public Health* 19, 631 (2019). <https://doi.org/10.1186/s12889-019-6978-8>.

⁷ <https://bmcpubhealth.biomedcentral.com/articles/10.1186/s12889-020-8359-8>.

⁸ There are 194 WHO member states and a country completes a JEE every 4-5 years.

states.⁹ Additionally, the Pandemic Influenza Preparedness (PIP) Framework¹⁰ contributed to this foundation of preparedness, as did the work of the Strategic and Technical Advisory Group on Infectious Hazards with Pandemic and Epidemic Potential (STAG-IH).¹¹ Between 2016 and 2019, the World Health Organization (WHO) reported that 63 After Action Reviews and 117 Simulation Exercises had been conducted.¹²

Emergence and impact of COVID-19

4. On 30 January 2020, WHO declared a PHEIC due to the outbreak of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). However, most countries did not take action until WHO characterized COVID-19 as a global pandemic on 11 March 2020.¹³
5. The scale and scope of the pandemic was extraordinary and the global nature of the response was of a magnitude and complexity that went far beyond any previous IAHE action. The dimensions of the crisis stretched the capacity of the collective humanitarian system for a number of reasons:
 - In 2020, the number of people assessed to be in need of humanitarian assistance was already at the highest level for decades and the pandemic occurred at a time when the system was already over-stretched.¹⁴
 - The increase in the scale and geographic spread of needs was significant. By December 2020, 243.8 million people across 75 countries required humanitarian assistance, an increase of 45% from pre-pandemic projections.¹⁵ The global nature of the pandemic had implications for funding as donors were responding to domestic needs in addition to funding the international response.
 - Movement restrictions and travel bans made it more difficult to access those in need and significantly disrupted humanitarian delivery systems.
 - The pandemic response was launched at a time when information about it was scarce; key gaps in knowledge included factors that were thought to exacerbate the spread of the virus, challenges in making sense of the caseload and mortality data, a lack of understanding and analysis of the secondary impacts of the crisis, and limited information about national response plans.

⁹ JEE | Strategic Partnership for Health Security and Emergency Preparedness (SPH) Portal (who.int).

¹⁰ The PIP Framework came into effect in May 2011 and brings together Member States, industry, other stakeholders and WHO to implement a global approach to pandemic influenza preparedness and response. See <https://www.who.int/initiatives/pandemic-influenza-preparedness-framework>.

¹¹ Established in 2018, STAG-IH provides independent advice and analysis to WHO on the infectious hazards that may pose a potential threat to global health security. It has an umbrella function as the overarching group advising WHO on relevant infectious hazards. See [https://www.who.int/groups/strategic-and-technical-advisory-group-for-infectious-hazards-\(stag-ih\)/terms-of-reference](https://www.who.int/groups/strategic-and-technical-advisory-group-for-infectious-hazards-(stag-ih)/terms-of-reference).

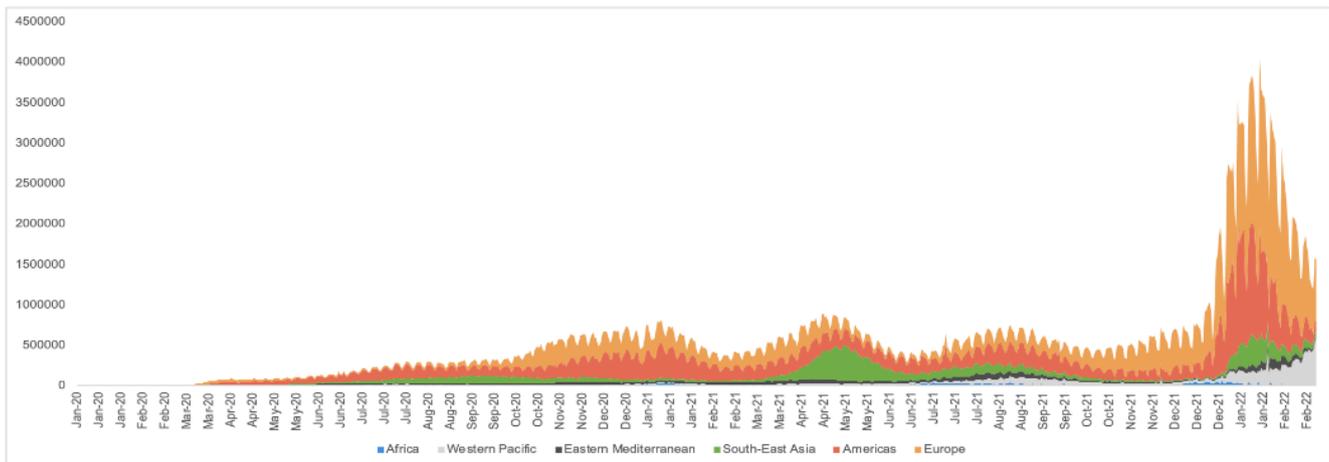
¹² Simulation exercises and after-action reviews – analysis of outputs during 2016–2019 to strengthen global health emergency preparedness and response | Globalization and Health | Full Text (biomedcentral.com).

¹³ The Independent Panel for Pandemic Preparedness and Response (2021) *COVID-19: Make it the last pandemic*.

¹⁴ United Nations Office for the Coordination of Humanitarian Affairs (2019) *Global Humanitarian Overview, 2020*. United Nations.

¹⁵ United Nations Office for the Coordination of Humanitarian Affairs (2021) *Global Humanitarian Overview, 2022*. United Nations.

Figure 1: Timeline of confirmed cases of COVID-19 by WHO region¹⁶



6. While almost all countries have reported cases of COVID-19, the timeline above (Figure 1) illustrates that countries and regions experienced waves of infection at different times for the period under review¹⁷ even taking into account relative testing and reporting capacities.
7. The COVID-19 pandemic was not only a health crisis, but also a disruption to long-term socio-economic development, impacting supply chains, unsettling financial markets, affecting education (particularly due to school closures), and livelihoods (particularly of low-wage workers and the informal sector). A combination of these factors and measures put in place to suppress the virus have led to higher levels of food insecurity as well. The pandemic highlighted global inequalities whereby lower-income countries or specific population groups are affected disproportionately in terms of access to food and basic services, causing existing vulnerabilities to be further exacerbated. Effects on vulnerable groups include domestic violence, early child marriage, and child protection (CP) risks.¹⁸ Border closures had a significant impact on refugee crises, as 160 countries fully or partially closed their borders, with over half of them making no exception for refugees or asylum seekers.¹⁹ This exacerbated the impact of a triple crisis (with health, socio-economic and protection dimensions) that the pandemic created for refugees, Internally Displaced Persons (IDPs), migrants and stateless persons.²⁰
8. The pandemic has continued into 2022 as well with significant ongoing global effects. According to the 2022 Global Humanitarian Overview (GHO), COVID-19 infections show no sign yet of abating and have claimed at least 1.8 million lives across the GHO countries. Economic and livelihoods continue to be affected which have served to increase humanitarian needs with additional millions of persons estimated to have been pushed into extreme poverty.²¹
9. COVID-19 has continued to also have indirect effects on health and education as school closures and strains on the health systems have limited children's access to health and education. Globally 870 million students face disruptions to education and 23 million children missed basic childhood vaccines just in 2021.²² The pandemic has also contributed to ongoing food security challenges with the Food and

¹⁶ Source: <https://covid19.who.int/> as of 5 March 2022.

¹⁷ From January 2020 through December 2021.

¹⁸ United Nations (2020) Shared Responsibility, Global Solidarity: Responding to the socio-economic impacts of COVID-19, March 2020.

¹⁹ <https://www.unhcr.org/news/latest/2020/10/5f7dfbc24/covid-19-crisis-underlines-need-refugee-solidarity-inclusion.html>.

²⁰ United Nations (2020) United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better, June 2020.

²¹ UN OCHA (2022) Global Humanitarian Overview 2022.

²² UN OCHA (2022) Global Humanitarian Overview 2022.

Agriculture Organization (FAO) reporting that by the end of 2021, food prices had increased by more than 30 percent since the initial COVID-19 outbreak and have reached their highest levels since 2011.²³

Planning for the COVID-19 pandemic response

10. In response to this multi-layered global crisis, in March 2020, the United Nations (UN) Secretary-General issued a ‘Call for Solidarity’, focusing on three objectives: (i) delivering a large-scale, coordinated health response, (ii) adapting policies and programming to address the socio-economic, humanitarian, and human rights aspects of the crisis, and (iii) rebuilding better – strengthening social protection systems.²⁴ The United Nations report on a comprehensive response to COVID-19 highlights three major response plans to address different needs and aspects of the crisis.²⁵
- The WHO Strategic Preparedness and Response Plan (SPRP), published on 4 February 2020, outlines WHO’s three key pillars of response: (i) coordination and support, (ii) country preparedness and response, and (iii) priority research and innovation acceleration.²⁶ Individual countries created preparedness and response plans, aligned with the response pillars. The initial SPRP (February – June 2020) was updated in April 2020.²⁷
 - The Inter-Agency Standing Committee (IASC) COVID-19 Global Humanitarian Response Plan (GHRP) was launched on 25 March 2020 and covered the period up to the end of December 2020.²⁸ It was the humanitarian community’s first-ever event-specific global appeal. It aimed to: (i) contain the spread of COVID-19, (ii) decrease the deterioration of human rights, assets, and livelihoods, and (iii) protect and assist people particularly vulnerable to COVID-19, such as refugees, IDPs, and migrants.²⁹ The second iteration, published in May 2020, requested US\$6.71 billion to respond to humanitarian needs in an expanded set of 63 countries, with additional countries added to an ‘at risk and to watch list’.³⁰ The third and final iteration of the GHRP, issued in July 2020, requested \$10.3 billion.³¹ Throughout its various iterations, the GHRP remained focused on the immediate humanitarian needs caused by the pandemic and related short-term responses. It did not attempt to cover the full spectrum of pre-existing needs and responses in GHRP countries, which continued to be encapsulated in existing humanitarian plans. These plans were updated during the year to incorporate COVID-19 and adjusted non-COVID-19-related needs and financial requirements (a timeline for the GHRP is provided in Figure 2).
 - The United Nations Framework for the Immediate Socio-Economic Response to COVID-19, which puts the United Nations Secretary General’s “Shared Responsibility, Global Solidarity” statement and report into action, including five streams of work: (i) Protecting health services and systems (ii) Social protection and basic services (iii) Protecting jobs and small and medium-sized enterprises (iv) Macroeconomic response and multilateral collaboration (v) Social cohesion and community resilience.

²³ UN OCHA (2022) Global Humanitarian Overview 2022.

²⁴ <https://unu.edu/news/news/un-secretary-general-covid-19-pandemic-calls-for-coordinated-action-solidarity-and-hope.html>.

²⁵ United Nations (2020) United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better, June 2020.

²⁶ WHO (2020) 2019 Novel Coronavirus (2019-nCoV) Strategic Preparedness and Response Plan, 4 February 2020.

²⁷ WHO (2020) *COVID-19 Strategy Update*, 14 April 2020.

²⁸ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, March 2020.

²⁹ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, March 2020.

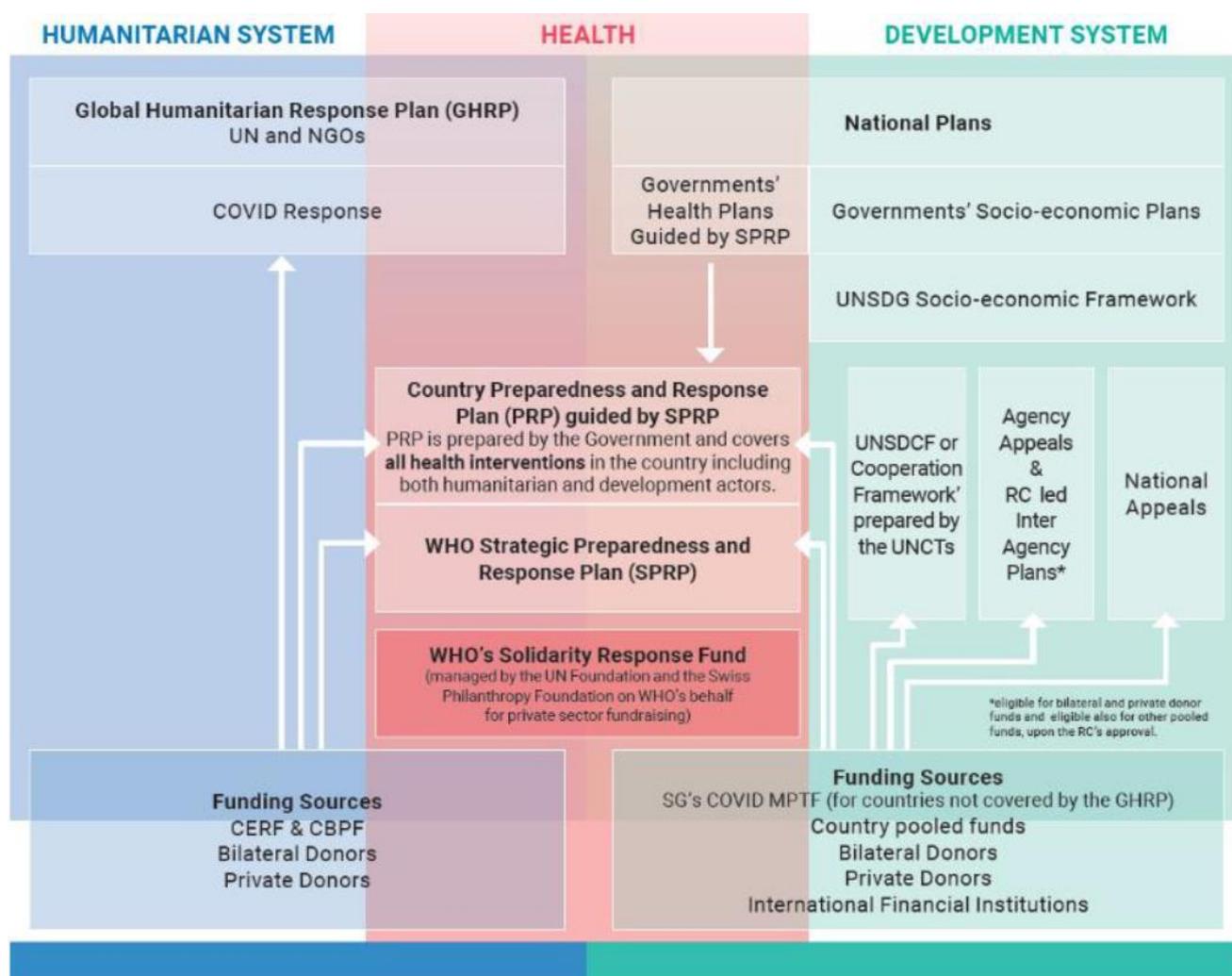
³⁰ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update.

³¹ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP July Update.

Figure 2: Timeline of key events associated with the GHRP³²



Figure 3: Overview of COVID-19 response and recovery frameworks and financing



- Given the multi-dimensional effects of COVID-19, there is a degree of overlap among the three response plans in terms of their objectives and planned activities. Figure 3 illustrates the interconnections among these three plans within the respective dimensions of health, humanitarian response, and development spheres.

³² KonTerra (2022) COVID-19 Global Humanitarian Response Plan: Learning Paper

12. Vaccine development and distribution became an important priority with the emergence of the pandemic. In April 2020, the WHO, in collaboration with the Coalition for Epidemic Preparedness Innovations (CEPI), the Global Alliance for Vaccines and Immunization (GAVI) and United Nations Children’s Fund (UNICEF) established a mechanism for the development and distribution of COVID-19 vaccines using coordinated international resources.³³ The COVID-19 Vaccines Global Access (COVAX) began distributing vaccines in February 2021 and 362 million doses of the vaccines were shipped globally through COVAX with a further 1.4 billion doses forecasted for 2022.³⁴
13. In 2021, the GHRP as a mechanism was discontinued and ongoing pandemic and related short-term responses were integrated into the existing 2021 Humanitarian Response Plans (HRPs), Refugee Response Plans (RRPs) or other humanitarian plans where they existed. This has had implications for reporting and tracking globally the response to the pandemic.

Humanitarian funding for the response

GHRP Funding

14. The first iteration of the GHRP requested \$2.01 billion but, as the full scale of the pandemic’s humanitarian impact began to emerge, this was increased to \$6.71 billion in the May 2020 iteration. The final iteration in July appealed for \$10.31 billion though this was subsequently revised down to \$9.5 billion. By February 2021, the GHRP had raised \$3.8 billion or 40 percent of the requested amount (see Figure 4).³⁵ Total humanitarian funding for COVID-19 in 2020 was \$6.6 billion and included direct funding to governments, the Red Cross/Red Crescent Movement, and funding to United Nations agencies and Non-Governmental Organizations (NGOs) for non-GHRP countries.³⁶ Although the pandemic has continued up until the present, it is not possible to track funding for the COVID-19 response specifically beyond 2020. This is because activities and funding requests have been mainstreamed into ongoing humanitarian responses since the end of the GHRP and there is no mechanism to track funding separately.

Figure 4: GHRP financial requirements and funding: March 2020-February 2021



³³ WHO (2021). WHO SPRP September Update: An urgent call to fund the emergency response. September 2021.

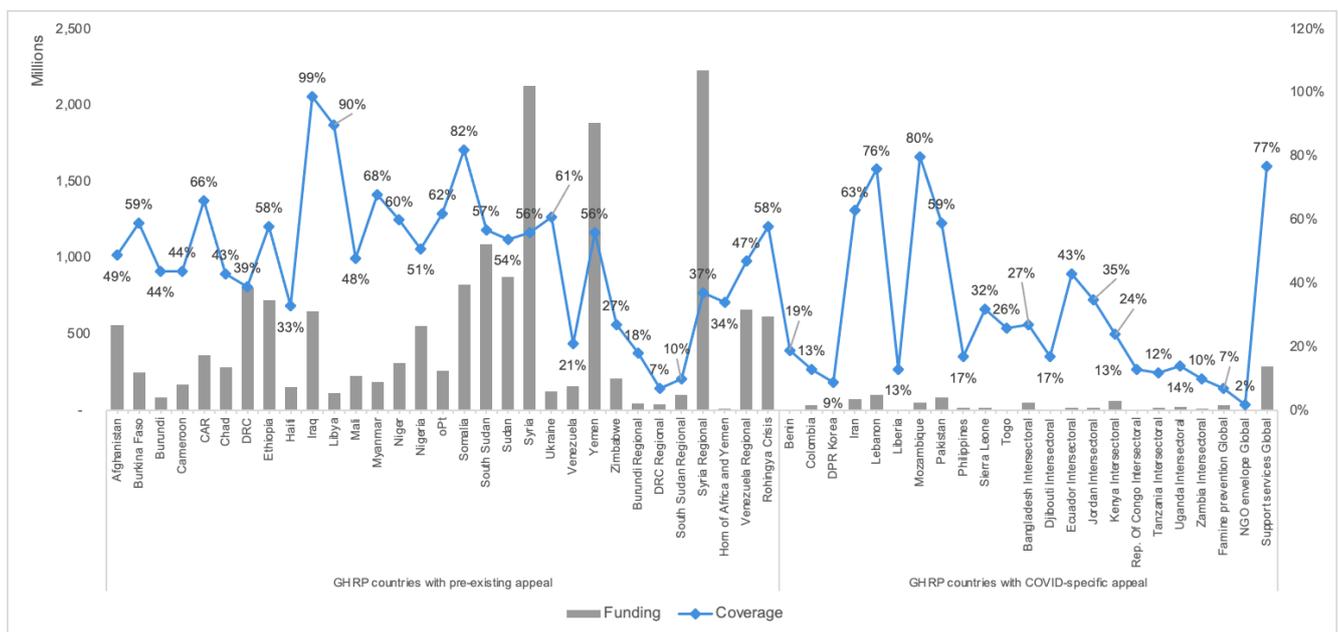
³⁴ UN OCHA (2022) Global Humanitarian Overview 2022.

³⁵ Source: OCHA (2021) Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021.

³⁶ OCHA (2021) Global Humanitarian Response Plan COVID-19, Final Progress Report, 22 February 2021.

15. The May and July 2020 iterations of the GHRP incorporated funding requests from 55 countries that had existing humanitarian appeals (some of these were part of regional appeals) and eight that had humanitarian needs due to COVID-19 specifically. Figure 5 below shows the COVID-19 funding received against each appeal in 2020 (including global funding requests included in the GHRP) and what percentage of the requested funding this represents. This shows that levels of funding varied significantly across the 63 countries included in the GHRP, with only five receiving over 75 percent of their COVID-19 funding requirements. Amongst countries with existing appeals, Iraq and Libya requested modest amounts of funding and received almost the full amount. Somalia also requested a relatively lower amount and received 82 percent of this. There were similar variations in funding for countries that launched COVID-19-specific appeals in 2020, with countries such as Mozambique and Lebanon receiving relatively high proportions of the funding requested and others, such as Colombia, receiving a much smaller proportion.

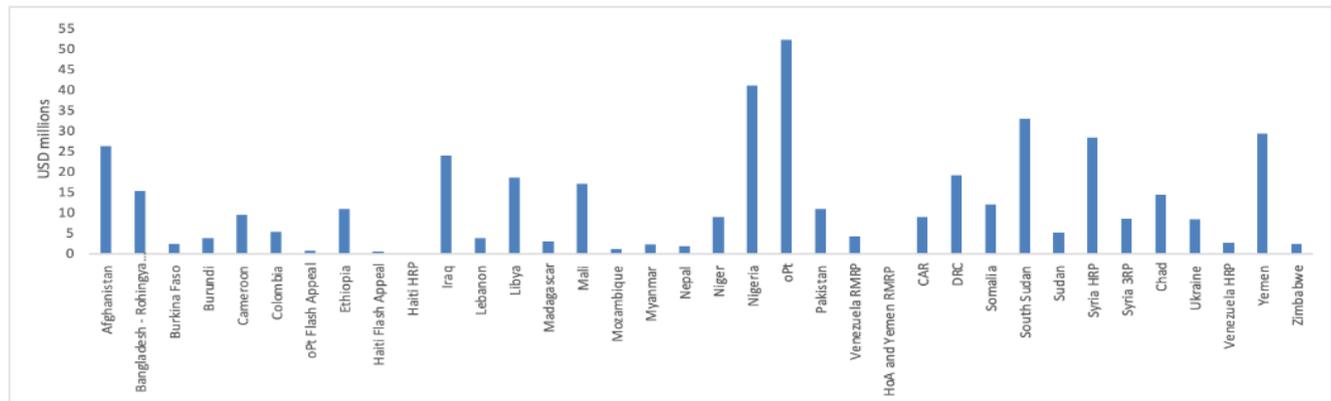
Figure 5: Funding by COVID-19 appeal and level of coverage in 2020³⁷



³⁷ Source: OCHA Financial Tracking Service.

COVID Funding in 2021

Figure 6: COVID-19 funding by appeal in 2021³⁸



16. From January 2021 onwards, once the GHRP period had ended, the IASC response to the effects of COVID-19 was integrated into country-specific HRPs, RRP and other country-level plans. Humanitarian funding for COVID-19-related needs totalled over \$1.5 billion in 2021, according to data from the Office for the Coordination of Humanitarian Affairs (OCHA) Financial Tracking Service (FTS). Of this, \$436 million was provided within humanitarian appeals and \$1.1 billion outside of appeals. Figure 6 shows COVID-19 funding by appeal in 2021.

Pooled Funding

17. As existing humanitarian pooled funds, Central Emergency Response Funds (CERF) and Country-Based Pooled Funds (CBPFs) responded to COVID-19-related needs with significant amounts of humanitarian funding. They began allocating funds from 27 February 2020, even before the launch of the GHRP, and had provided \$204 million by 15 May 2020 (\$95 million through CERF block-grant allocations, \$7.2 million through CERF reprogramming; \$100.2 million through CBPFs allocations and \$1.7 million through CBPF reprogramming).³⁹ Figure 7 shows CERF and CBPF funding for COVID-19 by country.

18. To increase the relevance of the CBPFs in responding to the COVID-19 pandemic, specific flexibility measures were added in the following areas: modifying project ceilings, reprogramming projects, increasing budget flexibility, and monitoring, spot checks, audits, and electronic signatures. The CBPF section also incorporated several measures into global guidance.⁴⁰ CBPFs have been an important mechanism for donors to meet their Grand Bargain commitment on funding to local actors⁴¹ and the GHRP also flagged them as one of the primary ways of channelling funding to local and national humanitarian organizations. In response to COVID-19, 32 percent (\$80 million) of CBPF funding is reported to have gone to local and national actors.⁴²

³⁸ OCHA Financial Tracking Service, data downloaded 8 March 2022.

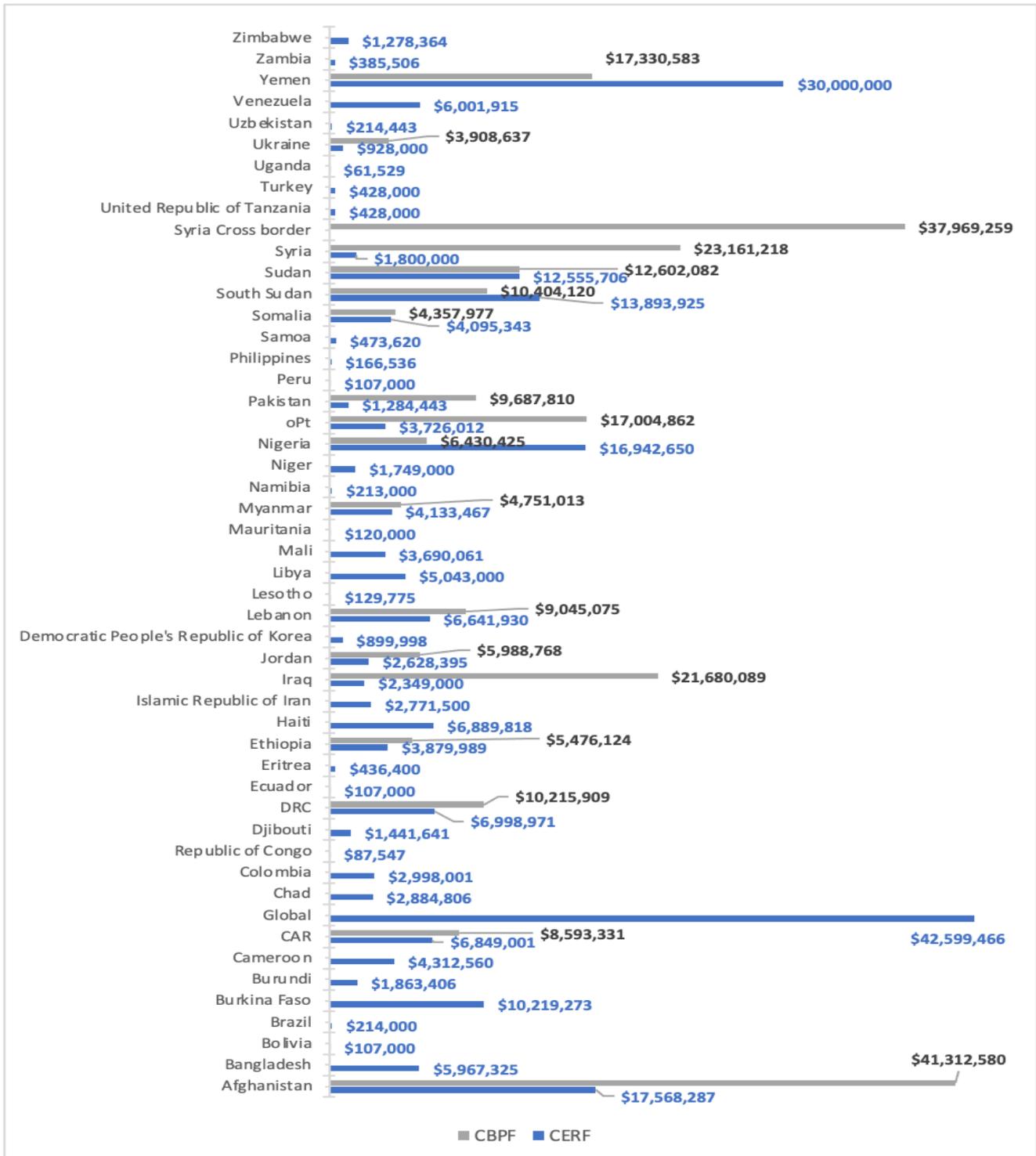
³⁹ UN OCHA (2020) Pooled Funds: Overview of Allocations for COVID-19, 15 May 2020.

⁴⁰ Featherstone, A., and T. Mowjee (2021) *Enhancing Programme Effectiveness of CBPFs*, unpublished.

⁴¹ UN OCHA (2019) *OCHA Evaluation of Country-Based Pooled Funds: Global Synthesis Report*, November 2019. For the full set of Grand Bargain commitments, see https://interagencystandingcommittee.org/system/files/grand_bargain_final_22_may_final-2_0.pdf.

⁴² UN OCHA (2021), *Global Humanitarian Response Plan COVID-19, Final Progress Report*, 22 February 2021.

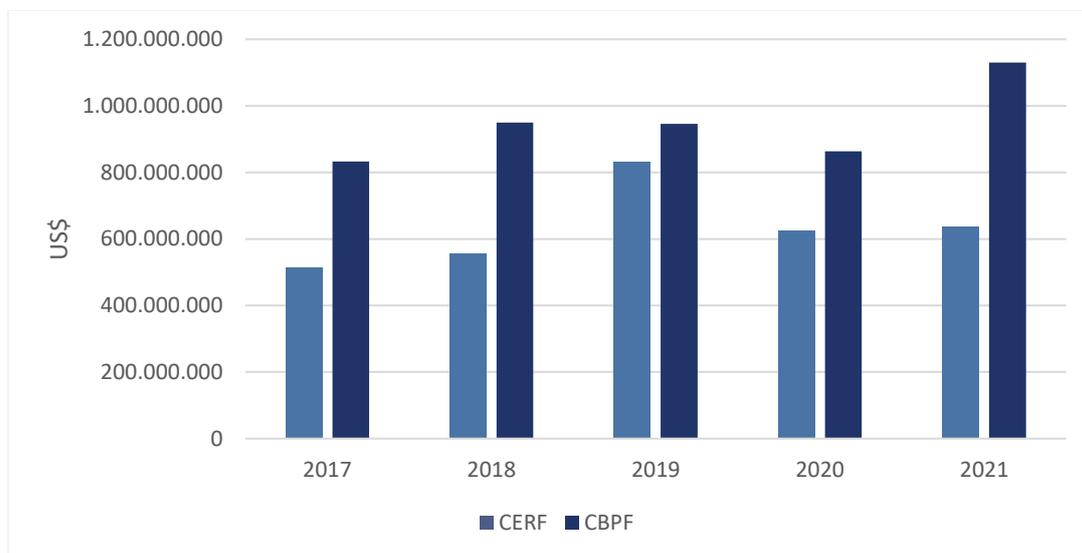
Figure 7: CERF and CBPF COVID-19 funding by country⁴³



⁴³ <https://pfddata.unocha.org/COVID19/>.

19. Although pooled funds played a very important role in providing quality funding to meet priorities within the GHRP, donor contributions to CERF and CBPFs fell in 2020 (see Figure 8).⁴⁴ However, contributions reached a record high of \$1.13 billion in 2021.

Figure 8: Contributions to CERF and CBPFs: 2017-2021



20. In 2020, dedicated pooled funds were set up to finance the SPRP and the socio-economic response plans. WHO, United Nations Foundation and Swiss Philanthropy Foundation jointly launched the Solidarity Response Fund (SRF) on 13 March 2020. Its purpose was to facilitate direct financial contributions from companies, organizations, and individuals to the COVID-19 response by WHO and its partners under the three pillars of the SPRP.⁴⁵ As of November 2021, the SRF had raised almost \$257 million from 676,626 donors. It ceased active fundraising at the end of 2021.⁴⁶
21. On 31 March 2020, the Secretary General launched the United Nations COVID-19 Response and Recovery Fund to support Low- and Middle-Income Countries ((LMIC) to respond to COVID-19 and its impact, particularly the socio-economic shock. The Fund’s purpose is to act as an inter-agency mechanism to contribute to the three objectives of the Secretary General’s Call for Solidarity. The Fund is managed by the United Nations Multi-Partner Trust Fund (MPTF) Office.⁴⁷ As of February 2022, the Fund raised over \$86 million and allocated funding to 80 countries.⁴⁸ Key messages from a lessons learning and evaluability exercise included the importance of the speed of response, the need for pre-existing coordination structures and human resources to sustain a collaborative response, the need for a participatory and inclusive approach to ensure a coherent response, the value of a global response framework with country-level plans, and the need for adequate levels of funding.⁴⁹

⁴⁴ Sources: <https://cerf.un.org/our-donors/contributions-by-donor>; https://cbpf.data.unocha.org/#contribution_heading.

⁴⁵ IOD Parc (2021) UNF-WHO COVID-19 Solidarity Response Fund: Joint Evaluation, December 2021.

⁴⁶ <https://covid19responsefund.org/en/>.

⁴⁷ UN (2020) The Secretary-General’s UN COVID-19 Response and Recovery Fund, April 2020.

⁴⁸ <https://mptf.undp.org/factsheet/fund/COV00>.

⁴⁹ Freeman, T., A. L. Esser, C. Chatterjee, and P. Vela (2021) Early Lessons and Evaluability of the UN COVID-19 Response and Recovery MPTF, April 2021.

Key features of the COVID-19 response

22. Responding to COVID-19 has posed unique challenges and every country has encountered difficulties in responding to it. For the collective humanitarian response, COVID-19 brought to the fore issues that had been long debated and presented new challenges. These included: i) the role of local actors in responses; ii) the differential impact of the pandemic on different population segments; and iii) sectoral and nexus integration to address the multi-layered effects of the pandemic. Other issues that are relevant for the COVID-19 response included the need to plan globally but act locally, the dilemma of access and the call for a global ceasefire, and road-testing collective pandemic preparedness and response.
23. COVID-19 also presented humanitarian actors with challenges and the need to find different ways of operating from the more traditional response to geographically specific emergencies (with the IASC scale-up activation protocols designed for this). Since COVID-19 was a global crisis affecting very large numbers of countries/regions at the same time, this strained the capacity of the existing system to respond adequately. Furthermore, as governments put in place regulations to contain the spread of COVID that shaped both the secondary impacts of the pandemic and the ways in which humanitarian actors assisted, requiring them to find different approaches to overcome restrictions on movement and in-person contact. Finally, the variable and cyclical nature of infections globally significantly affected global capacities for a coordinated response.

Evaluation findings

1 Preparedness

Summary findings

- There was strong evidence across the case studies that preparedness for a global pandemic was a significant weakness. Humanitarian actors were better prepared for other types of emergencies, particularly natural disasters, but these were not considered sufficiently relevant for a pandemic response (section 1.2).
- Despite lessons learned from the responses to other epidemics – Ebola Virus Disease (EVD) in particular – there was strong evidence that the humanitarian sector had not prioritized investment in pandemic preparedness for at least 10 years, due to other competing priorities, as well as a lack of leadership and political will (section 1.1).
- While there was some evidence of better readiness in contexts with recent experiences of other epidemics there was little evidence of systematic learning at a collective level (section 1.2).
- To support the delivery of a timely and relevant humanitarian response, the IASC developed the GHRP within a few weeks and adapted its Scale-Up Protocols for COVID-19. However, the large number of countries targeted stretched the capacities of IASC organizations and limited the relevance of the Scale-up Protocols. Global guidance on Emergency Response Preparedness (ERP) was timely and clear, but there was no evidence that it had been used in the case study countries. Hands-on support from regional offices to countries for post-scale-up preparedness was considered more useful and effective (section 1.3.1).

Individual organizations quickly developed contingency and business continuity plans following the declaration of the pandemic but there were a number of challenges with these, given the scale and complexity of COVID-19, which ultimately overwhelmed capacities and compromised staff wellness. Overall, there was limited evidence of post-declaration collective action on contingency planning (section 1.3.2).

24. In principle, the humanitarian system is a complex network of interconnected institutional and operational entities through which humanitarian assistance is provided when local and national resources are insufficient to meet the needs of the affected population. However, in practice, it has also been described as a *'rather messy assemblage of actors and activities in the humanitarian sector'*,⁵⁰ and notes that some commentators objected to the term on the grounds that it implies an internal logic and functional order that simply does not exist.⁵¹
25. It is this complex system that is required to work together in advance of and during crises to provide assistance to affected people according to need. This section of the report seeks to use the lessons from previous pandemics and a broader analysis of the state of pandemic preparedness to assess the

⁵⁰ Stoddard, A., Harmer, A., Haver, K., Taylor, G., Harvey, P., (2015) *The state of the humanitarian system, 2015 edition*. ALNAP, October 2015.

⁵¹ Ibid.

performance of the sector in preparing for the pandemic and the initial actions that were taken after the Declaration of the pandemic as a PHEIC.

1.1 Lessons from global pandemic preparedness

26. Reflecting on the last ten years of pandemic preparedness, the 2019 annual report on Global Preparedness Monitoring Board (GPMB) lamented that “*many of the recommendations reviewed were poorly implemented, or not implemented at all, and serious gaps persist.*”⁵² This conclusion came after a post-EVD period, during which pandemic preparedness was far from the top of the global priority list. Notably, it was not directly prioritized during the 2016 World Humanitarian Summit, the Agenda for Humanity, nor within the 2030 Sustainable Development Goals (SDGs).
27. Leadership is key to making the shift that is required in pandemic preparedness. The GPMB 2019 annual report emphasized that ‘Leaders at all levels hold the key. It is their responsibility to prioritize preparedness with a whole-of-society approach that ensures all are involved and all are protected.’⁵³ Echoing that sentiment, interviews for this evaluation emphasized that those countries that had demonstrated leadership to sustain investment, undertake simulations and achieve whole-of-government involvement were more successful in their COVID-19 responses. There was also broad consensus among key informants that pandemic preparedness was not considered a sufficiently urgent priority for donors and institutions and that the humanitarian sector’s subsequent investment and preparedness-related activities were shallow due to competing and perceived more urgent priorities.
28. The failure to prioritize pandemic preparedness was not down to a lack of knowledge or warning; between the H1N1 influenza pandemic and the declaration of COVID-19 as a PHEIC, many high-level reports were commissioned on pandemic preparedness activities and responses. These touched on key issues but failed to galvanize collective action.⁵⁴ One analysis of Global Public Health governance indicates that more than 7,000 priority tasks await action; and, while there was strong consensus around priority recommendations, the global governance system lacks the necessary impetus to shift from report writing to system change. It argues that the impact of pandemics is commensurate with other spheres of regulation due to their potential impact on well-being. Therefore, pandemic preparedness requires an approach that repositions global health governance in the world order and puts it on par with economic interdependence or financial stability in terms of governance, institutional backing and resources.⁵⁵
29. This ambition for systemic change was seen as a step too far by many, however.⁵⁶ Interviews undertaken during the evaluation suggested that the period prior to the COVID-19 pandemic was typified by a failure to reach consensus on key issues and a lack of willingness to agree to binding commitments to update the instruments, leaving many of the perceived weaknesses in the IHR unresolved.⁵⁷ This was still the case as COVID-19 spread across the globe, with concerns about issues of compliance and empowerment, early alert and response, as well as insufficient financing and political commitments.⁵⁸

⁵² Global Preparedness Monitoring Board (2019) A World At Risk: Annual Report on Global Preparedness for Health Emergencies, September 2019.

⁵³ Ibid.

⁵⁴ See for example: The Independent Panel for Pandemic Preparedness and Response (2021) *COVID-19: Make it the Last Pandemic*.

⁵⁵ Bucher, A., Papaconstantinou, G. and Pisani-Ferry, J (2022) The Failure of Global Public Health Governance: A Forensic Analysis in *Policy Contribution* Issue n° 03/22 | February.

⁵⁶ <https://www.devex.com/news/majority-of-who-member-states-want-legally-binding-pandemic-instrument-103669>

⁵⁷ Duff, J. et al (2021) A Global Public Health Convention for the 21st Century in *Lancet Public Health* 2021; 6: e428–33 Published Online, May 5, 2021. [https://doi.org/10.1016/S2468-2667\(21\)00070-0](https://doi.org/10.1016/S2468-2667(21)00070-0).

⁵⁸ WHO (2021) WHO’s Work in Health Emergencies. Strengthening Preparedness for Health Emergencies: Implementation of the International Health Regulations (2005). SEVENTY-FOURTH WORLD HEALTH ASSEMBLY A74/9 Add.1 Provisional agenda item 17.3.

30. Now, two years on from the start of the pandemic, COVID-19 has significantly shifted infectious disease events closer to the top of the priority list; at the time of this evaluation, a new proposal for changes to the IHR was under consideration. Presented within the WHO White Paper ‘10 proposals to build a safer world together – Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience’,⁵⁹ the proposal is outlined alongside more than 300 reaffirmed recommendations from various independent reviews of the global response to COVID-19.⁶⁰ Overall, it is more modest in its scope than previously proposed reforms, but may garner greater agreement for this very reason.

1.2 Country and regional preparedness

31. The overriding sentiment from country-level key informants – across all stakeholder groups, both national and international – was that the humanitarian system was not adequately prepared for an event like COVID-19. Although many organizations had preparedness plans and standard operating procedures in place, these were not considered sufficient or relevant for a multi-country crisis of the magnitude and level of complexity of COVID-19.⁶¹ Government stakeholders in some case-study countries similarly described a sense of being taken by surprise by COVID-19, even in contexts subject to frequent shocks and emergencies. Few in-country actors made reference to the IHR which set out the legally binding duties of States and WHO to contain the spread of disease. This, combined with fragile health systems in many of the case-study contexts – demonstrated by shortages of relevant facilities, equipment and a lack of trained healthcare personnel – led to health systems being quickly overwhelmed by the additional burden of COVID-19 and an overall lack of preparedness to respond to the indirect impact of the pandemic on the lives of vulnerable populations.
32. Regional key informants and documents also described gaps in corporate readiness and preparedness across regions before the pandemic, due in large part to an emphasis on disasters caused by natural hazards.⁶² The evaluation found strong evidence that several countries had prepared for other types of emergencies, but these were considered only partially relevant or not relevant at all in response to the pandemic. This was the case in Turkey, for example, where United Nations contingency plans for earthquakes and other natural disasters had been developed but were largely considered irrelevant in response to COVID-19. In Bangladesh, the Humanitarian Coordination Task Team shared an example of a response preparedness plan for flooding,⁶³ and there was evidence of similar plans for cyclones and earthquakes.⁶⁴ Similarly in the Philippines and Colombia, key informants referred to contingency plans for earthquakes, typhoons and other disasters caused by natural hazards. While valid in the context of such events, and undoubtedly useful for countries particularly prone to natural hazards, these plans were generally not found to be useful in the case of a health emergency, particularly one of the scale and complexity of COVID-19, where government actors were clearly in the lead, and restrictions imposed on populations to limit transmission of the virus generated their own negative socio-economic impacts on

⁵⁹ WHO (2022) 10 proposals to build a safer world together Strengthening the Global Architecture for Health Emergency Preparedness, Response and Resilience. White Paper for Consultation, June 2022.

⁶⁰ COVID-19 Pandemic Demonstrates Multilateral Cooperation Key to Overcoming Global Challenges, President Stresses as General Assembly Concludes Annual Debate | UN Press

⁶¹ COVID-19 Global Evaluation Coalition (2021) COVID-19 Pandemic: How are Humanitarian and Development Cooperation Actors Doing so Far? How could we do better? Synthesis of Early Lessons and Emerging Evidence on the Initial Response Efforts, Draft, June 2021.

⁶² See for example: WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022; UNICEF East Asia and the Pacific Regional Office Evaluation Section (2021) COVID-19 Response Real Time Assessment Report, Volume I, Main Report, April 2021; UNICEF (2021) Real-Time Assessment (RTA) of UNICEF’s response to COVID-19 in Latin America and the Caribbean (LAC), Synthesis Report, April 2021; UNICEF Regional Office for South Asia Evaluation Section (2021) Real-Time Assessment of the UNICEF South Asia Response to COVID-19, January 2021.

⁶³ Humanitarian Coordination Task Team Bangladesh (2018) *Response Preparedness Plan Bangladesh: Floods, Final Draft*, June 2018.

⁶⁴ UN Bangladesh (2018) Bangladesh National Cyclone Contingency Plan 2018 (to be updated); UN Bangladesh (2019) Contingency Plan for Earthquake Response in Major Urban Centres, Bangladesh - Scale-Up Activation – Update May 2019.

vulnerable populations. Moreover, preparedness measures and contingency plans at country-level generally did not consider the likelihood of restrictions on movement – of either populations or personnel – and the knock-on effect of those restrictions on supply chains, humanitarian access, duty of care and overall ways of working to respond to increasing humanitarian need.

33. There was some evidence of better preparedness in contexts that had been affected by other epidemics with comparable modes of transmission. Key informants in countries and regions with experience of preventing and responding to EVD, for example, referred to a greater sense of readiness and a familiarity with prevention measures, such as handwashing and the use of Personal Protective Equipment (PPE), and quicker activation of coordination structures, protocols and other ways of working to limit transmission and manage the response. This was the case to some extent in the Democratic Republic of the Congo (DRC) and Sierra Leone, for example, where the relatively recent experience of responding to EVD was noted to have increased familiarity and readiness for response to disease outbreaks. Less tangibly, but arguably just as importantly, key informants from countries with experience of outbreaks such as EVD and SARS, noted a level of fluency in working within public health emergencies and liaising with national and international health actors. Even just being familiar with the terminology and jargon of epidemics and pandemics was described as helpful when working together during the response to COVID-19. In some instances, previous and existing experience and capacity for polio campaigns were utilized for responding to the pandemic.⁶⁵
34. That said, there were limitations to levels of preparedness and readiness, even in contexts with relatively recent experience of viral outbreaks. While individuals and teams in particular contexts may have had relevant experience to draw on, key informants noted a lack of systemized institutional learning, resulting in missed opportunities to collectively act on lessons learned, dispersed capacities and inadequate corporate investment in preparedness systems and assets for epidemic outbreaks and other comparable emergencies.

1.3 IASC Scale-up after declaration of the pandemic

1.3.1 Global action

35. Following WHO's declaration of COVID-19 as a global pandemic, the IASC took a series of important steps at a global level to prepare the ground for a timely and relevant response to humanitarian needs. As outlined in the context section, it published the GHRP, which was the humanitarian community's first-ever event-specific global appeal.⁶⁶ It was developed in a very short timeframe and covered countries with existing or multi-country/subregional response plans as well as non-appeal countries that had requested international assistance.⁶⁷
36. In April 2020, after considerable discussion within the Emergency Director's Group (EDG), the IASC published its System-wide Scale-up Protocols Adapted to the COVID-19 Pandemic.⁶⁸ Within the COVID-19 Scale-up Protocols, resources and funding were to be aligned with countries specified in the GHRP (and

⁶⁵ UNICEF (2021) *Real Time Assessment of the UNICEF South Asia Response to COVID-19*, UNICEF Regional Office for South Asia Evaluation Section, January 2021.

⁶⁶ UN OCHA (2020), *Global Humanitarian Response Plan COVID-19*, United Nations Coordinated Appeal, April – December 2020, March 2020.

⁶⁷ The COVID-19 GHRP is the subject of a separate and more detailed Learning Paper developed as part of this same evaluation: IAHE (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, 15 April 2022. Given its significance, the GHRP is referenced throughout this report.

⁶⁸ IASC (2020), *System-wide Scale-up Protocols Adapted to the COVID-19 Pandemic*, April 2020.

subsequent revisions of the GHRP). The IASC System-wide Scale-up response was activated on 17 April 2020 and deactivated on 17 January 2021.⁶⁹

37. A comparison of the COVID-19 Scale-up Protocols and the April 2019 generic IASC Protocols for the Control of Infectious Diseases,⁷⁰ on which they were based, shows several key differences. Notably, as referenced within the COVID-19 adapted protocols, the generic Protocols “*were designed for a response model in one country or small group of neighbouring countries and not for a global response to a pandemic situation*”. While still including aspects of global support to country operations and specifying coordination modalities at country level, the adapted protocols were ‘*lighter*’ and, according to interviews with a small number of key informants involved in their development, designed to be ‘*credible*’ and ‘*focused*’, noting their proposed application across all sixty-three countries included in the GHRP.
38. Some key informants at global level questioned the feasibility of prioritizing all 63 GHRP countries for additional support as per the Scale-up Protocols, not to mention those countries considered ‘*at risk and to watch*’. Interviewees suggested that resources were stretched thin and there was a need to identify “*priorities within the priorities*” – in other words, additional resources and support should be prioritized for a smaller set of critical contexts where needs were particularly acute. Others indicated that the over-stretch limited the value of the Scale-up Protocols, and the overall approach should be reconsidered in the event of future global emergencies, either by limiting the number of priority countries or scaling back the level and type of support that countries could expect to receive.
39. Another key document issued after the declaration of COVID-19 as a global pandemic was the IASC’s Interim Guidance on ERP Approach to the COVID-19 pandemic.⁷¹ The evaluation found the interim guidance to be succinct, clear and practical with an emphasis on either supporting the development or strengthening of collective preparedness measures to address COVID-19. Despite its clarity, however, the evaluation found no evidence that the guidance had been used and followed in case-study countries. Even in Sierra Leone – the only country case study without an existing HRP or other appeal at the outset of the emergency – key stakeholders did not refer to the ERP guidance. They did, however, note the considerable hands-on support they had received within the region to prepare for and respond to humanitarian needs because of COVID-19 (see Box 1).

Box 1: Regional Support for Post-Scale-up Preparedness in Sierra Leone

Key informants working in Sierra Leone emphasized the significant support they had received from OCHA’s Regional Office in West and Central Africa, stressing the timeliness and relevance of hands-on support from the Regional Office to prioritize humanitarian interventions and prepare an early response plan. OCHA support was also referenced as critical in allowing the Regional Coordinator’s Office (RCO) to track ongoing humanitarian and development activities, organized in alignment with the Government of Sierra Leone’s own coordination pillars for the response. This allowed for a more streamlined approach to ongoing inter-agency preparedness and information management across the humanitarian-development nexus and in support of government leadership

⁶⁹ Note that the dates differ from those cited within the COVID-19 IAHE Terms of Reference i.e., 17 April or 18 2020 (both dates are mentioned) to 25 January 2021.

⁷⁰ IASC (2019), System-wide Scale-up Activation, Protocol for the Control of Infectious Disease Events, April 2019.

⁷¹ IASC (2020) Interim Guidance on Emergency Response Preparedness (ERP) Approach to the COVID-19 pandemic. Preparedness, Early Action and Readiness Sub-Group, IASC Results Group 1 on Operational Response, April 2020.

1.3.2 Country action

40. At a country level, numerous references were made, during interviews, to individual institutional (post-declaration) contingency plans to respond to the pandemic. Several organizations in different contexts spoke about the rapid development of business continuity plans to ensure the continued delivery of vital assistance and protection to vulnerable communities, despite the impact of COVID-19 on staff presence, movement and disruptions to the supply of goods and services. The speed at which many of these plans were produced, by United Nations agencies, International NGOs (INGOs) and Local/National Actors (L/NAs) alike, in the midst of challenging and rapidly changing working environments, is noteworthy.
41. The content of different organizational business continuity plans varied, though with key common themes such as duty of care policies, changes to logistical and administrative procedures, and funding strategies. Existing evaluations and reviews of organizational performance during COVID-19 found that plans were often insufficient given the scale, complexity and intensity of COVID-19;^{72,73} were not matched with sufficient human capacity to deliver leading to serious implications in terms of staff wellness;⁷⁴ lacked the benefit of experienced technical support for designing business continuity plans;⁷⁵ and demonstrated a mismatch between centralized and decentralized continuity planning.⁷⁶
42. In terms of collective IASC action to enhance preparedness and readiness to respond at country level, there was limited evidence of good practice. Rather, country-level key informants spoke of inter-agency contingency plans and ERPs that remained ‘*on the shelf*’ or proved difficult to adapt to the specific nature of COVID-19. Responding to different populations of concern was found to be challenging, as was planning to respond in different geographic areas which had not previously been considered of humanitarian concern, including in urban areas. There was also a degree of confusion at the initial onset of the emergency about whether and how HRPs, RRP and other existing response plans should be adapted to reflect changing needs and funding requirements because of the pandemic.

⁷² The COVID-19 Global Evaluation Coalition (2021) The COVID-19 Pandemic: How are Humanitarian and Development Co-operation Actors Doing so Far? How Could we do Better. Synthesis of early lessons and emerging evidence on the initial COVID-19 pandemic response and recovery efforts, June 2021.

⁷³ UNICEF (2021) Real-Time Assessment (RTA) of UNICEF’s response to COVID-19 in Latin America and the Caribbean (LAC), Synthesis Report, 12 April 2021.

⁷⁴ WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022.

⁷⁵ IFRC (2022) Evaluation Report: IFRC-wide response to the COVID-19 Pandemic, March 2022.

⁷⁶ IFRC (2022) *Evaluation Report: IFRC-wide response to the COVID-19 Pandemic*, March 2022. This learning was specific to the relation between National Societies and the IFRC and their respective legal liabilities for staff, but can be generalized to cover links between HQ-driven business continuity plans and country-led plans and processes for other international organizations.

2 Needs assessment

Summary findings

- At country level, needs assessments were particularly challenging due to restricted access because of COVID-19 preventive measures, lack of methodological clarity, and pressure to respond. In lieu of clear guidance, countries took different approaches to estimating the numbers of People in Need (PiN) and calculating funding requirements, highlighting the need for guidance on reprioritization to promote greater methodological consistency (section 2.1).
- Data gaps led to experimentation with predictive models and forecasting to inform humanitarian response strategies. These have not yet demonstrated proof of concept in humanitarian contexts but generated significant learning for future crises (section 2.3).
- Despite operating constraints, a number of collective needs assessments were conducted and highlighted the impact of COVID-19 on vulnerable populations. Assessments often relied on local organizations and remote data collection to overcome access challenges, exacerbating the risk of exclusion for some particularly vulnerable groups (sections 2.1 and 2.2).
- In some instances, there was evidence that assessments included the needs of particularly vulnerable groups, including women and girls and persons with disabilities. These were not consistent, however, and there were few examples of targeted needs assessments and those applying a protection, gender and inclusion lens. Also, the numbers of persons with disabilities were often based on rough estimates rather than a detailed understanding of disability, including those with non-visible/non-physical disabilities (section 2.5)

43. As COVID-19 began to spread across the globe, it was a challenge for humanitarian agencies to understand and analyze the implications of its transmission on the lives and livelihoods of affected people. While COVID-19 and its secondary impacts generated new needs and heightened existing vulnerabilities, at the same time, access was severely restricted in many locations, due to lockdowns and other restrictions imposed during the pandemic, making it difficult to assess and understand those needs. Compounded by urgency and the pressure to respond, as well as a lack of methodological clarity on what to look for and how in the early stages of the pandemic, needs assessments became a particularly challenging aspect of the Humanitarian Program Cycle (HPC). This section examines the generation and use of evidence for assessment and response planning for the pandemic.

2.1 Evidence on PiN to inform response strategies

44. Interviews across the case-study countries indicated that during the initial onset of COVID-19, humanitarian agencies' understanding of the needs of affected populations was based more on assumptions than on evidence. Lack of time and the pressure to respond immediately, combined with rapidly changing needs and movement restrictions led to a heavy reliance on pre-existing secondary data. Other observations of needs assessments in the early stages of the virus included an emphasis on the immediate health impacts of the pandemic and less focus on secondary socio-economic impacts, and a time lag in understanding the needs of new vulnerable groups outside established humanitarian caseloads.
45. Despite the significant data gaps, contexts with existing HRPs, RRP and other types of response plans in 2020 were instructed to take the opportunity of the mid-year revision process to incorporate new needs and priorities resulting from COVID-19. OCHA hosted webinars in the lead-up to the process and published

a ‘frequently asked questions’ document summarizing the step-by-step process for revision of HRPs.⁷⁷ Countries were advised to base their analysis of needs on a most likely scenario, rather than on newly gathered primary evidence of need, informed by existing data and accompanied by a range to indicate changes to the number of PiN. The guidance stressed that there was no established scientific approach for the calculation of the PiN and emphasized the value of qualitative analysis with a clear articulation of the assumptions used. In the absence of any clear methodology from headquarters for the HRP revision process, in-country teams approached the reprioritization exercise in different ways, as summarized for the case-study countries in Table 1 below.

Table 1: Case-study country approaches to issuing/reprioritizing HRPs to include COVID-19 needs and financial requirements

Country	Type of response plan	Change in PiN	Change in financial requirements	Explanation
Somalia	HRP	Minor increase from 5.1m to 5.2m	Reduction of requirements by \$30m	PiN for projects of Integrated Phase Classification (IPC) 2 and below were excluded and those projects without funding were deleted or cut by 50 percent. Financial requirements for most clusters decreased, except for Health, WASH and the newly activated Logistics Cluster, which increased.
Turkey	3RP	Not available	Increase in requirements of \$118m	The increase in financial requirements was for scaling up of assistance to support access to essential services for Syrian refugees and vulnerable host community members.
Syria	HRP	Not available		The Humanitarian Country Team (HCT) took the decision not to separate COVID-related needs from other humanitarian needs in the Syrian context, given the large-scale humanitarian needs caused by conflict and the economic crisis. It developed an operational response plan designed as an annex to the HRP but the HRP itself was not published until December 2020.
Bangladesh (Rohingya Refugee Response)	Joint Response Plan (JRP)	Increase from 1.3m to 1.8m	Increase in requirements of \$181m	The PiN figure increased by just over 0.5m to incorporate people at risk of COVID-19 in Cox’s Bazar District. Notable increases in funding requested for Food Security, WASH, Protection, Health, Communication with Communities (CWC) and Logistics Sectors.
DRC	HRP	Increase from 15.6m to 25.6m	Increase in requirements of \$250m	Significant increase in PiN to incorporate PiN of COVID-19-related risk communication and messaging. Financial requirements increased for most clusters, Health and WASH in particular, except for Protection Cluster, which decreased requirements.
Sierra Leone	New HRP as part of the GHRP	n/a – no previous HRP		The total number of people targeted by The HRP in Sierra Leone in 2020 targeted 1.8m people at a cost of \$63m.
Philippines	New COVID-19 HRP	n/a – new HRP to respond to COVID-19 specifically		The HRP in the Philippines estimated a PiN of 39m and requested \$122m to respond.
Colombia	COVID-19 Response Plan	PiN of 5m	Financial requirements of \$150m	The Colombia HCT issued a separate response plan for COVID-19 covering the period from April to December 2020 to complement the HRP and Refugee and Migrant Response Plan.

⁷⁷ UN OCHA (2020), HRP Revision Questions – OCHA Webinars 8 & 15 April 2020 (unpublished).

46. There was no right or wrong way for countries to approach the task of assessing need and reprioritizing existing HRP or publishing new appeals, and the diverse approaches taken demonstrate how differently the task was interpreted by country teams. Looking across the plans for the case-study countries, however, highlights Somalia as something of an outlier in terms of the decision of the HCT to exclude a segment of the population in need and reduce financial requirements. Rather than any attempt at a needs-based prioritization, the HCT in Somalia took a more pragmatic approach to what could realistically be achieved in the context of COVID-19. The reduction in financial requirements, albeit minimal, gave the impression that the Somalia HRP was comparatively well-funded in mid-2020 and may have led donors to prioritize other countries for funding. It is worth considering whether future guidance on HRP reprioritization exercises should strive for a level of consistency in the methodology used to avoid specific contexts being unwittingly penalized, as may have been the case for Somalia in this instance.
47. Despite constraints in operational environments, humanitarian organizations did find ways to assess and analyze needs in 2020. Assessments were mainly driven by individual agencies, but the evaluation also encountered several early examples of inter-agency needs assessment processes in the case-study countries, often with significant and important participation by local organizations.

2.2 Data gaps and deficiencies

48. From the outset, COVID-19 has been described as ‘*moving faster than the surveillance and alert system*’.⁷⁸ Even after the outbreak had spread to pandemic proportions and epidemic surveillance began to pick up pace, there were multiple information gaps and speculation about the different key factors thought to be affecting the spread of the virus and its varying impacts on countries around the world. Basic statistics on case numbers and mortality rates were only partially available or unreliable in many contexts, and seemingly low case rates and reported deaths from national data clearly influenced how humanitarian actors responded.
49. Subsequent data on excess deaths associated directly or indirectly with the COVID-19 pandemic, published by WHO in May 2022, revealed a more accurate picture of the scale and severity of the crisis. Excess mortality data showed that the global death toll associated with COVID-19 in 2020 and 2021 was approximately 14.9 million.⁷⁹ This compares with previous estimates of 5.4 million in the same period using reported COVID-19 mortality data.⁸⁰ Differences between reported data and excess mortality data were particularly stark in some countries, including several of the case studies for this evaluation (see Table 2 below).

⁷⁸ The Independent Panel for Pandemic Preparedness and Response (2021) COVID-19: Make it the Last Pandemic, May 2021.

⁷⁹ WHO (2022) 14.9 million excess deaths associated with the COVID-19 pandemic in 2020 and 2021, News Release, 5 May 2022: <https://www.who.int/news/item/05-05-2022-14.9-million-excess-deaths-were-associated-with-the-covid-19-pandemic-in-2020-and-2021>.

⁸⁰ For the purposes of this analysis, the evaluation has used data from ‘Our World in Data’ – an open access platform that combines a range of different data sources on different issues. Ritchie, H. et al (updated daily) “Coronavirus Pandemic (COVID-19)”. Published online at OurWorldInData.org. Retrieved from: ‘<https://ourworldindata.org/coronavirus>’ [Online Resource].

Table 2: Comparison of reported deaths versus excess deaths associated with COVID-19 in case-study countries, 2020-2021

Case-Study Country	2020-2021		
	Reported deaths ⁸¹	Excess Deaths ⁸²	Difference
Bangladesh	28,072	140,906	112,834
Colombia	129,942	164,670	34,728
DRC	1,205	117,985	116,780
Philippines	51,504	92,663	41,159
Sierra Leone	123	7,904	7,781
Somalia	1,333	35,449	34,116
Syria	2,897	7,240	4,343
Turkey	82,361	264,277	181,916

50. These numbers were important in that they influenced the scale and scope of the humanitarian response to COVID-19 relative to other, seemingly more pressing, priorities. For example, in a context like DRC, with already severe humanitarian needs, COVID-19 was perceived by many country-level interviewees as a less serious risk relative to other threats – including displacement linked to conflict and disasters caused by natural hazards, severe protection concerns, acute food insecurity and malnutrition and epidemic outbreaks and the continuing threat of EVD. The situation in Somalia was similar at the time of the evaluation, though community perceptions and the later published excess deaths data offers a contrast to the perceptions of humanitarian actors, as described in Box 2.

Box 2: Perceptions of the impact of COVID-19 in Somalia^{83 84 85 86}

Despite considerable evidence of engagement and planning for the impact of COVID-19 in Somalia, by the time of the evaluation, several interviewees perceived the pandemic as a lesser threat to lives than other pre-existing risks, including desert locusts, floods, emerging drought, and continuing conflict and displacement. Official mortality statistics substantiated that perception, with 1,333 deaths reported from COVID-19 during 2020 and 2021, compared with the 5.2 million people already estimated to be in humanitarian need at the start of 2020, prior to the first reported case of COVID-19 in Somalia.

In contrast, consultations with communities as part of the evaluation revealed considerable fears about the impact of COVID-19. Residents of internal displacement camps in Kismayo expressed serious concerns about the virus. One focus group discussion (FGD) participant said that *“Coronavirus was one of the most devastating challenges we’ve faced in our lifetime. We learned many lessons. I personally witnessed many people dying because of it”*. Another said, *“We have seen many difficulties including many deaths in the community. There was a time many people died such as days when 10 to 18 people died in a single day”*.

Subsequent data from WHO on excess deaths, albeit at a national level, begins to make sense of community perceptions, in that it shows that over 35,000 people are estimated to have died as a direct or indirect result of COVID-19 in Somalia during 2020 and 2021, considerably more than previously reported figures.

⁸¹ Our World in Data.

⁸² WHO (2022) Global excess deaths associated with COVID-19, January 2020 – December 2021, May 2022: <https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021>.

⁸³ OCHA shared a series of ‘COVID Impact Reports’ with the evaluation team that were published on a regular basis between April 2020 and 2021, which included updates on the impact of the pandemic, the Government response and updates on the response by humanitarian partners.

⁸⁴ Our World in Data.

⁸⁵ OCHA (2020) Humanitarian Response Plan 2020, January 2020.

⁸⁶ WHO (2022) Global excess deaths associated with COVID-19, January 2020 – December 2021, May 2022: <https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021>.

51. It is important to stress that data on excess deaths for Somalia or elsewhere was not available at the time of planning and preparedness for the pandemic, and as such, humanitarian actors could not reasonably have been expected to factor such numbers into their response plans. It does, however, highlight the deficiencies of data to inform decision-making and response planning, and the serious consequences they can have on the lives of vulnerable people.

2.3 The use of predictive models to fill the data gaps

52. An unprecedented demand for data in the humanitarian sector led to experimentation with predictive models to inform humanitarian response strategies.⁸⁷ Beyond HCTs working with scenarios to inform response planning, more scientific exercises were conducted to forecast peaks and the size of outbreaks for more detailed operational planning. For example, OCHA partnered with the Johns Hopkins University Applied Physics Laboratory to pilot a COVID-19 model adapted for humanitarian contexts, referred to as the ‘OCHA-Bucky model’.⁸⁸ The approach was designed to forecast the number of COVID-19 cases, hospitalizations and deaths over two or four weeks at national and sub-national level, with a view to informing planning, decision-making and management of resources.⁸⁹
53. There is limited evidence of the use of the OCHA-Bucky model or other predictive models in humanitarian contexts. However, anecdotal evidence suggests that the modelling was not readily absorbed and used at the country level for operational purposes, given the speed at which it became outdated and because of other competing shocks and priorities at country level. The Rohingya Refugee Response, while not a participant in the OCHA-Bucky model pilot, provides a useful illustration of modelling the predicted spread of COVID-19 and linking forecasts to the adapted response (see Box 3).

Box 3: The use of COVID-19 Modelling in Cox’s Bazar, Bangladesh^{90 91}

Modelling by Johns Hopkins University in March 2020 informed initial preparedness and response planning for the COVID-19 response in Cox’s Bazar, Bangladesh. Based on a worst-case transmission scenario, forecasting projected that as many as 16,000 refugees across 34 camps could require hospital treatment in a single day.

Faced with only two Intensive Care Unit (ICU) beds in Cox’s Bazar District at the outset of the pandemic, humanitarian actors decided to urgently scale up. By the end of July 2020, humanitarian organizations had equipped twelve Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) with 655 beds, and five further Intensive ICUs were under construction. A further ICU facility at Sadar Hospital was also operational for the host community and refugees; as well as four new quarantine and isolation facilities where patients could receive multi-sector support.

Ultimately, the worst-case scenario predictions did not come to pass in Cox’s Bazar. As of 31 July 2020, there were 3,348 confirmed cases of COVID-19 in the district and most cases were mild. A total of 70 refugees and 150 host community members had been admitted to SARI ITCs and isolation and treatment centres at that time.

Despite the differences in projected versus actual cases, there was broad consensus among interviewees at country level of the importance of a ‘no regrets’ approach and the need to keep developing epidemic forecasting methodologies to inform preparedness.

⁸⁷ OCHA Centre for Humanitarian Data (2021) The State of Open Humanitarian Data 2021: Assessing Data Availability Across Humanitarian Crises.

⁸⁸ OCHA, The Centre for Humanitarian Data & The Johns Hopkins University Applied Physics Laboratory (2020) *OCHA-Bucky: A COVID-19 Model to Inform Humanitarian Operations, Model Methodology*, October 2020

⁸⁹ The modelling was conducted for several countries, including Afghanistan, DRC, Iraq, Somalia, South Sudan and Sudan.

⁹⁰ Truelove, S. et al (2020) The potential impact of COVID-19 in refugee camps in Bangladesh and beyond: A modelling study, PLOS Medicine, 16 July 2020.

⁹¹ ISCG Secretariat (2020) *2020 Mid-Term Review, Rohingya Humanitarian Crisis, Bangladesh, January-July 2020*.

54. It is early days for the effective use of predictive forecasting and modelling in humanitarian contexts and COVID-19 has already generated significant learning on the strengths and weaknesses of existing models. General research on the use of predictive analysis for anticipatory action recommends, among other things, scaling up investment and engagement to fill data gaps, building technical capacity, engaging technical partners and local actors more consistently throughout the process to agree on triggers and response mechanisms, and combining predictive models with other types of analysis and evaluation.⁹² While the modelling practice has not yet demonstrated proof of concept in humanitarian contexts, the ‘*no regrets*’ approach⁹³ resonated with country and global actors and there remains a good case for continuing to invest and learn to work towards a more anticipatory approach to pandemics and other related crises in the future.

2.4 Remote data gathering

55. The reduction in international humanitarian personnel during COVID-19 and the imposition of lockdowns and other movement restrictions undoubtedly resulted in fewer needs assessments being conducted in the early stages of the pandemic.⁹⁴ However, a shift to remote methodologies – such as mapping, phone interviews and the use of social media – did allow for a degree of essential data collection to continue.
56. The evaluation encountered many examples of remote needs assessment exercises, which overall proved effective, but in some instances, did affect the quality of the analysis and understanding of the ‘*why*’ needed to inform planning processes, such as response planning, and advocacy. Box 4 provides an example of the challenges associated with adopting remote assessment tools from the Philippines.

Box 4: Challenges to conducting post-typhoon rapid needs assessments in the Philippines

Seasonal natural hazards compounded the impact of the pandemic in the Philippines in 2020 and the imposition of strict lockdowns prevented humanitarian organizations from conducting rapid face-to-face needs assessments when the first typhoon hit in 2020. The Philippines HCT piloted remote assessment tools by utilizing technologies and relying heavily on local partners with an established presence in the affected areas. Despite the best efforts of humanitarian organizations, interviewees noted challenges related to lack of connectivity due to power and communication outages, lack of availability of key informants and gaps in the capacity of local partners. Overall, there was consensus that the challenges affected the quality of rapid needs assessments.

2.5 Identifying the needs of particularly vulnerable groups

57. The evaluation looked at the extent to which COVID-19 needs assessments identified the specific needs of particularly vulnerable groups, including women and girls, persons with disabilities, older people, displaced populations, and marginalized groups. Overall, efforts were made to focus attention on these groups in humanitarian needs assessments, and Humanitarian Needs Overviews (HNOs), where they exist for HRP in 2021, do acknowledge that COVID-19 affected groups and individuals differently according to their age, gender and other factors affecting their vulnerability, such as disability. Data to inform HNOs was almost always disaggregated by gender and age, and for the most part by disability. However, the numbers

⁹² Bodanac, N. (2020) Predictive Analysis for Anticipatory Action: Challenges and Opportunities, OCHA Center for Humanitarian Data, December 2020.

⁹³ i.e., faced with considerable uncertainty, interventions were prioritized that would benefit recipient communities, regardless of the course of the pandemic, rather than waiting until more evidence was available.⁹³

⁹⁴ ACAPS (2020), Understanding the Impact of COVID-19, Key Questions and Information Gaps, Thematic Report May 2020.

of persons with disabilities were often based on rough estimates and not on a more detailed understanding of disability, including those with non-visible/non-physical disabilities.

58. Though not widespread, there were instances of assessments covering the impact of COVID-19 on specific vulnerable groups and in response to particular protection risks. In Colombia, the United Nations High Commissioner for Refugees (UNHCR) and partners conducted a needs assessment in Nariño, which identified the specific needs of persons with disabilities, girls and women. In the Rohingya Refugee Response, REACH with support from the Age and Disability Working Group (ADWG), conducted an age and disability needs assessment across Rohingya populations in May 2021.⁹⁵ While not specific to COVID-19, the assessment drew out findings about the needs of persons with disabilities pre- and post-COVID in many instances; and the assessment methodology meant that the results covered a broad range of disability types, not limited to physical disability.
59. Despite isolated examples of good practice, however, targeted needs assessments – or even assessments of broader populations applying a protection, gender and inclusion lens – were not widespread. In terms of gender, there were several examples of assessments and analysis that specifically focused on the gendered and disproportionate impact of COVID-19 on women and girls. One such example is the Voices from Syria 2021 Report, which was conducted by the Gender-Based Violence (GBV) Area of Responsibility (AoR) in the Whole of Syria response through an extensive set of FGDs.⁹⁶ The report was provided as a resource for humanitarian workers to prevent and respond to GBV across sectors. The DRC case study also offered an example of good practice (see Box 5).

Box 5: Analysis of the gender impact of COVID-19 in DRC⁹⁷

One particularly strong example of analysis of the impact of COVID-19 on very vulnerable groups was done by the inter-agency '*Cellule d'Analyse en Sciences Sociales et l'approche AMIE*' (CASS) in DRC. CASS carried out a detailed analysis of the impact of COVID-19 on women and girls, covering a range of areas such as protection risks, access to Sexual and Reproductive Health (SRH) services, the socio-economic impact of the pandemic on women, and the impact of school closures. Overall, it concluded that COVID-19 had a disproportionate impact on the health, security and socio-economic stability of women and girls in DRC. A number of interviewees referred to the analysis in DRC and said that they had used it to either inform response strategies or develop advocacy materials.

60. While the COVID-19 response highlighted the potential for remote methodologies and digital adoption, including as part of needs assessment exercises, it also demonstrated the pitfalls of relying exclusively on remote ways of working. This includes the risk of excluding communities with low connectivity and individuals with limited digital literacy, as well as the importance of proximity for building trust and confidence with people affected by humanitarian crises.^{98,99} For example, FGD facilitators for the Voices from Syria 2021 report on GBV noted the reluctance of some women and girls to use remote case management services, lamenting the lack of face-to-face contact.¹⁰⁰

⁹⁵ REACH (2021) Age and Disability Inclusion Needs Assessment, Rohingya Refugee Response, May 2021.

⁹⁶ UNFPA & GBV AoR Whole of Syria (2021) Voices from Syria 2021, Assessment Findings of the Humanitarian Needs Overview.

⁹⁷ CASS (2020) Les impacts de la réponse COVID-19 sur les femmes et les filles en République Démocratique du Congo.

⁹⁸ UN OCHA (2020) Global Humanitarian Policy Forum 2020, Outcome Paper, A Case for Transformation?

⁹⁹ GSMA (2022) The Mobile Gender Gap Report 2022, June 2022.

¹⁰⁰ UNFPA & Whole of Syria Gender-Based Violence Area of Responsibility (2021) Voices from Syria 2021, Assessment Findings of the Humanitarian Needs Overview.

2.6 Incorporating COVID-19 into broader analysis of needs

61. After an initial focus on COVID-19-generated needs in the first half of 2020, driven largely by prioritization at headquarters, there was considerable pushback thereafter to considering the pandemic separately from other risk factors, and from assessing COVID-19-related needs in isolation from other pre-existing or new humanitarian needs. In several of the case-study countries, this strong resistance to assessing needs and response planning for the pandemic separately from other humanitarian needs was referred to by interviewees as, among other things, *‘the neglect of non-COVID needs’*, and *‘a disproportionate focus on COVID-19’*. As a result, COVID-19 began to be incorporated into broader assessments of humanitarian needs in many contexts, and HNOs and HRP from 2021 onwards generally included COVID-19 as one of many risk factors – compounding existing risks and layering on top of other shocks to worsen patterns of vulnerability.
62. This was the case from the outset in Syria, where the HCT agreed that there was no logic in isolating COVID-19 from other, arguably more severe, humanitarian needs resulting from the conflict and the economic crisis that started in 2019. Other contexts followed suit, particularly where COVID-19 transmission rates did not accelerate as anticipated and other risk factors overshadowed the pandemic – in DRC, for example; and where other shocks, such as disasters caused by natural hazards, created more acute and obvious humanitarian needs – such as in the Philippines during the typhoon season of 2020.
63. The evaluation did find examples of more nuanced analysis of the effects of COVID-19 on vulnerability and humanitarian needs. Cross-country analysis also usefully considered the impact of COVID-19 and associated response measures on the severity of needs and access to services overall.¹⁰¹ Similarly, OCHA’s Global Humanitarian Overview for 2022 featured COVID-19 among other global trends as taking a heavy toll on developing countries, alongside climate change, rising food insecurity and increased forced displacement.¹⁰² This does not diminish the devastating impact that COVID-19 had on vulnerable populations, but rather, acknowledged the multitude of natural and man-made risks faced by people living in humanitarian contexts and placed COVID-19 alongside other hazards generating and exacerbating humanitarian needs. As such, it aligns with the evolution of joint humanitarian analysis and efforts to work towards more holistic, intersectoral analysis.¹⁰³

¹⁰¹ See for example: REACH (2022) Evaluating the impact of COVID-19 on multi-sectoral humanitarian needs, April 2022.

¹⁰² UN OCHA (2021) Global Humanitarian Overview 2022.

¹⁰³ See resources related to the Joint Intersectoral Analysis Framework: <https://www.jiaf.info/>

3 Strategic planning

Summary findings

- For the sake of expediency, the initial iteration of the GHRP did not incorporate a detailed assessment of the needs and priorities of vulnerable populations and required some pragmatic ‘best guesses’ based on trends and assumptions, primarily for the purpose of providing donors with a vehicle for allocating resources. Subsequent iterations were more evidence-based but the process remained headquarters-led with a lack of clarity about where responsibility for determining needs lay (section 3.1).
- A lack of pre-agreed methodologies and tools for assessing country-level risk in the event of a pandemic made it more difficult for GHRP decision-makers to overcome institutional differences, but investments in advanced data analytics during the GHRP process resulted in new data products and learning on what is needed to support collective decision-making, including the use of modelling with a ‘no regrets’ approach (section 3.1).
- There was consistent evidence that the GHRP largely achieved its purpose of providing strategic direction to the response. However, its ‘UN-centric’ nature and the decision not to make women and girls a priority, despite evidence on GBV and protection risks, were limitations (section 3.1).
- There was early recognition in the ‘Call for Solidarity’ and response plans that the impacts of COVID-19 went beyond the immediate health effects, leading to the development of the GHRP and the socio-economic response framework (section 3.2).
- There was considerable overlap between the response plans. Although there was a focus on avoiding duplication at the global and country levels, there was no attempt to achieve greater coherence through the development of collective outcomes, in line with IASC guidance. Instead, the aid system designed the response on the basis of existing structures and interests rather than what the intertwined impacts of the pandemic required (section 3.2).
- Staff at country level found the development of Socio-Economic Recovery Plans (SERPs) burdensome, particularly as they felt they were responding to headquarters’ needs rather than country-level needs. There was also a view that it would have been better to adapt existing United Nations Sustainable Development Cooperation Framework (UNSDCFs) than to introduce a new development framework in the midst of a crisis, particularly as there was limited funding available for the SERPs (section 3.3).

64. At a global level, strategic direction for the response was provided by the GHRP. While an articulation of humanitarian response priorities was important, the Secretary General’s ‘*Call for Solidarity*’ issued in March 2020 outlined the need to go beyond a purely health response to COVID-19 and to address its secondary impacts in a holistic and coordinated way. This commitment was also encapsulated in the United Nations’ outline of a comprehensive response to COVID-19.¹⁰⁴ This section presents evaluation findings on the extent to which the health, humanitarian and socio-economic responses to COVID-19 were planned in a coordinated and coherent manner.

¹⁰⁴ United Nations (2020) United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better, June 2020.

3.1 The GHRP as a strategic framework for the global COVID-19 response

65. The first iteration of the GHRP acknowledged the absence of a detailed assessment of needs at country level. It stated that, at the time of writing, *‘humanitarian and United Nations country teams were in the process of gathering and analyzing information on the situation in-country’*.¹⁰⁵ The criteria for the first set of countries selected for inclusion in the GHRP were those with an ongoing HRP, RRP or multi-country/subregional response plan, as well as countries that had requested international assistance.
66. GHRP documentation shows that the second and third iterations used some basic additional criteria,¹⁰⁶ as well as data from a nascent OCHA-developed COVID-19 risk index.¹⁰⁷ The latter offered criteria for an initial screening process, resulting in a ranking of potential GHRP countries and providing decision-makers with a suggested short-list of additional countries for inclusion. This was followed by the establishment of a Global Information Management, Assessment and Analysis Cell (GIMAC) on COVID-19, co-led by OCHA, UNHCR, WHO and International Organization for Migration (IOM), to provide technical support to GHRP countries and undertake secondary data analysis to support decision-making.
67. In addition to data analysis from the global level, the May update of the GHRP began to build in more comprehensive contributions from field teams, claiming that, *“resource requirements have been defined at the country level in revised humanitarian response plans, reflecting needs, operational environments and links with other country-specific activities and plans”*.¹⁰⁸ These were rough estimates, however, and country teams were advised not to undertake a revised estimate of PiN due to the limited time available and other competing priorities for the May update.¹⁰⁹
68. While the move towards a more evidence-based approach for subsequent iterations of the GHRP is clear, the overall process was still very much headquarters-led with a lack of clarity about where responsibility lay for determining needs. Ultimately, decisions on country selection for the GHRP were a collective compromise, based on a range of factors and the best available information at the time. As the GHRP Learning Paper concludes, the chronology of the GHRP’s development suggests a reactive approach to gathering and analyzing data to inform priorities. Furthermore, interviewees suggested that a lack of pre-tested and common analytical data tools, as well as depleted analytical capacity and resources dedicated to data analysis (in OCHA in particular), compromised the ability of decision-makers to guide the early stages of the GHRP process and overcome institutional differences on key issues such as the prioritization of countries. More positively, investments made during the period covered by the GHRP have resulted in quality products and set a new bar for data and advanced analytics to support crisis preparedness and response, as well as generating important learning on the type of data and advanced analytics needed to support collective decision-making.¹¹⁰
69. Interviews elicited broad agreement that the GHRP had largely achieved its purpose of providing strategic direction for the response, but it did experience some challenges; its initial process of development was

¹⁰⁵ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, March 2020.

¹⁰⁶ The additional criteria were i) the impact of the outbreak on affected people’s ability to meet their essential needs, considering other shocks and stresses; ii) the government’s capacity to respond and iii) the possibility of benefitting from other sources of assistance from development plans and funding. See UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update

¹⁰⁷ The risk index comprised two main sets of indicators on i) vulnerability (including poverty indicators, co-morbidity factors and demographic information) and ii) capacity to respond (including indicators on government effectiveness and access to healthcare and water, sanitation and hygiene services). See OCHA (2020), Covid-19 Risk Index - Version 1.0.

¹⁰⁸ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update.

¹⁰⁹ Templates for OCHA Country Offices to complete for the May and July GHRP updates show a progressive shift towards more detailed information requirements on needs and priorities, including estimates of PiN and People Targeted.

¹¹⁰ KonTerra (2022), COVID-19 Global Humanitarian Response Plan: Learning Paper.

not regarded as inclusive, despite the engagement of NGO consortia within IASC mechanisms. INGOs expressed frustration at the ‘UN-centric’ nature of the process and the end product. Despite a more collaborative approach for later iterations of the GHRP as the focus switched to country-level, this early experience appears to have had a negative impact on some aspects of UN-NGO relations and generated a lack of trust.

70. Concerns were also raised about important omissions from the GHRP. One such example of this is the focus on women and girls and growing awareness of increasing GBV and protection risks as a result of the pandemic and its secondary impacts. As fears began to emerge about an alarming worldwide spike in instances of GBV, so the GHRP progressively highlighted GBV as a priority issue. In response, there was a clear attempt to advocate for specific issues, including GBV – both within the updated GHRP and through related advocacy and to earmark funding allocations. Ultimately, for the sake of consistency, however, the decision was taken not to reconfigure the basic structure of the GHRP.
71. This evaluation is sympathetic to the need to maintain consistency in the GHRP for its relatively short lifespan, though it highlights the importance of ensuring adequate breadth of consultation in the early stages of drafting. Given the considerable knowledge that existed about the risks to women and girls from prior Ebola responses in west and central Africa, the omission was significant.

3.2 Global alignment between health, humanitarian and development strategies¹¹¹

72. While the SPRP was understandably focused on the health impact of COVID-19, the GHRP, the socio-economic response framework and a document on the United Nations' comprehensive response to COVID-19, published in June 2020, highlighted the intertwined effects of the pandemic. As emphasized in the socio-economic response framework, during the Ebola outbreak in 2014, “*more people died from the interruption of social services and economic breakdown than from the virus itself. This should not have happened, and the world cannot let it happen again... we need to connect health needs to social, economic and environmental well-being.*”¹¹² The overview of the United Nations' comprehensive response to COVID-19 argued that “*The pandemic is more than a health crisis; it is an economic crisis, a humanitarian crisis, a security crisis, and a human rights crisis.*”¹¹³ The strategic objectives of the GHRP demonstrate its commitment to addressing both the health and non-health (including livelihoods) needs of vulnerable populations in crisis-affected contexts. This framework provides important evidence that, at the global level, efforts were made across the response frameworks to identify and address the intertwined effects of the pandemic.
73. In terms of proposed objectives, activities and short- to medium-term outcomes, there was considerable overlap across the three plans and frameworks (see Figure 3 in the context section). Documents and interviews suggest that there were substantial efforts made to try to clarify the parameters of the different plans and their *modus operandi*. There is documentary evidence of numerous attempts to represent either graphically or in narrative descriptions how the three plans aligned but were different in terms of scope, target population, implementation modalities, governance and resourcing. The document on the United Nations' comprehensive response outlined how the three ‘pillars’ (health, safeguarding lives and livelihoods, and a recovery process to build back better) were contributing to a comprehensive response.

¹¹¹ Please note that the genesis of the GHRP and details of its linkages with the WHO SPRP and the UN SGs SERP are provided in the context section of this report.

¹¹² UN (2020) A UN Framework for the Immediate Socio-Economic Response to COVID-19, April 2020, pg. 1

¹¹³ United Nations (2020) United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better, June 2020, pg. 1.

This included the activities that the United Nations was undertaking under each ‘pillar’.¹¹⁴ Nevertheless, a number of global-level interviewees, particularly donors, expressed confusion about how the frameworks fitted together. As a result, there were suggestions that it would have been better to have a single, shared plan¹¹⁵ although this would have had implications for the timeliness of the GHRP.

74. Another option would have been to identify collective outcomes for the COVID-19 response to which the individual plans could have contributed, an approach implemented in several of the GHRP countries (see section 9 on coherence and complementarity in the COVID-19 response). OCHA has worked on identifying ways to operationalise collective outcomes (first introduced at the World Humanitarian Summit)¹¹⁶ though the IASC’s guidance on collective outcomes, which identified these as “*the main tool for closer humanitarian-development and peace collaboration*”, was not published until June 2020,¹¹⁷ by which time the separate response plans had already been developed. As one interviewee pointed out, “*COVID was an excellent opportunity to do the nexus right, to have collective outcomes. But ... it was very much about everyone doing their thing and leading their own framework and looking after their own priority populations.*” This is echoed by other reviews of the global response – “*the COVID-19 response has been designed based on institutional interests and existing structures within the aid system, rather than what the challenges of the pandemic require*”.¹¹⁸

3.3 Country alignment between health, humanitarian and development plans

75. At country level, the three overlapping frameworks were translated into context-specific plans in different configurations. Box 1 in section 1.3.1 described how Sierra Leone developed an HRP specifically for COVID-19. The United Nations also developed a SERP based on a July 2020 socio-economic impact assessment commissioned by the United Nations Development Programme (UNDP). Table 1 outlined the United Nations’ approach to developing an annex to the HRP in Syria.¹¹⁹ Although United Nations agencies jointly conducted a socio-economic impact assessment, a SERP was never published. In oPt, the third and final iteration of the COVID-19 response plan in 2020 incorporated activities to address the socio-economic impact of COVID-19 in sectors such as food security, WASH, shelter and education. The rationale was that both sets of activities were targeting the same populations, i.e., those who had been poor and vulnerable but were more so now because of the effects of COVID-19. In Turkey, development actors were working on the UNSDCF when the resident coordinator (RC) received the headquarters request to develop a SERP. The RCO and UNDP developed a socio-economic response offer¹²⁰ to the Government of Turkey and development partners based on the findings of a socio-economic impact assessment. The offer incorporated health components as Pillar 1 as well as activities from the 3RP COVID-19 Appeal under Pillar 5 on Social Cohesion and Community Resilience. Although this was an independent document, the intention was to fold it into the UNSDCF.
76. Interviewees in case study contexts including Colombia and Turkey suggested that SERPs and amendments to HRPs were developed to satisfy headquarters requests, not due to country-level needs. This was reinforced by an interviewee pointing out that countries were incentivized to develop SERPs by

¹¹⁴ United Nations (2020) United Nations Comprehensive Response to COVID-19: Saving Lives, Protecting Societies, Recovering Better, June 2020.

¹¹⁵ <https://theglobalobservatory.org/2020/06/what-happened-to-nexus-approach-in-covid-19-response/>.

¹¹⁶ OCHA (2018) Collective Outcomes: Operationalizing the New Way of Working, April 2018; OCHA (2019) Operationalizing Collective Outcomes: Lessons learned and Best Practices from and for Country Implementation, August 2019.

¹¹⁷ IASC (2020) *Policy: Light Guidance on Collective Outcomes*, Developed by IASC Results Group 4 on Humanitarian-Development Collaboration in consultation with the UN Joint Steering Committee to Advance Humanitarian and Development Collaboration, June 2020, pg. 3.

¹¹⁸ <https://theglobalobservatory.org/2020/06/what-happened-to-nexus-approach-in-covid-19-response/>.

¹¹⁹ United Nations (2020) COVID-19 Operational Response Plan Within Syria (April-December 2020), as of 11 May 2020.

¹²⁰ United Nations Turkey (2021) UN Turkey COVID-19 Socio-Economic Response Offer.

making this a requirement for accessing funding from the United Nations COVID-19 Response and Recovery Fund, even though the fund only raised \$85 million in total¹²¹ and so could not meet the funding needs identified. A headquarters-level interviewee noted that it was unhelpful to launch a new development framework in the midst of a crisis, particularly as the United Nations was also rolling out the new UNSDCFs that could have been adapted for the COVID-19 response.

77. Although there is no evidence that the overlaps and complementarities between the three frameworks were problematic for agencies at headquarters-level, it was harder to make sense of them at country level. Some field-level staff also found the development of the SERP burdensome because they were required to report against standard indicators at the global level. In Colombia, interviewees reported a lack of clarity on whether to report on COVID-19 activities to the HRP or the SERP and eventually defaulted to reporting to the HRP as the main operational framework for the COVID-19 response.
78. This section has focused on the planning frameworks across the health, humanitarian and development components of the response. The extent of linkages across the humanitarian-development-peace nexus at a programmatic level is discussed in section 10 of this report, on operational coherence and complementarity, which also examines the level of alignment of the international plans and response with national priorities.

¹²¹ <https://mptf.undp.org/fund/cov00>.

4 Leadership and coordination

Summary findings

- The adapted IASC Scale-Up protocols provided the framework for global leadership of the pandemic response. At the global level, the ERC (Emergency Relief Coordinator) and the IASC bodies (particularly the EDG) played an important leadership role though some criticized their lack of diversity (section 4.1).
- At country-level, RC/Humanitarian Coordinators (HCs), HCTs and RCOs played a pivotal role in priority-setting and leading IASC collective action in support of government and local actors. However, in fragile contexts, such as Somalia and DRC, for the COVID-19 response, governments took on a much greater leadership role than has been the case in the past and so efforts were as much focused on support as they were on leadership (section 4.2).
- The Global Clusters/sectors were an essential pillar of the IASC's coordination of the COVID-19 response and played a key role in providing essential support. While the scale of the response stretched them far beyond their standing capacity but they responded well and provided a relevant service to their constituents (section 4.3).
- At country-level, and in the context of a rapidly evolving situation, it was logical to work through existing coordination structures rather than significantly adapting them. Country-level clusters/sectors/pillars played an essential role in the provision of coordination services, contextualized thematic guidance and evidence generation. Most were quick to adapt by moving coordination online and while this was a challenge to some members, it did result in increases in the quantity of participants in coordination meetings, if not in the quality of participation (section 4.4).
- While pre-existing challenges of inter-cluster coordination (ICC), incorporation of cross-cutting issues (CCI) and sub-national coordination persisted, efforts were made to articulate the linkages between the clusters (section 4.4).

79. The focus of this section is on the collective leadership and coordination of the IASC's response to COVID-19. It examines both global-level structures as well as country leadership and coordination mechanisms, drawing from global and regional interviews, in addition to the eight country case studies.

4.1 Global leadership of the COVID-19 response

80. The adapted IASC System-wide Protocols,¹²² which were finalized in April 2020, provided a framework for leadership of the pandemic response. The ERC had overall responsibility for announcing the Scale-Up activation at a global level and the EDG took on a strategic leadership role during the initial months of the response.
81. The leadership role of the EDG included agreeing to the basic parameters of the GHRP, discussing and agreeing to the scale-up activation, and identifying top-line response priorities and themes for collective advocacy with donors and governments.¹²³ Many interviewees responded positively to the EDG's leadership efforts; the lack of obvious channels for regional and country inputs was raised on several occasions, however, the different configuration of regions for IASC member organizations would likely

¹²² IASC (2020) IASC System-wide scale-up protocols adapted to respond to the COVID-19 pandemic, April 2020.

¹²³ IASC EDG teleconference on the novel Coronavirus outbreak. Summary Notes from March 2020 – June 2020.

have complicated any attempts to systematically include regional views and at country-level, the task of leading and supporting the response was the priority.

82. The work of the EDG was complemented by the role of other IASC groups, including the Operational Policy and Advocacy Group (OPAG), and the five Results Groups that report to OPAG, which focused on the development of normative policies, strategies, and guidance to support the implementation of the GHRP and the wider COVID-19 response (and, unlike the EDG, does include national NGO representation).¹²⁴ While some global interviewees expressed criticism of the issuance of guidance and questioned whether field staff would be able to digest it, the team collected sufficient evidence at country-level to suggest that the guidance was being used in practice. The evaluation acknowledges the ‘*infodemic*’ that followed in the wake of the pandemic and was typified by large volumes of literature that risked overwhelming the limited absorption capacity of the front-line responders;¹²⁵ however, many of the norms that humanitarian staff were used to working with had changed and while the guidance was not universally read, it was found to be useful by those that engaged with it; others ignored it. Moreover, the guidance served as important benchmarks which could be contextualized at country-level by clusters or technical leads (see section 4.4).
83. A number of interviewees spoke of their frustration at the limited diversity of IASC and EDG membership at a time when the value of diverse operational leadership is becoming better understood and accepted. There is some evidence that the COVID-19 response benefitted from this, demonstrating that diverse and inclusive leadership teams were able to assist the sector to better understand and respond to a rapidly changing global landscape, by bringing depth of talent, diverse approaches, and new ways of thinking.¹²⁶ While the evaluation did not look in detail at the issue of diversity within the IASC’s membership, questions were raised by interviewees about an absence of local NGO participation at strategic levels in the IASC. This issue is addressed in the section on localization (section 9).

4.2 Country leadership of the COVID-19 response

84. Leadership models varied in each of the case study countries with examples both of empowered RC/HCs leading from the front, while others worked far more closely with HCT. Two of the case studies were refugee responses and came under the United Nations High Commissioner for Refugees’ (UNHCR) leadership (or an adapted version of this). A further two countries did not have a humanitarian appeal and hence leadership was through the RC and RCO.
85. The HC/RC and HCT (or similar leader/leadership group) played an important role in coordinating the actions of the humanitarian system across the case study countries. Where sufficient evidence was provided, the evaluation team was able to examine their role in setting humanitarian priorities (section 2), addressing system-wide issues such as localization (section 9) or addressing the multi-dimensional nature of the crisis (section 10) in addition to the broader role they played in liaising with and supporting governments, which included strengthening coordination and raising access concerns. In a number of the case study countries, the HC or HCT members played a pivotal role in advocating for exemptions so that humanitarian agencies could access those in need of assistance (section 6.5) and in a few cases, attempts were also made to negotiate humanitarian access with armed groups.
86. The peculiarity of each context means that there are few generalisable findings. Feedback from those in leadership roles and those being led was either broadly positive or neutral in tone with the over-riding sentiment being that ‘*good leaders, led well*’; while significant steps have been taken by the IASC and

¹²⁴ KonTerra (2022) COVID-19 Global Humanitarian Response Plan: Learning Paper, April 2022.

¹²⁵ See, for example, COVID-19 Global Evaluation Coalition (2021) The COVID-19 pandemic. How are humanitarian and development co-operation actors doing so far? How could we do better? June 2021.

¹²⁶ See for example, Humanitarian Advisory Group, ICRC, IFRC (2021) How diverse leadership shaped responses to COVID-19 within the International Red Cross And Red Crescent Movement, May 2021.

United Nations to strengthen humanitarian leadership, experience, competence and capacity remains uneven. Those leaders with a greater humanitarian experience were more familiar with the response mechanisms, and where experience was limited, responsibilities were sometimes delegated to HCT members (where HCTs existed), members of the RCO, or efforts were made to draw on the specific knowledge and capacities of humanitarian agencies. In at least one of the case study countries, targeted support for planning was provided by OCHA's Regional Office. It is important to acknowledge that across the case studies, it was often stated that there was a strong sense of *'team'* and purpose from within HCT members; and similarly positive feedback was received from interviewees from within RCOs.

87. In many of the case study countries, the necessity for international and government actors to work closely together strengthened this important partnership. Even in contexts where government capacity was weak, relationships with international humanitarian actors often improved because of the severity of the situation and the need for coherent action; in the context of a global pandemic, efforts were stepped up to overcome disagreements and find ways to work together. That is not to say that governments routinely led well, or that the members of the humanitarian community were routinely effective in the support they provided, but that the need to work together was often far more compelling than it had been in the past.

4.3 The role of the Global Clusters in the COVID-19 response

88. An essential pillar of the IASC's global coordination of the COVID-19 response was the clusters. At a global level, the clusters received very little visibility from the GHRP which instead prioritized input from the nine United Nations agencies. It is not possible to determine the effect this ultimately had on the motivation or work of clusters in the COVID-19 response, but it is the view of this evaluation that it was short-sighted and represents a significant failure; moreover, that the United Nations coordinating agency (OCHA) and the majority of Cluster Leader Agencies omitted to substantively include the global clusters in the GHRP served to reinforce an already well-held perception that clusters had been de-prioritized.
89. Despite being passed over during the drafting of the GHRP, the Global Clusters threw themselves into the task of supporting sectoral support needs. To this end, work was quite quickly initiated in most clusters to strengthen surveillance, refresh analysis and prepare and disseminate guidance to country-based clusters and field staff who were faced with the task of adapting programmes to respond to the pandemic.
90. There were several common requirements for the clusters at a global level of which the need for adapted guidance, relevant to the changed context, was the most significant. Support for the shift of national clusters to remote working was less arduous at a global level, given the remote links that already existed with country-based clusters. The shift also offered opportunities to take distance learning to scale and was also rewarded, at least in the short-term, by better engagement from field-based partners. Those clusters that had already established Helpdesk facilities were similarly well-prepared to receive the additional requests for support that they received.
91. While most clusters were active in between 10 and 30 countries and had resources and systems established for this caseload, none were prepared for the challenge posed by the 63 countries included in the GHRP. There were two specific challenges that this posed for Global Cluster Coordinators: the first was the scale of the support that was required and the volume of enquiries that were received by a two-to six-fold increase in the number of clients. The second was how the Global Clusters should best engage with countries that were not part of the formal cluster system. The extent of this burden differed by cluster and in the absence of additional cluster resources, most primarily adapted by working harder and longer hours, particularly in the initial months of the response. Ultimately, cluster staff did the best they could do to provide support, despite the additional burden placed upon them.

92. While acknowledging that Inter-cluster coordination has long been recognized as a weakness of IASC coordination structures, and one that requires strengthening,¹²⁷ it is noteworthy that there were very deliberate attempts made at the global level both collectively between all clusters, but also bilaterally between specific clusters, to identify and explain some of the more important linkages. These guidance documents were made available on cluster websites and were also frequently disseminated at country-level through the clusters and ICCGs. Notwithstanding the fact that the sectoral nature of the clusters meant they continued to work independently of each other, this evaluation acknowledges the efforts that were made to identify and promote synergies between them.

4.4 Country-level sectoral coordination structures

93. At a country-level, multi-sector, inter-agency coordination played an essential role in the COVID-19 response and in the majority of the countries targeted by the GHRP, IASC structures already existed either in the form of the clusters or as UNHCR-led sectors. Of the eight countries that participated in the evaluation, pre-existing OCHA or UNHCR-led sectoral coordination structures existed in six of them; while in two countries (the Philippines and Sierra Leone), government-led structures were used to coordinate the pandemic response.
94. The evaluation found that in the context of a rapidly evolving situation, the humanitarian response was best served by working through existing coordination structures rather than seeking to adapt them.¹²⁸ Moreover, the evaluation did not find any conclusive evidence to favour one coordination structure over another. This finding is consistent with the Active Learning Network for Accountability and Performance (ALNAP) lessons paper on responding to Ebola epidemics, which found that *'no single coordination model has emerged as most effective but ensuring clarity of roles and responsibilities is important across contexts.'*¹²⁹
95. The performance of humanitarian coordination mechanisms was influenced by numerous external factors which included the support they received from Cluster Lead Agencies, staff capacity, adequacy of resourcing, and nature of government engagement, among many others. While there was no pre-eminent coordination structure, there were a number of common successes and challenges experienced across clusters. These are examined in Table 3 below.

¹²⁷ The 2020 ICCG retreat included an agenda item and discussion about ICCG's *'Fitness for purpose'*. GCCG (2020) *Mid-Year Retreat, Draft Summary Record and Action Points*, 7-8 July 2020.

¹²⁸ This echoes the earlier findings of the COVID-19 Global Evaluation Coalition. See COVID-19 Global Evaluation Coalition (2021) *The COVID-19 pandemic. How are humanitarian and development co-operation actors doing so far? How could we do better?* June 2021.

¹²⁹ Lamoure, G. and Juillard, H. (2020) *Responding to Ebola epidemics: a lessons paper*. London: ALNAP.

Table 3: Analysis of adaptations and challenges common to IASC coordination structures

Coordination issue	Description
Ways in which IASC Coordination structures adapted to the COVID-19	
The shift to using remote modalities	Lockdowns and movement restrictions resulted in almost all clusters adopting remote approaches to meetings. The evaluation received significant feedback on this, with local actors and members from cross-cutting initiatives reporting the benefits of a perceived ‘democratization’ of coordination mechanisms as online access to meetings made it easier to participate in meetings.
Coordination convening capacity	The balance of the feedback elicited by the evaluation was generally positive, with a high value placed on the convening capacity, functions and leadership of coordination bodies and staff.
Contextualizing and synthesizing global guidance	Global guidance on technical adaptations for the COVID-19 response was abundant in quantity and normative in nature. An important role played by many coordination structures was to synthesise, adapt and disseminate guidance to strengthen contextual relevance.
Generating evidence to inform adapted response	Most coordination structures invested in primary data collection and analysis to inform operational response or supported the analysis and synthesis or secondary evidence to strengthen the relevance and effectiveness of partner responses.
Facilitating a multi-sectoral response to the pandemic	One clear advantage of using pre-existing cluster/sector coordination mechanisms was that it permitted a coordinated cross-sectoral response to the pandemic. This meant that COVID-19 was addressed as a humanitarian emergency rather than purely as a health emergency which was a criticism of the Ebola response. ¹³⁰
Challenges common to IASC Coordination structures	
Quality of participation in coordination meetings	While online coordination meetings meant that the number of participants often increased, it also made it more difficult for some members to participate in a meaningful way. This was particularly the case for those less familiar with the language used, the technology, or due to the need to compete for space with those that were most confident. It tended to be local and national actors who were least confident which affected the quality of their participation.
Inter-cluster coordination (ICC)	ICC was considered by interviewees to be a particular challenge in the early months of the response because clusters prioritized internal discussions about how to adapt their own programmes rather than how to work with others. It did, however, improve with time as there was more space to explore linkages, develop guidance and promote good practice, with the support and guidance from the global clusters. It did remain a challenge though if for no other reason than the siloed nature of coordination meant that ICC tended to be a secondary consideration.
Incorporation of cross-cutting issues	The incorporation of CCI into cluster activities is an issue that the evaluation received mixed feedback on. While coordination structures frequently included forums for cross-cutting issues (such as gender, disability or age), they tended not to be routinely effective or well-attended. That said, the evaluation also noted good practice (see Box 6 below). Even when coordination mechanisms advocated for the incorporation of CCI into programming, it still proved difficult to effect change at agency or response levels due to the lack of staff capacity, organizational agility to make the changes, or resources.
Challenges of sub-national coordination	Decentralized coordination structures were considered valuable by many interviewees, but these were also the structures that were most badly affected as coordination staff withdrew from field locations. It also often took the longest time to move to remote modalities because it was more difficult to harness the technology to support the change. This served to deepen the sense of isolation of some front-line responders in the early stages of the response.

¹³⁰ Lamoure, G. and Juillard, H. (2020) *Responding to Ebola epidemics: a lessons paper*. London: ALNAP.

Box 6: The Age and Disability Working Group in the Rohingya response^{131 132}

In 2018, Humanity and Inclusion, CBM, Centre for Disability in Development and HelpAge International established the ADWG in Cox's Bazar to promote the inclusion of persons with disabilities in established humanitarian coordination structures. In the first two years of its existence, the ADWG struggled to have a tangible influence on the larger humanitarian response. In 2020, the ADWG member organizations also formalized their cooperation with the Protection Working Group, which further increased demands from mainstream actors for technical support and capacity-building. Simultaneously, mainstream actors became involved in the work of the ADWG. While some joined as active members, others regularly attended the meetings.

In 2020, together with the UNHCR-led Protection Working Group, the ADWG published a joint COVID-19 Guidance Note on making the response age- and disability-inclusive. The Guidance Note highlights factors that put older persons and persons with disabilities more at risk of contracting the virus and provides humanitarian actors with recommendations on mitigating these risks (ADWG and Protection Working Group, 2020). Moreover, together with the Protection Working Group and the REACH Initiative, the ADWG started working on a joint needs assessment. The ADWG provides training to enumerators and technical support to the project team to ensure that the methodology, tools, data-collection process, analysis and use of data is inclusive to all persons with disabilities, including hard-to-reach groups, such as deaf persons and persons with autism.

96. In the countries where IASC members were playing a support role to government-led coordination mechanisms, the coordination architecture was less familiar to IASC members. In these contexts, the case studies demonstrated that IASC member agencies supported government structures either through co-leadership or liaison arrangements, as well as through the provision of strategic and operational support at the national and sub-national level (engagement between national actors and IASC members is addressed in section 9).
97. Many of the challenges encountered by government coordination structures were similar to those faced by the IASC Clusters, and included difficulties in working across thematic 'siloes' and challenges in adequately identifying and addressing the needs of particularly vulnerable groups.

4.5 Technical leadership of the COVID-19 response

98. WHO had a number of global responsibilities during the COVID-19 response, which included acting as the focal point for health within the IASC; leadership of the Global Health Cluster (GHC); custodian of the IHR; and provider of technical guidance, leadership and operational capacity for the collective response to infectious disease events. It is the last of these responsibilities that are outlined in the Adapted Scale-Up Protocol and are within the scope of this evaluation.
99. This technical coordination task was supported by the GHC COVID-19 Task Team, based at WHO headquarters, which was given the role of identifying critical challenges and providing support for the adaptation and implementation of WHO COVID-19 guidance in low-capacity, humanitarian settings. In several of the case study countries, this conflation of roles was extended to the country level and elicited some concern from interviewees who identified the demarcation between the health cluster leadership role in the country and the WHO country team as ambiguous.

¹³¹ Funke, C. and Dijkzeul, D (2021) *Mainstreaming Disability in Humanitarian Action: A Field Study from Cox's Bazar, Bangladesh*. Institute for International Law of Peace and Armed Conflict.

¹³² REACH & Protection Sector, Cox's Bazar (2021) *Age and Disability Inclusion Needs Assessment*. Rohingya Refugee Response, May 2021.

100. Technical leadership and coordination responsibilities are not explicitly outlined in the Adapted Protocols, but the System-Wide Scale-Up Activation for Infectious Disease Events refers to the preparation of common, inter-agency situation reports, and support for the identification of key priorities for national preparedness and response.¹³³ Added to these are a range of responsibilities under the IHR; of relevance to this evaluation are the provision of technical guidance and operational support to governments. A review of the evidence for each of the technical leadership functions from a review of the literature and the country case studies is summarized below (see Table 4).

Table 4: Country-level reflections on WHO’s technical coordination role

Function	Assessment from country case studies
Situation reporting	Information management and situation reporting was prioritized by WHO and the provision of regular updates was evident across all of the case studies as well as at the global level. A WHO briefing on the situation was frequently a standing agenda item for HCTs and inter-agency coordination meetings. Feedback from the case studies on the quality and timeliness of the information was broadly positive.
Technical coordination	WHO’s technical coordination was welcomed, albeit with some concerns raised about the slow pace of staff recruitment which meant that the capacity of country teams sometimes lagged behind what was required. This issue was also raised in the Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme in its May 2021 report. ¹³⁴
Operational support to Ministry of Health	Across the case studies WHO benefitted from having well-established relationships with government and Ministry staff. High levels of trust provided an important foundation for the support provided by WHO during the COVID-19 response. Given the importance of government leadership in the responses and the implications of this on the collective humanitarian response, this aspect of WHO’s technical leadership role was valued.
Development of policy and guidance	By March 2021, WHO had published over 600 COVID-related documents for the public, health workers and countries, providing advice on the COVID-19 response. ¹³⁵ The guidance was broadly welcomed and was frequently found to be relevant, although there was some concern about the frequent changes in policy, particularly in the early months of the response which made it difficult at times to have confidence in the information that was being shared.

101. Of note is that WHO’s technical leadership role brought it into greater proximity with other IASC members in a context that required strong collaboration. At a global level, WHO worked in partnership with World Food Programme (WFP) on Supply Chain issues, with OCHA on GIMAC, and with UNICEF on vaccinations; at a country level, WHO played a much more visible role in the response than it often does, which meant that it had considerable influence.

4.6 Regional support for the collective COVID-19 response

102. An assessment of IASC action at the regional level is complicated by the fact that the IASC does not have a regional structure and neither has it established specific ways of working; in both the 2019 and 2022 versions of the IASC structures and working methods, no reference is made to regions.¹³⁶ Moreover, there is no common regional geography for United Nations agencies and INGO members, many of which also have different reporting and management structures.

¹³³ IASC (2019) Standard Operating Procedures. Humanitarian System-Wide Scale-up Activation. Protocol for the Control of Infectious Disease Events, April 2019.

¹³⁴ Independent Oversight and Advisory Committee for the WHO Health Emergencies Programme (2021) *Seventy-Fourth World Health Assembly*, 5 May 2021.

¹³⁵ The Independent Panel for Pandemic Preparedness and Response (2021) *Second report on Progress*, January 2021.

¹³⁶ IASC (2019) IASC Structure and Working Method, January 2019; IASC (2022) IASC Structures 2022 – 2023, January 2022.

103. The lack of formalized structures or responsibilities for regional IASC action means that this evaluation was not able to examine collective action. In the absence of any clarity, the support and activities of IASC members were undertaken either individually, through membership networks, or in the case of the UN, via DCO Regional Offices. In terms of the broader role that regional hubs played in the coordination of the COVID-19 response, United Nations Regional Directors coordinated with the United Nations Development Coordination Office Regional Directors on strategy, planning and information sharing. While the capacities of DCO Regional Offices are limited given that they are still fairly new, feedback received by the evaluation suggested that they played a useful role in fostering coherence given the multi-dimensional nature of the response.
104. During the evaluation, examples were given of targeted technical advisory support being provided by regional offices, and modest assistance with surges, where travel restrictions permitted. Where there were existing inter-agency coordination mechanisms, these were frequently re-purposed or mandated to provide support to specific aspects of country-led COVID-19 response. In addition to the provision of strategic planning and support for the COVID-19 response, it is important to acknowledge the important leadership role played by Regional Directors in the COVID-19 response as most United Nations agencies and INGOs had decentralized management structures.

5 Funding

Summary findings

- The GHRP was the first ever event-specific global humanitarian appeal document, with the first iteration developed with an emphasis on speed and efficiency. Donors were engaged actively with the GHRP process and appreciated it for enabling them to release funding quickly (section 5.1).
- COVID-19 and the GHRP did not result in significant changes in donor funding patterns. By the end of the GHRP period, donors had provided 40 percent of the funding requested. The GHRP emphasized that funding for existing humanitarian needs remained the top priority and appeals for non-COVID-19 humanitarian needs were better funded than COVID-19 appeals (section 5.1).
- The final iteration of the GHRP included separate funding envelopes for NGOs and famine response. There was recognition that an appeal like the GHRP could be useful for highlighting certain issues or stakeholders for advocacy purposes but, ultimately, it did not achieve the purpose of mobilizing additional funding for these issues (section 5.1).
- The GHRP attracted funding quickly, raising almost \$1 billion by May 2020, although it is unclear from available data if all of the pledged funding was paid in a timely way. While early funding for the response was important for investment in scaling up the health response, the pandemic lasted longer than anticipated with larger waves of infections and deaths occurring well beyond 2020. A lack of sustained funding meant that, in some contexts, funding had run out by the time of the larger COVID waves (section 5.2).
- While donors provided considerable un-earmarked funding at the start of the pandemic, in line with Grand Bargain commitments, they soon reverted to pre-pandemic levels of earmarking. There were suggestions that this was due to a lack of clarity on how initial funding had been spent against GHRP priorities (section 5.3).
- CERF and CBPFs made an effort to provide timely and flexible funding for the COVID-19 response. CERF made an early, fast-tracked provision of completely flexible funding to nine United Nations agencies. The CBPFs introduced a set of flexibility measures for their partners. A few also made early allocations for COVID-19 but these were modest and some CBPFs also attracted criticism for not speeding up project approvals (section 5.4).

105. Section 3.1 noted that the GHRP had multiple functions but a key one was to mobilize funding quickly for the COVID-19 response. This section starts by presenting findings on the timeliness, flexibility and adequacy of funds raised against the GHRP before going on to review the role of OCHA-managed pooled funds in supporting the COVID-19 response.

5.1 Resource mobilization through the GHRP

106. The humanitarian system mobilizes resources through country-level response plans that are usually annual (with some exceptions). OCHA also compiles an annual GHO that aggregates the needs, priorities and financial requirements of country-level HRPs. This is very different from focusing on one specific emergency so the GHRP was the first ever event-specific global humanitarian appeal. Its remit went well beyond the GHO because it also covered countries that did not have a humanitarian appeal but had requested international assistance in responding to COVID-19.

107. Global-level interviewees described intense pressure to publish a humanitarian plan as quickly as possible to provide donors with a vehicle for funding decisions so there was an emphasis on speed and efficiency in developing the first iteration of the GHRP.¹³⁷ As a result, NGO engagement with the GHRP process was limited, at least initially, but donor engagement was strong. Overall, donors expressed their appreciation for the speed with which the first GHRP was published, which was helpful for them to release funding, and for the consistency and quality of progress reporting.¹³⁸
108. Figure 4 showed that funding to the GHRP started flowing quickly, with donors having contributed \$923 million by May 2020.¹³⁹ However, an analysis of global funding data suggested that around 40 percent of funding committed to the COVID-19 response remained unpaid for around six months. This should be treated with caution because it may also be due to poor reporting but it is the best available data on the timeliness of COVID-19 funding. Based on this reported data, the US disbursed funding most quickly, taking around 9 days from commitment to payment on average.¹⁴⁰ The United Kingdom (UK) was also quick to provide significant funding very early in the COVID-19 response. This is because the government took a ‘no regrets’ approach.¹⁴¹
109. As described in the context section, by February 2021, the GHRP had mobilized \$3.8 billion or 40 percent of the final amount requested. Figure 5 showed that this funding was spread unevenly across the 63 countries in the GHRP. Interviews and documentary evidence did not make clear the reasons for the disparities, which could be unrelated to COVID-19.¹⁴²
110. The GHRP emphasized that funding for existing humanitarian responses remained the top priority because people being assisted through them would be most affected by the pandemic. In line with this, COVID-19 appeals were generally less well-funded than non-COVID-19 humanitarian needs. Only Yemen and DRC had a greater proportion of their COVID-19 requirements met, compared with non-COVID humanitarian needs. Some case study interviewees expressed concern that funding was being diverted from existing humanitarian needs, such as non-COVID-19 health programmes, education and agriculture/livelihoods to meet COVID-19-related needs. This was a worry because funding has not kept pace with the increase in overall humanitarian needs, particularly as these grew considerably in many contexts in 2020 and again in 2022. Figure 9 shows levels of humanitarian funding to inter-agency appeals and the levels of unmet requirements over the last 10 years. It highlights that, in 2020, the proportion of funding provided was at its lowest compared to funding requested (at 50 percent). Therefore, one view on funding for the COVID-19 response is that “*A humanitarian system already under strain was unable to mobilize sufficient additional resources when faced with a global shock*”.¹⁴³

¹³⁷ KonTerra. (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, Commissioned by the Inter-Agency Humanitarian Evaluation Steering Committee.

¹³⁸ KonTerra. (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, Commissioned by the Inter-Agency Humanitarian Evaluation Steering Committee.

¹³⁹ OCHA (2020) *Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, GHRP May Update*.

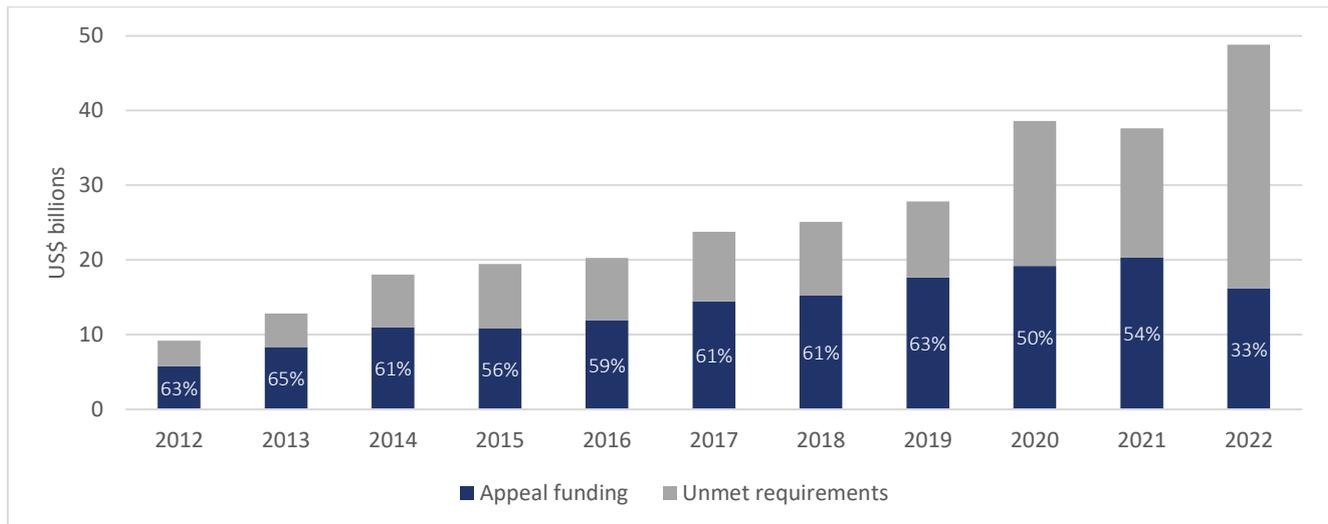
¹⁴⁰ Development Initiatives and International Rescue Committee (2021) *Tracking the Global Humanitarian Response to COVID-19: Report*, April 2021.

¹⁴¹ ICAI (2022) *The UK’s Humanitarian Response to COVID-19: A review*, Independent Commission on Aid Impact, July 2022.

¹⁴² An example of this is Yemen, where one interviewee pointed out that funding levels fluctuate based on contributions from Gulf donors and the 2020 funding level was not greatly influenced by COVID-19.

¹⁴³ Development Initiatives and International Rescue Committee (2021) *Tracking the Global Humanitarian Response to COVID-19: Report*, April 2021, pg. 10.

Figure 9: Humanitarian funding against appeals and unmet requirements: 2012-2022¹⁴⁴



111. The top five humanitarian donors contributed over half of the funding against the GHRP,¹⁴⁵ with the United States (US) alone providing nearly one-quarter of the funding (see Figure 10).¹⁴⁶ This mirrors previous trends in humanitarian funding¹⁴⁷ so COVID-19 and the GHRP did not result in a significant change in donor funding patterns. Available funding data does not track the extent to which donors provided additional funding for the COVID-19 response compared with re-purposing their existing humanitarian funding, particularly at the start of the pandemic. Interviewees noted that the US Congress passed supplemental COVID-19 appropriations and ECHO provided additional funding. The UK government allocated £218.7 million (\$280 million), largely un-earmarked, to partners at the global level in the first few weeks of the pandemic. However, at country level, it re-programmed existing funding instead of providing new funding. A planned second tranche of COVID-19 funding did not go ahead due to budget cuts in the summer of 2020.¹⁴⁸

¹⁴⁴ Source: OCHA Financial Tracking Service, data downloaded on 25 August 2022.

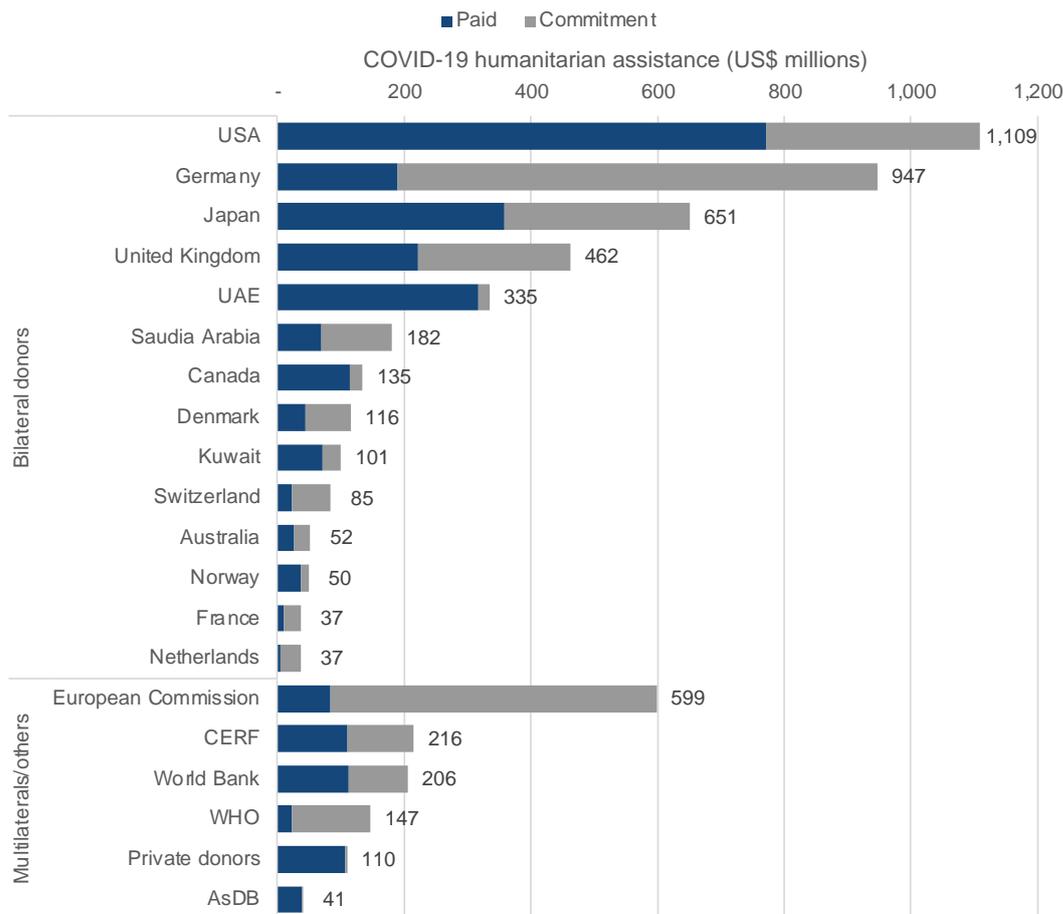
¹⁴⁵ According to reporting on OCHA's FTS, the US, Germany, the European Commission's Humanitarian Aid and Civil Protection Department (ECHO), the United Kingdom and Japan provided a combined total of \$2.1 billion against the GHRP, representing 55 per cent of overall contributions.

¹⁴⁶ Source: Development Initiatives and International Rescue Committee (2021) *Tracking the Global Humanitarian Response to COVID-19: Report*, April 2021

¹⁴⁷ Development Initiatives and International Rescue Committee (2021) *Tracking the Global Humanitarian Response to COVID-19: Report*, April 2021.

¹⁴⁸ ICAI (2022) *The UK's Humanitarian Response to COVID-19: A review*, Independent Commission on Aid Impact, July 2022.

Figure 10: Top 20 humanitarian donors for COVID-19 response



112. As a way to mobilize specific *‘thematic’* funding, the July 2020 iteration of the GHRP included two separate envelopes. One was for \$300 million for the supplemental NGO response to COVID-19 (both INGOs and L/NNGOs) in response to concerns that COVID-19 funding was not flowing to NGOs even though they were critical to the response.¹⁴⁹ The other envelope was for \$500 million for famine prevention. A number of interviewees criticized this approach to resource mobilization for being *‘too little, too late’* to be useful, particularly the NGO envelope. This is because there was a lack of consultation with INGOs and L/NNGOs prior to its inclusion in the GHRP and also a lack of clarity on how supplemental funding would work compared with funding already channelled to the NGO response and/or famine prevention through country-level plans. In addition, there was no way of tracking and reporting back on that funding, raising questions about accountability. Overall, interviewees recognized the value of highlighting certain issues or stakeholders in the GHRP for visibility and advocacy purposes but pointed out that the approach did not achieve the intended purpose of mobilizing additional funding. This is supported by the data that shows that, as of the final GHRP progress report in February 2021, only 2 percent of the funding requested for the NGO envelope and 7 percent of the famine prevention envelope was raised.¹⁵⁰

¹⁴⁹ <https://interagencystandingcommittee.org/system/files/2020-04/Summary%20Record%20of%20IASC%20Ad%20hoc%20Principals%20Meeting%20on%20nCoV%20-%202017.04.20.pdf>.

¹⁵⁰ KonTerra. (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, Commissioned by the Inter-Agency Humanitarian Evaluation Steering Committee; OCHA (2021) *Global Humanitarian Response Plan COVID-19, Final Progress Report*, 22 February 2021.

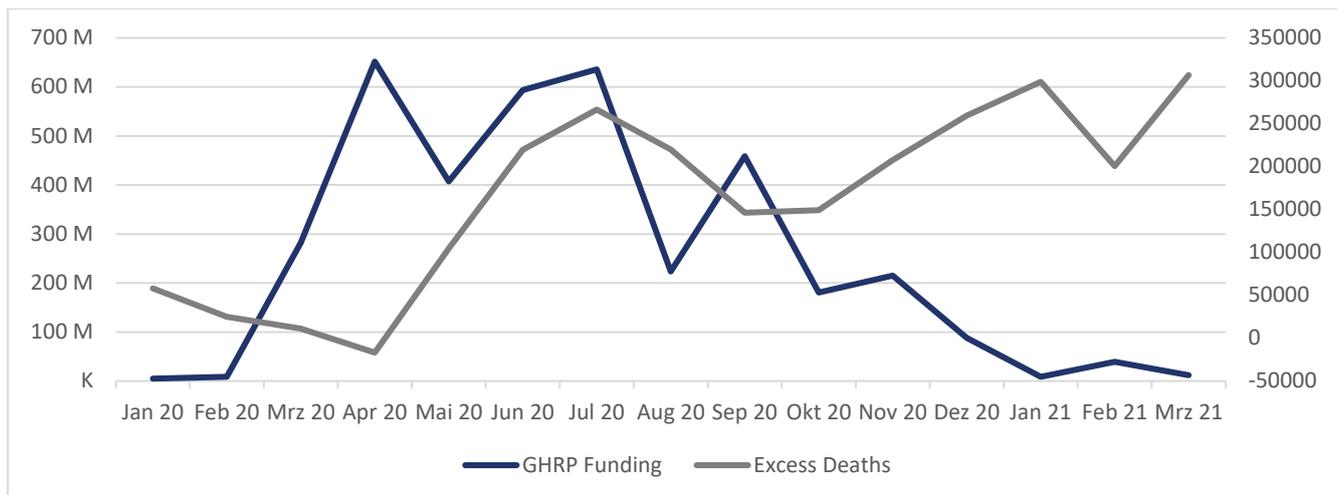
5.2 Timeliness of funding

113. As noted above, the GHRP mobilized funding quickly at the beginning of the pandemic. There was also some evidence that humanitarian actors that had their own emergency or contingency funds used these to start activities while waiting for additional funding or permission to reprogramme funds. UNICEF used \$8.2 million from its Emergency Programme Fund, an internal loan mechanism, to meet critical needs and scale up the response until it secured additional funding. However, it was able to secure funding very quickly and had received \$50 million by 20 March 2020 from the private sector, bilateral donors and CERF.¹⁵¹ A Syrian NGO that had a social enterprise, giving vulnerable people the opportunity to earn an income by making clothes, used funds generated by the company to start its COVID-19 response while waiting for other funding. In Bangladesh, an INGO used an internal humanitarian fund to set up a COVID-19 isolation and treatment centre in 2020. It was then able to secure external funding to set up another facility in 2021 when there was a surge in COVID-19 cases.
114. Interview data from the case studies suggest that the time taken to disburse funds was less of an issue than for other crises because donors generally provided flexibility to re-programme existing funding. Also, with lockdown restrictions in most contexts, humanitarian actors were unable to deliver some activities and they needed time to find alternative delivery modalities for others. Thus, there was limited absorption capacity at the beginning of the pandemic.
115. There have been calls for early and even anticipatory funding for crises, particularly natural disasters (and CERF has been proactive in testing anticipatory financing approaches, including in Somalia and Bangladesh in 2020).¹⁵² Therefore, it is positive that donors made an effort to provide funding for the COVID-19 response at the start of the pandemic. This could then be invested in PPE, medical equipment, health facilities, etc. so that humanitarian actors were ready to respond when COVID-19 cases appeared in a country. However, COVID-19 affected countries at different times and over a much longer period than expected (for example, some countries had their biggest waves of infection in 2021 or even at the beginning of 2022). There was, therefore, a challenge with sustaining funding beyond the initial phase, when socio-economic impacts also became more pronounced. This is illustrated by the situation in North West Syria. Humanitarian actors made an initial investment in health facilities to treat COVID-19 or isolate infected patients but, by the time of the second and bigger wave in late 2021, some organizations had run out of funding to maintain services and communities reported that health facilities had closed or treatment was no longer available. This was less of an issue in Bangladesh because humanitarian actors operating Severe Acute Respiratory Infection Isolation and Treatment Centres were able to expand and reduce capacity to respond to changing levels of demand.
116. Figure 11 below shows humanitarian funding to the 63 GHRP countries alongside excess deaths in 2020 (as a more accurate mortality figure than reported COVID-19 deaths, which were recorded and reported in different ways across countries). This shows high levels of funding early in the crisis but then a reduction as the GHRP period came to an end, which was about the same time that excess deaths started to increase, at the end of 2020/early 2021. The pattern of funding against waves of COVID-19 infections and deaths was different in each case study context but highlighted that a pandemic is likely to last much longer than expected and so the timing of funding and the ability to adjust to changing levels of need is as important as timeliness, in the sense of early funding.

¹⁵¹ UNICEF (2020) Humanitarian Action for Children: Novel Coronavirus (COVID-2019) Global Response, Revised March 2020.

¹⁵² <https://reliefweb.int/report/world/mark-lowcock-under-secretary-general-humanitarian-affairs-and-emergency-relief>; <https://www.thenewhumanitarian.org/the-wrap/2021/9/13/the-push-to-anticipate-crises-gains-steam>; FAO (2021) Anticipatory Action: Changing the way we manage disasters, Rome.

Figure 11: GHRP funding flows and mean excess deaths across 63 GHRP countries: January 2020-March 2021¹⁵³



5.3 Flexibility of funding

117. The Grand Bargain made specific commitments on reducing earmarked funding as a way to provide flexible funding, with a donor commitment to achieve a global target of 30 percent of humanitarian contributions that are non-earmarked or softly earmarked by 2020. Aid agencies also committed to reducing earmarking when channelling funding to their partners.¹⁵⁴ A number of donors have made significant progress in the provision of flexible funding but there is a view that politics and risk appetite are the main barriers to systemic change and these cannot be overcome by technical solutions. Progress on cascading flexible funding from United Nations agencies to INGOs and L/NNGOs has been more challenging.¹⁵⁵
118. GHRP progress reports show that donors provided considerable un-earmarked or softly earmarked funding to United Nations agencies in the first three months of the COVID-19 response. As of June 2020, an average of 42 percent of the funding to seven United Nations agencies was flexible (although there were large differences between United Nations agencies). However, this decreased over time as bilateral donors began to scrutinize spending and to ask for increasingly detailed reporting. By February 2021, the average amount of un-earmarked GHRP funding was down to 25 percent. Interviews suggested that there was a level of frustration among donors at the inability of individual United Nations agencies to account for their initial spending against GHRP priorities beyond illustrative examples provided in GHRP progress reports.¹⁵⁶
119. In the context of responding to the pandemic, other types of flexibility in funding were almost more important because it was no longer possible to deliver humanitarian assistance in the same way due to COVID-19 preventive measures. This is discussed in section 9.4 on funding for frontline responders.

¹⁵³ Sources: OCHA Financial Tracking Service and WHO: <https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021>. Excess death data does not include Aruba, Curacao and occupied Palestinian territory (oPt) as they were not in the WHO database.

¹⁵⁴ The Grand Bargain: A shared commitment to better serve people in need, Istanbul, Turkey, 23 May 2016.

¹⁵⁵ Metcalfe-Hough, V., W. Fenton, B. Willitts-King and A. Spencer (2021) *The Grand Bargain at Five Years: An independent review*, Humanitarian Policy Group, Overseas Development Institute.

¹⁵⁶ KonTerra. (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, Commissioned by the Inter-Agency Humanitarian Evaluation Steering Committee.

5.4 Pooled funding

120. As outlined in the context section, CERF and CBPFs provided a total of \$493 million for the COVID-19 response in 2020 - \$241 million from CERF and \$252 million from CBPFs.¹⁵⁷ In line with the GHRP's message that funding for the COVID-19 response should not be at the expense of meeting non-COVID-19 humanitarian needs, the pooled funds also provided significant funding for ongoing humanitarian needs. For both funds, COVID-19 funding was around 28 percent of the total funding allocated in 2020.¹⁵⁸

5.4.1 Timeliness of pooled funds

121. CERF made an early funding allocation of \$95 million in the form of block grants to nine United Nations agencies between February and March 2020.¹⁵⁹ This included \$40 million to WFP for logistics and humanitarian supply-chain services (covered in section 6.6 on common services). The introduction of a fast-tracked approval process meant that agencies received funding within three to five days of their original proposal submission. Some agencies made use of the 'early start date' provision, enabling them to cover expenses made before they had received funds. As a result of this fast-track process, CERF supported the start of the response as early as 3 February 2020, well before WHO's pandemic declaration on 11 March.¹⁶⁰ FAO, UNICEF and WHO reported that CERF provided their first COVID-19 allocation in some countries and identified what they were able to achieve as a result.¹⁶¹
122. This was the first time that CERF had funded United Nations agencies directly at the global level rather than through country-specific grants. The aim was to provide maximum flexibility for agencies to prioritize according to critical needs at global and country levels, in line with the GHRP.¹⁶² However, some global-level interviewees argued that this approach undermined the benefits of CERF as a mechanism for facilitating a collective response at country level and made it difficult for some agencies to report back on where and how they had used CERF funding and the results achieved.¹⁶³
123. While CERF made a laudable effort to release funding early on in the pandemic, as noted in the previous section, more sustained funding was important because the pandemic lasted much longer than anticipated. The Colombia case study highlighted that a CERF Under-Funded Emergency allocation of \$5 million disbursed in November 2020 was instrumental in enabling United Nations agencies to respond to the effects of COVID-19 in neglected areas (such as the Amazonas department) as well as a deteriorating conflict situation in some parts of the country.
124. Some CBPFs also responded early to COVID-19, with the Afghanistan Humanitarian Fund (AHF) providing \$1.5 million to improve preparedness and response capacities in February 2020. This was the first of five Reserve Allocations (RAs) for the COVID-19 response in 2020 (which totalled \$41.9 million).¹⁶⁴ The Sudan Humanitarian Fund made a small allocation of \$500,000 in March 2020 to improve COVID-19 preparedness. This was the first of three RAs for the COVID-19 response, which totalled \$13.6 million.¹⁶⁵ Both the AHF and

¹⁵⁷ OCHA (2021) *OCHA-Managed Pooled Funds: 2020 Overview*, Country-Based Pooled Funds (CBPF), United Nations CERF (Central Emergency Response Fund).

¹⁵⁸ CERF allocated \$848 million in total in 2020 while CBPFs allocated \$909 million. See OCHA (2021) *OCHA-Managed Pooled Funds: 2020 Overview*, Country-Based Pooled Funds (CBPF), United Nations CERF (Central Emergency Response Fund).

¹⁵⁹ The nine agencies were FAO, IOM, UN Habitat, UNDP, UNFPA, UNHCR, UNICEF, WFP and WHO. See CERF (2021) *Global Rapid Response COVID-19 2020: 20-RR-GLB-41473, 20-RR-GLB-42285*, CERF Allocation Report on the Use of Funds and Achieved Results.

¹⁶⁰ CERF (2020), CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020.

¹⁶¹ CERF (2021) *Global Rapid Response COVID-19 2020: 20-RR-GLB-41473, 20-RR-GLB-42285*, CERF Allocation Report on the Use of Funds and Achieved Results.

¹⁶² CERF (2020), CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020.

¹⁶³ KonTerra. (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, Commissioned by the Inter-Agency Humanitarian Evaluation Steering Committee.

¹⁶⁴ Afghanistan Humanitarian Fund (2021) *Afghanistan Humanitarian Fund 2020 Annual Report*.

¹⁶⁵ Sudan Humanitarian Fund (2021) *Sudan Humanitarian Fund 2020 Annual Report*.

the Sudan Humanitarian Fund made their largest COVID-19-related RAs in May (allocating \$15.7 million and \$11.5 million respectively). The Jordan Humanitarian Fund, one of the smaller CBPFs, provided \$900,000 through its first RA in March 2020, when there was an increase in COVID-19 cases in the country and the government imposed a full lockdown. The purpose of the allocation was to respond to COVID-19 in the hardest-to-reach areas.

125. The data shows that CBPFs had made a modest allocation of \$3.9 million for the COVID-19 response until April 2020, when eleven CBPFs made their first COVID-19 allocations. The CBPFs recognized that speed was important because L/NAs, in particular, can rarely start to scale-up activities until they have received funding. They reported taking two to four weeks to review and approve proposals and less than a week to disburse funds, which was fast in light of the strategic and technical reviews required.¹⁶⁶ However, interviews from the case studies suggested that the CBPFs generally took at least a month to approve projects and the Syria fund, in particular, attracted criticism for being slow.

5.4.2 Flexibility of pooled funds

126. As noted above, CERF provision of global block grants to United Nations agencies was designed to give them maximum flexibility to address critical needs. In addition, the CERF secretariat introduced a streamlined process for United Nations agencies to request no-cost extensions and to re-programme funds. As of late October 2020, the secretariat had approved requests to re-programme \$15.6 million in 30 countries.¹⁶⁷
127. In addition to providing greater flexibility to partners for the COVID-19 response, the CERF secretariat itself demonstrated flexibility in trying out new approaches that are discussed in section 9.4 on the flexibility of funding for frontline responders. CBPFs also introduced flexibility measures, designed to support NGOs by simplifying procedures, in April 2020 (see section 9.4).¹⁶⁸

¹⁶⁶ CBPF (2020) Country Based Pooled Funds: On the front line of the COVID-19 response, June 2020.

¹⁶⁷ CERF (2020), CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020.

¹⁶⁸ CBPF (2020) Country Based Pooled Funds: On the front line of the COVID-19 response, June 2020.

6 Collective mechanisms for the response

Summary findings

- Feedback from communities indicated a decrease in the accountability of aid during the COVID-19 response. A shift to remote approaches to community engagement hampered participation and created further distance between communities and aid agencies, compromising attempts to strengthen accountability (section 6.1).
- Women and girls had less access to accountability mechanisms than men, which limited the reflection of their perspectives (section 6.1).
- Attention to collectively mitigate against or respond to Sexual Exploitation and Abuse (SEA) within the collective COVID-19 response was not adequately prioritized. (section 6.2).
- Investments and innovations in collective Risk Communication and Community Engagement (RCCE) were strong and demonstrated learning from previous public health emergencies, particularly in terms of two-way dialogues with communities. In some case study contexts, faith leaders played an important role in transforming community behaviour (section 6.3)
- There was some evidence of efforts to work collectively to assess and manage risk and to overcome access constraints. This included RC/HCs advocating for humanitarian access and exemptions from COVID-19-related restrictions. The commitment to stay and deliver varied between agencies and from country to country (section 6.4).
- Problems of both supply and demand have hindered collective efforts to vaccinate populations against COVID-19, thereby demonstrating the difficulties of operationalizing COVAX in complex humanitarian settings (section 6.5).
- Linked to COVAX, the COVID-19 Vaccination Humanitarian Buffer (HB) was innovative in that it intended to allocate Emergency Use Listed vaccines directly to NGOs, alongside allocations to sovereign countries but it suffered delays and obstacles. Lack of funding for vaccine delivery and the need to work outside of state-based health architecture have raised a range of concerns. The need for swift decision-making and action in places where the HB was most in demand was not compatible with the protracted negotiations and lengthy importation processes which meant that opportunities were missed (section 6.5).
- Operationalization of the Common Services was impressive and the transport, supply chain, response hubs and medevac services played an important role in facilitating parts of the humanitarian community to ‘stay and deliver’. The services also demonstrated flexibility and agility in scaling up and down in response to need (section 6.6).

128. This section explores some of the ways that the system leveraged collective approaches and mechanisms with a focus on planning and implementation of the response to COVID-19, namely: collaborative ways of working to ensure accountability of the response to affected populations; collective approaches to risk management and access; collective efforts to vaccinate vulnerable populations against COVID-19; and Common Services.¹⁶⁹

¹⁶⁹ Please note that collective mechanisms for coordination, planning and needs assessments are covered elsewhere in this report (see sections 4, 3 and 2 respectively). The coordinated approach to global IASC strategy and scale-up in response to the pandemic is also captured elsewhere, predominantly in section 1 on preparedness.

6.1 Accountability mechanisms for community feedback and complaints¹⁷⁰

129. Despite significant efforts to reform agency-specific and system-wide approaches, progress to ensure the meaningful participation of affected people within humanitarian action has been slow.¹⁷¹ Even before the pandemic, there were few examples of collective accountability mechanisms,¹⁷² which in October 2020 prompted ODI to conclude that ‘*the humanitarian system is not accountable at the collective level to the communities it serves*’.¹⁷³ While important to note, for the purposes of this exercise, the evaluation cast a wider net and looked at accountability of the collective response more broadly, including agency-specific accountability mechanisms and approaches.
130. The evaluation found that there was limited investment in mechanisms for community feedback and complaints. This is borne out by agency-specific evaluations of the COVID-19 response. For example, the evaluation of the response of the International Federation of the Red Cross and Red Crescent Societies (IFRC) to the pandemic found that receiving feedback from communities was a challenge for some National Societies;¹⁷⁴ and recent Inter-Agency Humanitarian Evaluations (IAHEs) in Yemen¹⁷⁵ and Ethiopia¹⁷⁶ both expressed concerns about the effectiveness of agency accountability mechanisms.
131. FGDs with communities consulted for this evaluation showed that while people made no distinction between collective or system-wide accountability mechanisms and programme or agency-specific systems, there was a general lack of community awareness about ways to provide feedback to aid providers. Even if FGD participants were aware of how to make complaints, there was a lack of trust in the effectiveness of community feedback and complaints mechanisms (see Box 7 below).

¹⁷⁰ While IASC guidance does not distinguish between mechanisms to strengthen Accountability to Affected Populations (AAP), including systems to prioritize PSEA, and RCCE,¹⁷⁰ this evaluation deliberately deals with AAP, PSEA and RCCE mechanisms separately. This is because of the different emphasis that was placed on each during the COVID-19 response, and, in several cases, the use and adaptation of existing collective AAP mechanisms for the purposes of RCCE.

¹⁷¹ IASC (2021) IASC Operational Policy and Advocacy Group (OPAG) Meeting, 23 November 2021, Face to Face Meeting, Summary Record.

¹⁷² Holloway, K. & Lough, O. (2020) Implementing collective accountability to affected populations. Ways forward in large-scale humanitarian crises, Policy Brief 78, October 2020, Humanitarian Policy Group, ODI.

¹⁷³ Holloway, K. et al (2020) Collective Approaches to Communication and Community Engagement. Models, challenges and ways forward. HPG Commissioned Report, ODI, October 2020.

¹⁷⁴ IFRC (2022) Evaluation Report: IFRC-wide response to the COVID-19 Pandemic, March 2022.

¹⁷⁵ Sida, L. et al (2022) *IAHE of the Yemen Crisis*, June 2022.

¹⁷⁶ Steets, J. et al (2019) *IAHE of the Drought Response in Ethiopia*, November 2019.

Box 7: Community feedback on accountability of the COVID-19 response

Many people consulted within case-study countries were unaware of accountability mechanisms. In Turkey, only half of all FGD participants were aware of complaints mechanisms; and in Sierra Leone there were few trusted channels for reporting and resolving complaints.

“We do not know to whom we should file a complaint.” female FGD participant, Syria

“They never really told us how we could communicate if we had any problem” FGD participant, Colombia

“We do not know where to complain. We are usually silent when we have a complaint.” female FGD participant, Somalia

In contexts with strong government-led responses to the pandemic, accountability mechanisms tended to be formalized within government-mandated institutions. This was the case in Sierra Leone, for example, where the National Human Rights Commission played a role (though evidence on the strength of its role was weak). FGD participants in Sierra Leone were similarly unaware of how to complain or request assistance and preferred to resolve issues within communities rather than seeking outside help.

“We have the chief and the chair lady. Our chair lady is very vibrant and most times she is the one that will address most of the issues in this community before they get to the police or to the chief.” female FGD participant, Sierra Leone

Where accountability mechanisms existed and there was better awareness of how to engage with them, communities referred to hotlines, suggestion boxes, camp managers, elders and other routes to provide feedback or make complaints. However, people described a lack of trust in accountability mechanisms in a number of cases. In Sierra Leone, there was some use of the Government’s hotline for reporting COVID-19 cases and leveraging of radio for raising concerns. However, people generally expressed skepticism that authorities and aid agencies would address issues, due to a history of complaints not being followed up. Similarly in DRC, despite complaints being directed to committees of elders, camp managers, government representatives and aid agencies, there was a lack of trust that complaints would be followed-up and addressed, as well as a fear of negative repercussions once complaints had been made. Also in the Philippines, communities expressed a preference to raise any concerns they had through elders or other local redress and justice systems.

“There are many complaints about various incidents but no one dares to file a formal complaint. They think it is useless if you complain as it will just fall on deaf ears.” female FGD participant, Philippines

“For me, I don’t see it as a solution because even if you complain they are not going to attend to you. They will pretend to listen to you but will never do anything about it.” male FGD participant, Sierra Leone

“If someone has a complaint, he files his complaint, he goes to the camp committee but we have no follow-up of these complaints.” female FGD participant, DRC

In Colombia, FGDs revealed that many communities did not feel entitled to accountability and there was an overall reported tendency to not complain about humanitarian aid, including for fear that aid would be withdrawn. This was repeated in other contexts, such as Sierra Leone and Somalia, where people were generally grateful for any assistance provided and unlikely to provide negative feedback.

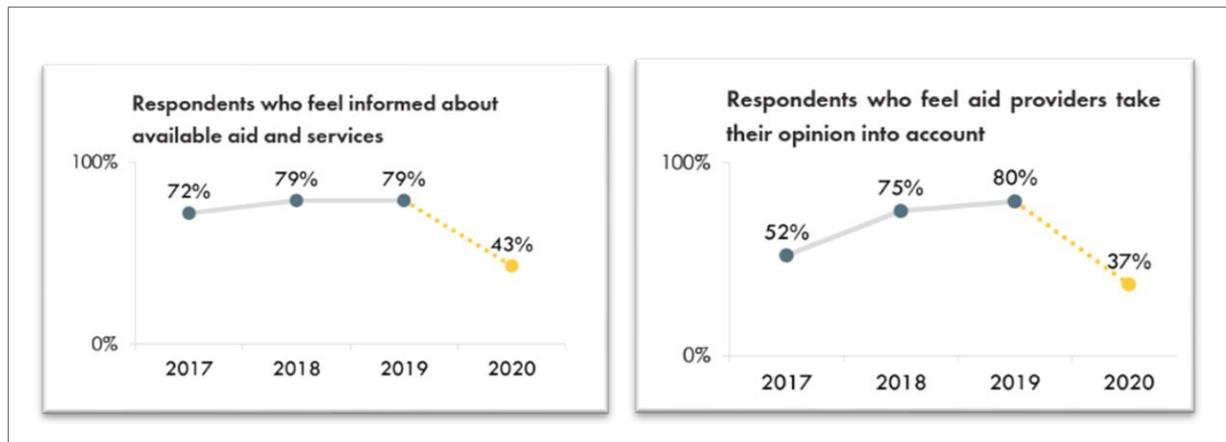
“Many people did not complain because it was the only thing that came to them. The fear if you complain is that they will take away what they give you.” FGD participant, Colombia

“To be honest with you, we do not have that culture to complain on issues in our community.” male FGD participant, Sierra Leone

“There is an office where we are told to file a complaint, but these people are poor and they just take what they are given and do not complain.” female FGD participant, Somalia

132. Secondary data sources substantiate the evaluation’s finding that aid became less accountable during COVID-19. In Somalia, for example, data collected by Ground Truth Solutions between 2019 and 2020 showed a general deterioration in accountability of aid to affected people, without identifying the reasons behind the decline (see Figure 12).¹⁷⁷

Figure 12: Perception of aid recipients in Somalia on accountability



133. Movement restrictions and physical distancing measures imposed by governments during COVID-19 are likely to have contributed to this increasing sense of distance between aid recipients and aid providers. There are multiple examples of guidance documents and other global resources advising aid organizations on how to continue engaging with communities during the pandemic, including ways of working remotely to strengthen the accountability of the response.¹⁷⁸ However, despite the efforts of aid organizations, evidence suggests that remote forms of community engagement, compared with direct contact, had negative impacts on the accountability of the response and community participation was compromised as a result.¹⁷⁹
134. Several of the case-study countries provided examples of how they had shifted their community outreach efforts online to continue to engage with communities and ensure at least a minimal level of Accountability to Affected Populations (AAP). In Turkey, for example, one organization shared how they had shifted their complaints system to WhatsApp to overcome movement and social distancing restrictions. However, access to the WhatsApp complaints system was limited to those with phones and adequate phone credit. In the Rohingya refugee response, where refugees are not permitted access to phones, it led to the collapse of some complaint and feedback mechanisms. Community members in Cox’s Bazar who participated in FGDs noted that accountability mechanisms were less active during the pandemic due to the reduction in aid agency presence within camps. Interviewees suggested that this was because the community preferred face-to-face communication. The finding was echoed in Somalia, where the perception was that aid agencies had become more distant during the response to COVID-19, making it harder to engage with humanitarian personnel for accountability and Protection from Sexual Exploitation and Abuse (PSEA) purposes, including in cases where serious abuses of power were alleged.

¹⁷⁷ Ground Truth Solutions (2020) *Perception survey of Aid Recipients in Somalia*, December 2020.

¹⁷⁸ See for example: GOARN, IFRC, UNICEF & WHO (2020) *Tips for Engaging Communities during COVID-19 in Low-Resource Settings, Remotely and In-Person*, 20 April 2020.

¹⁷⁹ See for example: Grunewald, F. et al, Groupe URD (2021) *DEC COVID-19 Appeal, Real-Time Response Review, Global Synthesis*, February 2021.

135. Women and girls found it particularly difficult to access complaint and feedback mechanisms, as has been observed in previous evaluations of the humanitarian system – including the IAHE on Gender Equality and the Empowerment of Women, which found that the perspectives of women and girls were limited as a result of their limited access to AAP mechanisms compared with men.¹⁸⁰ Indeed, FGDs for this evaluation in Syria showed that awareness of feedback mechanisms varied between men and women, with 5 of the 11 female FGDs saying that they did not know how to make a complaint or request assistance, compared with 1 of the 8 male FGDs reporting a similar lack of awareness.

6.2 Prevention of Sexual Exploitation and Abuse

136. SEA prevention and response is a central part of coordinated humanitarian action and should be part of any emergency response. In the context of COVID-19, as in previous public health emergencies, the risk of SEA increased, with women and children facing particularly heightened protection risks.¹⁸¹ Moreover, the increased use of remote and online reporting mechanisms during the COVID-19 response introduced additional challenges in terms of data protection and paying full attention to safety, confidentiality and sensitivity when handling complaints. Learning from past public health emergencies, the IASC was quick to issue Interim Guidance on PSEA, providing recommended actions to reduce risk, prevent SEA, provide safe and accessible reporting channels, ensure adequate protection and support, and coordinate PSEA actions across organizations.¹⁸²
137. Overall, there was some evidence that PSEA guidance has been translated into practice and collective capacities on PSEA were being built at country level. The IASC’s Accountability and Inclusion Portal aggregates data from 33 humanitarian contexts, of which 32 had established PSEA networks by 2021 and 19 had full-time PSEA coordinators in place. However, the evaluation found only limited evidence of collective efforts to strengthen SEA prevention and response in case-study countries. Among them, DRC offered the most comprehensive evidence of efforts to review and strengthen PSEA within the humanitarian response during COVID-19 (though not specifically in response to the pandemic).
138. Following media reports of serious and repeated incidents of SEA in DRC,¹⁸³ and after internal IASC reviews noted weaknesses in systems within DRC to protect and respond to SEA, the IASC initiated a senior PSEA technical support mission.¹⁸⁴ The mission report took note of initiatives to mitigate SEA risks during the COVID-19 pandemic – for example by strengthening community-based complaints mechanisms, initiating a ‘*Ligne Verte*’ for victims of SEA, witnesses and whistle-blowers to safely raise the alert and make complaints, and carrying out PSEA Ebola Network field assessments during COVID-19. Such initiatives may explain the increase in the proportion of the surveyed population in DRC who can access safe and accessible complaint channels, which increased from less than 25 percent in 2019 to between 26 to 50 percent in 2020 and 2021.¹⁸⁵

¹⁸⁰ IAHE (2020) Inter-Agency Humanitarian Evaluation on Gender Equality and the Empowerment of Women and Girls, Final Evaluation Report, October 2020.

¹⁸¹ Insecurity Insight (2020) Reporting Sexual Violence, Exploitation and Abuse. Lessons from the 10th Ebola Outbreak in DRC, 2018-2020; Lamoure, G. & Juillard, H. (2020) Responding to Ebola Epidemics, An ALNAP Lessons Learned Paper, ALNAP.

¹⁸² IASC (2020) Interim Technical Note, Protection from Sexual Exploitation and Abuse (PSEA) During COVID-19 Response, Version 1.0, March 2020; and IASC (2020) Interim Guidance, Checklist to Protect from Sexual Exploitation and Abuse during COVID-19, June 2020.

¹⁸³ Reports sexual exploitation and abuse in the DRC were published by the New Humanitarian and Thomson Reuter Foundation, affecting several IASC member organizations and other partners in the Ebola response. See, for example: <https://www.thenewhumanitarian.org/2020/09/29/exclusive-more-50-women-accuse-aid-workers-sex-abuse-congo-ebola-crisis>

¹⁸⁴ IASC (2020) Senior PSEA Technical Support Mission to the Democratic Republic of Congo, Emergency Directors Group, undated.

¹⁸⁵ Data is drawn from the IASC’s Accountability and Inclusion Reporting Portal, which tracks global implementation of PSEA in humanitarian response. For results on DRC see: <https://psea.interagencystandingcommittee.org/location/west-and-central-africa/congo-democratic-republic>

139. Overall, however, the senior PSEA technical mission concluded that the efforts taken by humanitarian agencies and partners to mitigate SEA risks have been inconsistent.¹⁸⁶ This evaluation concurs and found that while some important mitigation measures are in place to strengthen PSEA in DRC, the absence of active cross-cluster AAP Working Group or PSEA Network during much of the COVID-19 response, weakened the inter-agency response to PSEA at a critical time. Revival of the AAP Working Group in 2021 may begin to address this important gap, but urgent attention is required given the seriousness of alleged abuses uncovered and the continued reliance of vulnerable communities on humanitarian aid.¹⁸⁷
140. Elsewhere, in the case of Syria for example, the establishment of an inter-agency PSEA mechanism has not been possible due to sensitivities with the government, which means that there has been a continued reliance on fragmented agency-specific systems and responses. The issue of government sensitivity was not applicable to North-West Syria and there was an active PSEA network and associated hotline that has been active since 2020. Other countries were at varying stages of strengthening their collective responses to SEA. Overall, given the clear additional risks of SEA during the pandemic, the evaluation considers that attention to collectively mitigate against or respond to SEA within the collective COVID-19 response was not adequately prioritized.

6.3 Collective mechanisms for Risk Communication and Community Engagement (RCCE)

141. RCCE emerged as a particularly strong aspect of the collective response to COVID-19, generating significant learning that can be applied to other responses, including but not limited to responses to public health emergencies. New practice during COVID-19 built on learning from other related emergencies, particularly lessons derived from community engagement as part of the response to EVD outbreaks in Western Africa and DRC. Among other things, those experiences highlighted important lessons about involving communities in all aspects of the response, prioritizing social as well as technical elements of the response, and the value of collecting and responding to community feedback to gain trust and increase the relevance of the response.¹⁸⁸
142. Recognizing the importance of working together to engage with communities to manage information and misinformation, groups were established at country level, or modified in cases where groups already existed, to bring relevant actors together to work on RCCE.¹⁸⁹ RCCE is a generic technical pillar of public health responses. As such, in the context of the response to COVID-19, RCCE pillars or working groups were typically established under Ministry of Health leadership and with the participation of a range of different health, humanitarian and development actors. In some instances, there were strong links and integration with clusters or sector working groups; and sometimes limited or no coordination.¹⁹⁰
143. One of the key functions of many COVID-19-related RCCE pillars/groups was to conduct early and ongoing assessments on community knowledge, perceptions, effective communication channels and barriers that prevent people from adhering to guidance and promoting healthy behaviours. information from

¹⁸⁶ IASC (2020) Senior PSEA Technical Support Mission to the Democratic Republic of Congo, Emergency Directors Group, undated.

¹⁸⁷ See, for example: <https://www.thenewhumanitarian.org/2020/09/29/exclusive-more-50-women-accuse-aid-workers-sex-abuse-congo-ebola-crisis>

¹⁸⁸ Lamoure, G. & Juillard, H. (2020) Responding to Ebola Epidemics, An ALNAP Lessons Learned Paper, ALNAP.

¹⁸⁹ At a global level, the IASC Results Group 2 on Accountability and Inclusion worked together with a newly formed COVID-19 RCCE Collective Service, led by WHO, UNICEF and IFRC, to support partners working with communities on responses to COVID-19 and improve national, regional and global coordination on RCCE approaches. See: IASC RG 2 and the COVID-19 RCCE Collective Service (2020) *COVID-19 Risk Communications and Community Engagement (RCCE) and the Humanitarian System: Briefing Pack*, September 2020.

¹⁹⁰ IASC RG 2 and the COVID-19 RCCE Collective Service (2020) *COVID-19 Risk Communications and Community Engagement (RCCE) and the Humanitarian System: Briefing Pack*, September 2020.

communities. The evaluation encountered multiple examples of perception studies conducted by individual organizations that shed light on community comprehension and behaviours during the COVID-19 response. In many instances, these resources were shared for the benefit of others. However, the evaluation found only limited examples of collective assessments and perception studies where there was evidence that they had been jointly analyzed and used to inform the collective response (see Box 8 below for an example from the Rohingya refugee response).

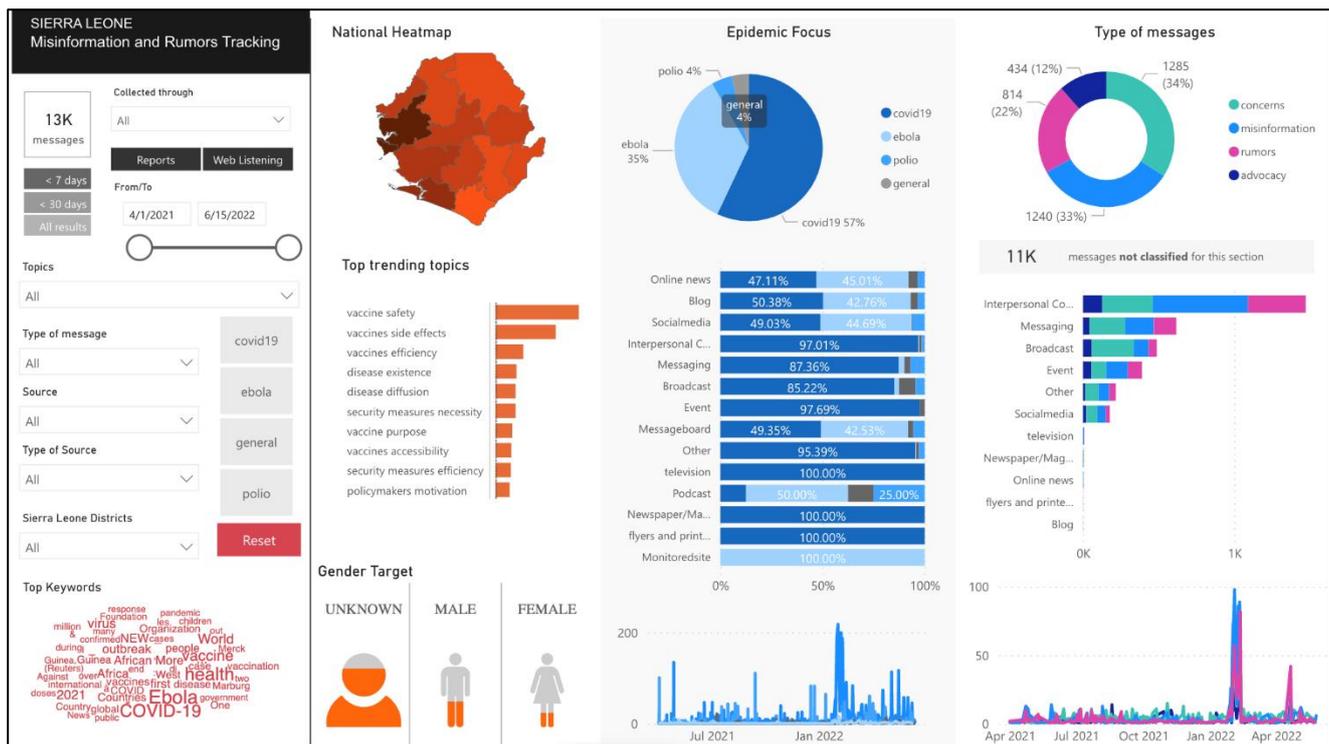
Box 8: Perceptions of COVID-19 among Rohingya refugees in Cox’s Bazar

In April 2020, IOM and the Assessment Capacity Project (ACAPS) conducted FGDs with Rohingya refugees in Cox’s Bazar to understand their willingness to shield or isolate, and their understandings, beliefs and experiences of containment measures. The data showed a common belief that health providers would harm those infected with the virus, based on pre-existing lack of trust in health services. Left unaddressed, this common negative perception could have had a significant impact on containment measures.

144. Two-way communication with communities was key to allowing authorities and organizations to listen to and immediately address specific concerns so that the advice they provided could be relevant, trusted and acted upon. Rumour tracking was used in several contexts to closely monitor misinformation and report back to relevant actors so that COVID-19 messaging materials and methodologies could be adapted accordingly. In Sierra Leone, UNICEF established and managed an online rumour tracking platform on behalf of the RCCE pillar, containing consolidated data on common topics of misinformation, their sources and types (see Figure 13).
145. The role of faith leaders, particularly in contexts where religion plays an important role in people’s lives was particularly evident. Experience from other epidemics and public health emergencies – EVD in particular – highlighted the transformational role that faith leaders can play in shaping attitudes and transforming the practice of community members.¹⁹¹ This lesson was once again in evidence during the response to COVID-19. In Sierra Leone, the RCCE Working Group collaborated closely with the Inter-Religious Forum, including both Christian and Muslim faith leaders, to share key messages and model health-seeking behaviour to their trusted communities in 26 camps.

¹⁹¹ Featherstone, A. (2015) *Keeping the Faith. The Role of Faith Leaders in the Ebola Response*, written on behalf of Christian Aid, CAFOD, Tearfund, Islamic Relief Worldwide, July 2015.

Figure 13: Misinformation and rumour tracking in Sierra Leone¹⁹²



6.4 Collective mechanisms on risk management and access

146. At a global level, The United Nations Secretary General’s urgent appeal for a global ceasefire was an attempt to increase access in conflict zones, creating opportunities to provide aid to those most vulnerable to the pandemic.¹⁹³ The impact of that statement and repeated calls for peace during COVID-19 is covered in section 10 on the coherence and complementarity of the response, including examples of limited or short-lived ceasefires, as well as contexts where there was a clear increase in armed violence during the pandemic, such as in Colombia, where non-state armed groups used the period of the pandemic to further expand their territorial presence and control. Recognizing that the initial call for a cessation of hostilities had not been fully heeded, United Nations Security Council Resolution 2565 was tabled and adopted, calling for greater international cooperation to facilitate equitable and affordable access to COVID-19 vaccines in situations of armed conflict, post-conflict and complex humanitarian emergencies.¹⁹⁴ The extent to which collective IASC action contributed to achieving safe and unhindered humanitarian access to facilitate COVID-19 vaccinations was touched on in section 6.5.
147. The evaluation found some evidence of collective efforts to assess and manage risk, and increase access for the purposes of delivering humanitarian assistance to vulnerable populations during the pandemic. Humanitarian Access Snapshots were a valuable tool in contexts where affected peoples’ access to assistance was constrained, some of which included movement restrictions because of COVID-19.¹⁹⁵ IOM updates on travel restrictions and their impact on the mobility of migrant populations showed that by April 2020, there were more than 52,000 travel restrictions in place due to COVID-19, implemented by over 200 countries, territories, and areas.¹⁹⁶ UNCHR also maintained an overview of temporary measures imposed

¹⁹² Sierra Leone Rumours & Misinformation Platform, UNICEF. Online resource.

¹⁹³ <https://www.un.org/en/un-coronavirus-communications-team/fury-virus-illustrates-folly-war>. The UN Secretary General’s call for a global ceasefire was endorsed by the Security Council through the adoption of resolution 2532: <https://www.securitycouncilreport.org/un-documents/document/s-res-2532.php>

¹⁹⁴ <https://documents-dds-ny.un.org/doc/UNDOC/GEN/N21/053/90/PDF/N2105390.pdf?OpenElement>

¹⁹⁵ UN OCHA (2021) Libya: Humanitarian Access Snapshot, May 2021.

¹⁹⁶ IOM (2020) COVID-19 Analytical Snapshot #23: Travel restrictions and mobility UPDATE (undated).

by governments to protect public health and their impact on the protection of refugees and others forcibly displaced. The information was summarized and shared on a live data platform with regular updates on temporary border closures during COVID-19 and their impact on the admission of asylum-seekers.¹⁹⁷ As of May 2022, UNHCR reported that at least 33 countries were still denying access to asylum based on public health or other measures put in place since the start of the pandemic.¹⁹⁸

148. Ongoing work within HCTs to share information on access constraints facilitated a collaborative approach. For example, the regular review of access restrictions by HCT in Somalia allowed the COVID-19 response to flex as the security situation and access changed. This analysis fed into a COVID-19 Access Strategy, which overlaid existing conflict and security access impediments with COVID-related restrictions to support senior leadership and partners in their engagement with authorities and communities to continue delivering humanitarian assistance.¹⁹⁹ Other actors outside of the IASC also contributed to information and analysis about government measures and their impact on the COVID-19 response. ACAPS maintained a web dashboard of government measures, which was updated weekly throughout the first year of the pandemic,²⁰⁰ and published regular updates summarizing the impact of national restrictions.²⁰¹ In several of the case study countries, including the Rohingya Refugee Response and Somalia, the monitoring of government measures informed United Nations advocacy with the respective governments to allow humanitarian agencies to continue their life-saving work.²⁰²
149. The extent to which IASC organizations collectively advocated for humanitarian access during the pandemic varied across the case-study countries. Clear evidence of such advocacy was only shared with the evaluation team in a handful of cases. For example, the Deputy Regional HC for the cross-border operation into North-West Syria engaged actively with the Turkish government to obtain tax exemptions and customs clearance for PPE as well as travel exemptions. These efforts were successful and the cross-border operation continued uninterrupted despite lockdowns and other restrictions. In Bangladesh, despite the RC's considerable efforts, the government was not responsive to the Secretary General's call for the free movement of humanitarian staff and goods, which made it very difficult to bring qualified medical staff into the country and also to transport relief items to Cox's Bazar.
150. Despite the existence of IASC Guidance on minimum standards of duty of care in the context of COVID-19,²⁰³ it was clear that different organizations took very different approaches and the risk appetite of senior United Nations and INGO leaders varied considerably from country to country. While there are examples of an active approach to increase humanitarian access to deliver vital humanitarian assistance and a '*stay and deliver*' approach in some of the case study contexts (such as Bangladesh and Turkey), there was also evidence from Somalia and Yemen that the United Nations took a more conservative approach to staff presence during the pandemic (see Box 9 below). The United Nations was also far more cautious than NGOs about staff movement in Colombia.

¹⁹⁷ See: <https://data.unhcr.org/es/dataviz/127>

¹⁹⁸ Itad and Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final Report, May 2022.

¹⁹⁹ UN OCHA (2020) COVID-19 Humanitarian Access Strategy, Somalia, April 2020.

²⁰⁰ <https://www.acaps.org/projects/covid19/data>.

²⁰¹ See: <https://www.acaps.org/report-thematics/covid-19-government-measures>

²⁰² See, for example, Site Management Sector Cox's Bazar, Shelter/NFI Sector Cox's Bazar and ACAPS NPM (2020) *Impact of the Monsoon and COVID Containment Measures. Flash Report*. 20 August.

²⁰³ IASC (2020) Minimum Standards on Duty of Care in the Context of COVID-19, Guidance, November 2020.

Box 9: Restrictions on United Nations staff presence and movements in Somalia

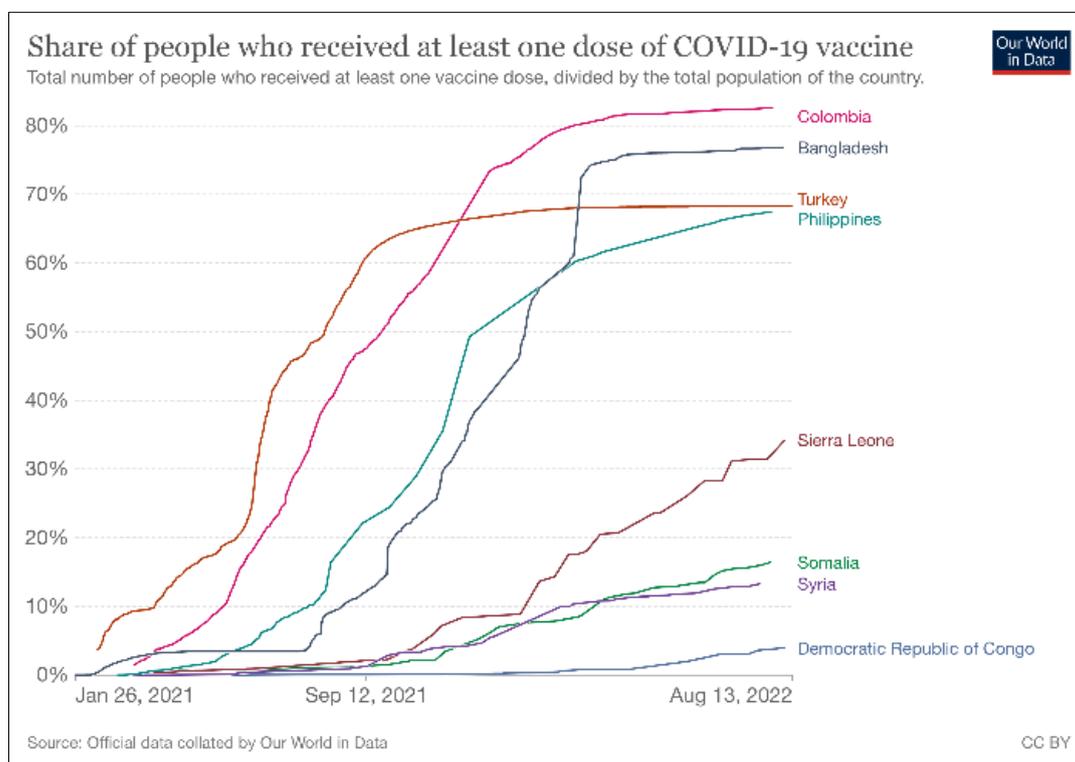
In Somalia, senior United Nations leadership opted to significantly reduce the presence of international staff (including humanitarian staff), placed ceilings on staff numbers and imposed strict restrictions on staff travel. These restrictions extended well beyond the timeframe of restrictions on movement and physical distancing imposed by national and sub-national authorities. The same cautious approach was mirrored by several INGOs, which similarly instructed international staff to leave the country and continue to work remotely in support of ongoing programmes. The evaluation found that this lack of proximity negatively affected the perceptions of communities, local organizations and government staff towards international aid workers and international organizations. Moreover, in the case of United Nations organizations, it introduced a difficult dilemma for those agencies with higher levels of risk tolerance in pursuit of delivering on their humanitarian mandates.

6.5 Collectively delivering on COVAX and the Humanitarian Buffer

6.5.1 COVAX

151. In October 2021, WHO expanded its initial COVAX targets and set a new goal to vaccinate 40 percent of the global population by the end of 2021 and 70 percent by mid-2022.²⁰⁴ Many countries around the world have fallen far short of this ambition, with particularly pronounced gaps in low- and lower-middle-income countries. Meeting targets in humanitarian contexts has been particularly challenging, including in several of the case-study countries for this evaluation as shown in Figure 14.

Figure 14: Share of people who have received at least one dose of COVID-19 vaccine in case-study countries²⁰⁵



²⁰⁴ WHO (2021) Strategy to Achieve Global Covid-19 Vaccination by mid-2022.

²⁰⁵ Notes: The data does not allow for an analysis of vaccination rates among refugee populations in Bangladesh and Turkey (Rohingya refugees and Syrian refugees respectively), which were the focus of case-studies for this evaluation.

152. There are numerous complex reasons why COVAX vaccination rates have fallen so far short of targets in many humanitarian contexts. Among them, the supply of vaccines to COVAX was reported to be unpredictable, with promised donations from high-income countries often late to materialise.²⁰⁶ In addition, several of the case-study countries spoke of receiving vaccines with brief expiry windows. This, combined with the logistical and communication challenges of administering vaccinations in low-resource environments, made it challenging for some recipient countries to use their allocated vaccines in time. In April 2021, DRC returned 1.3 million doses to COVAX on the basis that they could not be administered before the vaccines expired, for example.²⁰⁷ Lack of vaccine choice was also cited by communities as a factor. In DRC, Somalia and Syria, key informants at country level spoke of the difficulties of successfully generating uptake of the AstraZeneca vaccine just after several European countries had suspended its use over fears that it caused rare but serious blood clotting.²⁰⁸
153. Multiple demand-driven challenges also existed and continue to exist within COVAX recipient countries. Vaccine hesitancy has been a major obstacle for many countries, despite concerted efforts to counteract misinformation. Lack of leadership in some instances is thought to have fuelled community suspicions about the vaccine. While national, regional and community leaders actively and publicly modelled health-seeking behaviour by receiving some of the first available vaccines in Sierra Leone; in other contexts, such as in DRC, senior politicians and other leaders, including community leaders and health workers, initially refused to be vaccinated, thereby modelling suspicion of the vaccine and fuelling community mistrust. More recently, since the arrival of the Omicron variant, perceived risk of the virus has decreased, further hindering the uptake of vaccinations. Other problems that were cited by interviewees at country level included limited access of populations to health centres for the purposes of vaccination and/or difficulties sustaining resource-intensive approaches to carry out mobile vaccination campaigns; lack of skilled health workers to administer vaccinations, and competing priorities within communities and governments in countries coping with multiple health and humanitarian crises.

6.5.2 COVID-19 Vaccination Humanitarian Buffer

154. The HB is a mechanism established within the COVAX Facility to act as a measure of '*last resort*' to ensure access to COVID-19 vaccines for high-risk and vulnerable populations in humanitarian settings. Both COVAX participants and humanitarian agencies are eligible to apply for HB doses where there are unavoidable gaps in coverage in national vaccination plans and micro-plans. Decision-making on HB doses was delegated by the GAVI Board to the IASC EDG.²⁰⁹
155. The process was designed to ensure that humanitarian experts are involved in decision-making so that allocations are appropriately prioritized, and judgments on the feasibility of delivery to populations of concern are made by those with experience in vaccination campaigns in humanitarian settings. An expert '*decision group*' reporting to the IASC EDG was established to take decisions on allocations from the HB, guided by the humanitarian principles of neutrality, impartiality, independence, and humanity.²¹⁰

²⁰⁶ WHO (2021) Achieving 70% COVID-19 Immunization Coverage by Mid-2022: Statement of the Independent Allocation of Vaccines Group (IAVG) of COVAX, 23 December 2021: <https://www.who.int/news/item/23-12-2021-achieving-70-covid-19-immunization-coverage-by-mid-2022>.

²⁰⁷ CARE (2022) At the Last Mile: COVID-19 Vaccines in DRC, 27 April 2022: <https://careevaluations.org/evaluation/at-the-last-mile-lessons-from-vaccine-distributions-in-dr-congo/>.

²⁰⁸ Gavi (2021) What is the blood clotting disorder the AstraZeneca vaccine has been linked to?, 8 April 2021: https://www.gavi.org/vaccineswork/what-blood-clotting-disorder-astrazeneca-vaccine-has-been-linked?gclid=CjwKCAjwo_KXBhAaEiwA2RZ8hMWijD_Waw5VgUunpeVBdA8WoRPiDhVm4M94gEM_1vXlOfNgmQ8yjRoC9GsQAvD_BwE

²⁰⁹ <https://interagencystandingcommittee.org/inter-agency-standing-committee/covax-humanitarian-buffer>.

²¹⁰ IASC (2022) Frequently Asked Questions: The COVAX Humanitarian Buffer, 16 May 2022.

156. As of the beginning of June 2022, eight requests for HB doses had been received; of which, six were approved by the IASC decision and the two which were not approved were subsequently withdrawn.²¹¹ The six approved requests were for the provision of vaccines to excluded or hard-to-reach populations. In June 2022 it was reported that 2,451,600 doses had been delivered to two approved HB recipients.²¹²
157. The HB was innovative in that it intended for the direct allocation of Emergency Use Listed vaccines to NGOs, alongside allocations to sovereign countries. However, it has suffered from delays and obstacles. The GAVI Discussion paper from June 2022 ‘*Taking stock of humanitarian access to pandemic vaccines*’²¹³ summarizes the difficulties of operationalizing the HB, many of which were endorsed during interviews. One of the key challenges was linked to the need to work outside of state health structures, as NGOs were unable to meet indemnity and liability obligations. The solution that was found, of obtaining waivers for NGOs that delivered the Buffer, required complex risk-sharing agreements, which took too long to negotiate. An additional challenge was the lack of funding for NGOs to deliver the vaccines to the intended beneficiaries. These problems remained unresolved during the period under evaluation.²¹⁴
158. In practice, it was found that the conditions in volatile contexts where the HB was most in demand were not compatible with the need for ‘*drawn-out indemnification waiver negotiations, multistakeholder contracting negotiations and complex product importation processes*’.²¹⁵ In contexts where agility and opportunism were key, opportunities for vaccine distribution were short-lived due to unpredictable contextual environments, making operationalization of the HB untenable. The withdrawal of an HB application by an international medical agency was illustrative of this problem.²¹⁶
159. With time passing, the approach of the HB has become less relevant; it was developed in a supply-constrained environment as a measure of last resort in humanitarian settings, which influenced its design. The context has changed, however, and the problem has shifted from one of supply to one of demand – despite the enduring issue of inequitable access. In the time it has taken to roll out the vaccine, communities have revised their risk appraisal and many have chosen to prioritize other basic needs above vaccinations, which has further undermined the relevance of the model.

6.6 GHRP Common Services

160. The concept of the Common Services first came to the fore in March 2020 as part of an EDG discussion about how to sustain and expand, where needed, humanitarian operations. During the meeting, WFP informed EDG of emerging plans for what would become the ‘*Global Service Operational Plan*’ for the provision of global transport and procurement services. These services were complemented by medical treatment services and medevac services delivered through a diverse range of intra-UN-agency partnerships which included WFP, WHO, UNICEF (supply chain management) and United Nations Department of Operational Support (construction of medical facilities and air transport). The delivery of these services also drew on several innovative private-sector partnerships.²¹⁷

²¹¹ GAVI (2021) Report to the Board: Annex C: COVAX Reporting Framework, June 2022.

²¹² Ibid.

²¹³ GAVI (2022) Taking stock of Humanitarian Access to Pandemic Vaccines: Discussion Paper, June 2022.

²¹⁴ Ibid.

²¹⁵ Ibid.

²¹⁶ Ibid.

²¹⁷ The WFP evaluation of its COVID-19 response lists several private-sector partnerships which were used to support the provision of treatment and isolation centres, assist in the transportation of humanitarian cargo, and to provide an online interface for the emergency services marketplace. For further details see WFP Office of Evaluation (2022) *Evaluation of the WFP Response to the COVID-19 Pandemic – Centralized Evaluation Report Volume I*, January 2022.

161. The Common Services System – the first of its kind - played a vital role in enabling the United Nations and NGOs to maintain services and demonstrated flexibility and agility to scale up and down as commercial air travel resumed and WFP, in particular, received praise during interviews for its ambition. However, in seeking to provide a global set of services for members of the humanitarian community, during a global pandemic, agencies set themselves a huge task and as a consequence, there were multiple challenges that offered the potential for learning. These have been tabulated for ease of reference (see Table 5).

Table 5: Actions taken and lessons from the Common Services

Common services	Successes, challenges and lessons
COVID-19 Supply Chain System	The COVID-19 Supply Chain System was established in a timely way, took a ‘no regrets’ approach and continued to operate during the height of travel bans. The independent evaluation of the System considered it a ‘game-changer’ for humanitarian agencies as it improved access to critical and life-saving COVID-19 supplies. It was developed during the crisis and the findings of the evaluation suggest that it could benefit from being (re-) built during ‘peacetime’. Other areas where there was considered to be scope for improvement were in improving its regional and local market and procurement linkages, enhancing its data sharing compacts and interoperability, and strengthening its strategic leadership. ²¹⁸
Humanitarian Response Hubs and Cargo service	The response hubs and cargo services received broad praise from users of the services. Protracted negotiations with governments often challenged the set-up of the four newly commissioned staging areas. While the cargo service was used by a diverse range of agencies, NGOs reported more limited use due to their mostly regionally-based procurement. ²¹⁹
Humanitarian Air Services	The provision of air services was lauded as both timely and effective by its users. ²²⁰ Minor concerns were raised about initial booking challenges, particularly by NGOs, although these were addressed with time. ²²¹
UN Medevac Cell	The United Nations Medevac Cell offered important reassurance to those eligible to use it. Roles and responsibilities between the implementing partners proved complex to negotiate and the closure of borders served to further hinder operations. It was only in September that a UN-wide agreement was reached on eligibility for the service. ²²²

162. In recognizing the challenges that IASC members faced in delivering the COVID-19 response, the IASC showed an important level of ambition in commissioning the Common Services; there can be little doubt that its operationalization was impressive, particularly given the enduring questions about the level of support countries could reasonably expect from headquarters in terms of additional staff, funding, access to air transport, medical evacuation, etc. if resources and funding were prioritized, as per the Protocols.

²¹⁸ Yellow House (2021) *Assessment of the COVID-19 Supply Chain System (CSCS) Summary Report*, February 2021.

²¹⁹ WFP Office of Evaluation (2022) *Evaluation of the WFP Response to the COVID-19 Pandemic – Centralized Evaluation Report Volume I*, January 2022.

²²⁰ WFP (2020) *WFP Common Services COVID-19: Air passenger and free-to-use cargo services feedback survey results*, November 2021.

²²¹ WFP Office of Evaluation (2022) *Evaluation of the WFP Response to the COVID-19 Pandemic – Centralized Evaluation Report Volume I*, January 2022.

²²² Ibid.

7 Responding to the needs of vulnerable groups

Summary findings

- Despite guidance and advocacy messages on the centrality of protection during the COVID-19 response, there is evidence that systemic problems in the implementation of this commitment persisted. This included an initial de-prioritization of protection in comparison with the health and WASH sectors (section 7.1).
- Refugees, IDPs and migrants were given high priority in the GHRP, which is credited with focusing attention on vulnerable groups that otherwise risked being excluded from national plans and responses to COVID-19 (section 7.2).
- Successive iterations of the GHRP progressively highlighted GBV risks but, despite efforts by the CERF to provide resources for GBV prevention and response, lack of funding remained a barrier to the provision of assistance (section 7.3).
- Beyond some isolated examples of good practice, there was limited evidence of the added value of IASC collective mechanisms for a more age- and disability-inclusive COVID-19 response (section 7.4).

163. IASC agencies quickly understood the disproportionate impact that COVID-19 had and would continue to have on vulnerable groups – including older persons, people with comorbidities, persons with disabilities, women, children and youth, forcibly displaced persons and migrants, those living in dense and already underserved locations, and people vulnerable to other risks, including conflict and disasters caused by natural hazards.²²³ Section 2.5 on needs assessment provides examples of efforts to understand the specific risks that different individuals and groups faced and the ways in which the pandemic deepened existing vulnerabilities and further marginalized already at-risk populations. This section looks at how the IASC utilized collective planning and response mechanisms to prioritize the most vulnerable during the COVID-19 response.

7.1 Centrality of protection

164. Within the IASC, there was an ongoing and live discussion about the centrality of protection during the COVID-19 response, noting the increase in protection risks and threats for vulnerable groups related to the socio-economic impacts of the pandemic.²²⁴ IASC Results Group 3 shared key messages for collective advocacy on protection during COVID-19, derived from protection concerns reported through national protection clusters.²²⁵ UNHCR, OHCHR and others also issued early global guidance and key messages to emphasize the importance of protecting the rights of vulnerable groups and guard against the further erosion of human rights during states of emergency declared as a result of COVID-19.²²⁶
165. Despite discussions and guidance on protection within the pandemic response, there was evidence that systemic problems in implementing the centrality of protection persisted during the collective response to COVID-19. A 2020 review of the centrality of protection in humanitarian action found that there is still a lack of clarity about what the term means in practice, with more emphasis placed on process and

²²³ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, May 2020.

²²⁴ For example: IASC (2021) IASC's OPAG Meeting, 21 January 2021, Summary Record.

²²⁵ IASC (2020) IASC Key Protection Advocacy Messages COVID-19, IASC Results Group 3 on Collective Advocacy, September 2020.

²²⁶ UNHCR (2020) The COVID-19 Crisis: Key Protection Messages, 31 March 2020; OHCHR (2020) Emergency Measures and COVID-19 Guidance, 27 April 2020.

structures than on concrete protection outcomes.²²⁷ The Review also highlighted the increasingly pivotal role that local actors played in implementing protection activities during COVID-19, yet the inadequate support they received to carry out their crucial work – only 9 percent of protection funding is estimated to have gone to local actors in 2020. Perpetual under-funding for protection overall also hampered efforts to prioritize protection within the pandemic response.²²⁸

166. A joint evaluation of the protection of the rights of refugees during COVID-19 noted that the focus on health in the initial stages of the collective response deprioritized protection services. GBV and child protection were rarely considered essential services in the first phase of the response, for example.²²⁹ This evaluation found concurring evidence, with examples of downgrading of protection activities by national authorities (see Box 10 below for an example from Cox’s Bazar, Bangladesh); and a relative downscaling within HRP and other response plans for responding to protection concerns and socio-economic needs compared with health and WASH sectors. There were some exceptions, such as in DRC, where a dedicated COVID-19 allocation from the DRC Humanitarian Fund in April 2020 prioritized support for Health, WASH and Protection Clusters, thereby including protection within the first line of response to the pandemic.²³⁰

Box 10: Compromised protection services in the Rohingya Refugee Response during COVID-19

In March 2020, the Government of Bangladesh put in place restrictive measures and reduced the refugee response in Cox’s Bazar to essential services only, meaning the closure of education facilities, multi-purpose centres (including women-led community centres), and child and elderly-friendly spaces. Government measures meant that structures could only be used for COVID-19 awareness sessions and individual service provisions, but with a 50 percent reduction in staff presence. Humanitarian organizations mitigated the impact of the restrictions by continuing to engage with communities on protection concerns within the overall context of permitted awareness-raising activities and advocating with local authorities for continued access to provide protection and other key services, which were deemed critical during the pandemic.

7.2 Refugees, IDPs and migrants

167. The structure of the GHRP itself highlighted the specific needs of refugees, internally displaced people and migrants given that one of the three strategic priorities of the plan was to protect, assist and advocate for these groups, as well as host communities.²³¹ High visibility for refugees, IDPs and migrants in the GHRP, given the increased risk they faced in terms of being excluded from national plans, is considered a good example of complementarity with other COVID-19 response and recovery plans. A joint evaluation of refugee rights during COVID-19 found that the recognition of refugees as a vulnerable group and a priority for the health response within the GHRP, ‘*created a locus for coordination, facilitating the inclusion of refugees in national plans and encouraging coordinated efforts along the spectrum of international humanitarian and development actors*’.²³² While not necessarily as a direct result of the GHRP, IFRC’s evaluation of its response to COVID-19 found that support to migrants gained more prominence as the

²²⁷ Global Protection Cluster (2020) The Centrality of Protection in Humanitarian Action 2020.

²²⁸ Ibid.

²²⁹ Itad & Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final report, May 2022.

²³⁰ UN OCHA (2021) DRC Humanitarian Fund 2020 Annual Report.

²³¹ UN OCHA (2020), Global Humanitarian Response Plan COVID-19, United Nations Coordinated Appeal, April – December 2020, March 2020.

²³² Itad & Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final report, May 2022.

response progressed, with a number of National Societies addressing important gaps in services to migrants.²³³

7.3 Gender-based violence

168. Other public health emergencies demonstrated the impact of health measures, including quarantines and lockdowns, on women and girls and the increased risk of GBV.²³⁴ Evidence quickly amassed to show that the COVID-19 pandemic was having a devastating effect on the safety of women and girls living in already complex humanitarian contexts, exacerbating existing gender inequalities and leading to alarming increases in GBV incidence.

Box 11: The effect of COVID-19 on GBV risk and the provision of GBV services in Syria²³⁵

The Voices from Syria 2021 Report described the worsening risk of GBV for women and girls across Syria. COVID-19 was highlighted as a new risk factor for GBV, with links between the restrictions put in place to control the spread of the disease and an increase in violence within the home. One Syrian woman interviewed said that *“the COVID-19 pandemic has increased the rate of violence, especially domestic violence, due to home quarantine and poor financial returns for families that depend on daily income”* (Adult woman, Kisreh sub-district, Deir-ez-Zor). Humanitarian personnel working in Syria confirmed the increasing incidence of intimate partner violence in Syria during COVID-19, as well as worrying trends concerning early marriage and sexual violence.

Humanitarian responders in Syria had to quickly adapt to new operating conditions once COVID-19 began to affect the region. This included scaling down or ceasing activities due to lockdown measures. In April 2020, United Nations Population Fund (UNFPA) in Syria reported that activities were interrupted in 19 out of 48 of their partner-run Women and Girls’ Safe Spaces and 90 out of 196 mobile teams providing GBV and Sexual and Reproductive Health services and awareness raising. In response, humanitarian organizations worked together to ensure a minimum level of continuity by shifting to remote service provision – using telephones, social media and other online platforms – and by offering door-to-door delivery for the distribution of food and non-food items. By September 2020, UNFPA’s partners reported that 120 GBV mobile teams and 47 out of 48 of the Safe Spaces had resumed their important work.

169. In response at the collective level, the initial iteration of the GHRP highlighted the risk of intimate partner violence and other forms of domestic violence, and successive iterations of the document progressively highlighted GBV as a priority issue. In early July 2020, before the publication of the final iteration of the GHRP, members of the GBV community wrote to the ERC highlighting a *‘pandemic of violence against women and girls’* and calling for a *‘standalone specific objective on GBV and corresponding indicators in the monitoring framework’*.²³⁶ Ultimately, for the sake of consistency, the decision was taken not to reconfigure the basic structure of the GHRP, provoking mixed reactions from interviewees and raising questions about the most effective way to increase visibility and funding for particularly vulnerable groups and priority areas of the response within all-encompassing, multi-dimensional plan such as the GHRP.
170. Funding continued to act as a barrier to gender mainstreaming within the humanitarian response, and local women’s rights organizations frequently encountered bureaucratic barriers to accessing funding

²³³ IFRC (2022) Evaluation Report: IFRC-wide response to the COVID-19 Pandemic, March 2022.

²³⁴ Neetu, J. et al (2020), *Lessons Never Learned: Crisis and gender-based violence*, Dev World Bioeth, 12 April 2020.

²³⁵ UNFPA & Whole of Syria Gender-Based Violence Area of Responsibility (2021) Voices from Syria 2021, Assessment Findings of the Humanitarian Needs Overview.

²³⁶ The letter was signed by 588 organizations, including local women’s led and women’s rights organizations, INGOs, several donors and one UN organization.

during the response to the pandemic.²³⁷ Multiple reports and previous evaluations have already highlighted the funding gap for gender, women’s empowerment and GBV interventions in successive emergency responses. The 2020 IAHE on gender equality found that gender equality projects targeting women and girls received disproportionately lower levels of funding compared with other humanitarian projects.²³⁸

171. Research by Colombia University on COVID-19 funding across five countries found that UN-led appeals rarely prioritized GBV or Sexual and Reproductive Health and Rights projects; and that those projects that were included failed to attract significant funding. Moreover, it claimed that GBV and Sexual and Reproductive Health programming actually lost ground during the COVID-19 pandemic due to a lack of additional resources, with United Nations agencies reporting little new external funding for these areas during the pandemic.²³⁹ Indeed, an analysis of UNHCR’s funding for GBV programming in the context of COVID-19 showed that 72 percent of its operational requirements for implementing GBV activities could not be met in 2021.²⁴⁰
172. CERF was one collective source of funding for GBV during COVID-19, with two special allocations during 2020 to increase its support for GBV programming.²⁴¹ There was strong support among interviewees for the allocation of CERF funding to support GBV programming during the pandemic, given its potentially catalytic effect on GBV funding more broadly and its focus on support for and capacity-building within local, women led organizations. A review of CERF allocations targeting GBV prevention and response also found CERF funding for GBV to be useful and valuable. The two-year grant period was appreciated (longer than the usual CERF project timeframe), though interviewees noted that three years would have been preferable to allow important outcomes to be achieved and measured. Other improvements recommended for future allocations included a longer turnaround time for project proposals and more transparency with countries concerning selection criteria.²⁴²

7.4 Older persons and persons with disabilities

173. Persons with disabilities are estimated to represent over 15 percent of the world’s population, and those figures are thought to be much higher in countries with existing conflicts and other humanitarian crises.²⁴³ Moreover, an estimated 46 percent of people aged 60 years and over are persons with disabilities. From early on, there was significant evidence that older persons and persons with disabilities were disproportionately impacted by COVID-19.²⁴⁴ The evaluation did find isolated examples of assessments

²³⁷ Feminist Humanitarian Network (2021) Women’s Humanitarian Voices: COVID-19 Through a Feminist Lens, A Global Report.

²³⁸ IAHE (2020) *Inter-Agency Humanitarian Evaluation on Gender Equality and the Empowerment of Women and Girls, Final Evaluation Report*, October 2020. The evaluation found that projects specifically targeting women and girls only received an average of 39 per cent of funds requested compared with 69 per cent for other types of projects.

²³⁹ Columbia University Mailman School of Public Health. (2020). *Missing in Action: COVID-19 Response Funding for Gender-Based Violence (GBV) and Sexual and Reproductive Health (SRHR) in Five Countries*, April 2021.

²⁴⁰ Itad & Valid Evaluations (2022) *Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final report*, May 2022. Data is drawn from UNHCR’s Global Appeal 2022.

²⁴¹ Special COVID-19 GBV CERF allocations in 2020 included \$5.5 million of earmarked funding from the Underfunded Emergencies Window, and \$25 million from the Rapid Response Window to UNFPA and UN Women (of which an estimated 40 per cent is allocated to women-led organizations and women’s rights organizations): *CERF (2020), CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020; CERF (2020), Protection from Gender-based Violence, CERF Special Allocations in 2020, As of July 2021*.

²⁴² Ward, J. for CERF Secretariat (2021) *OCHA Support to Gender-based Violence Programming, Rapid Review of Recent CERF Allocations Targeting GBV Prevention and Response in Humanitarian Action*, December 2021.

²⁴³ Humanity and Inclusion (2020) *COVID-19 in Humanitarian Contexts: No excuses to leave persons with disabilities behind! Evidence from HI’s operations in humanitarian settings*, June 2020.

²⁴⁴ For example: Humanity and Inclusion (2020) *COVID-19 in Humanitarian Contexts: No excuses to leave persons with disabilities behind! Evidence from HI’s operations in humanitarian settings*, June 2020; WHO (2020) *Disability Considerations During the COVID-19 Outbreak*; ICRC (2020) *COVID-19: Inclusive Programming – Ensuring Assistance and Protection Addresses the Needs of Marginalized and At-risk People*.

focusing on the specific vulnerabilities of older persons and/or persons with disabilities – such as in the Rohingya Refugee Response. It also came across cross-cutting working groups covering age and disability or broader inclusion in some contexts – such as the North West Inclusion Technical Working Group within the Syria Protection Cluster/Turkey and the ADWG in the Rohingya Response. Within planning frameworks, the GHRP, HRP, RRP and other planning documents frequently listed older persons and persons with disabilities among other vulnerable populations as most in need of humanitarian assistance. These varied in emphasis, from a passing mention in several response plans to a more expansive articulation of how responses would target these groups. For example, the COVID-19 Operational Response Plan for Syria (issued as an annex to the 2020 HRP) included a special focus on older persons and persons with disabilities as particularly vulnerable groups.

174. In some cases, communities consulted for this evaluation acknowledged that older persons and persons with disabilities were particularly in need of urgent assistance during the pandemic and were correctly targeted and prioritized for support (see box 12 below). Overall, however, beyond some positive perceptions and isolated examples of good practice, there was little consistent evidence of the added value of IASC collective mechanisms for a more age- and disability-inclusive COVID-19 response.

Box 12: Community perceptions of targeting aid to the most vulnerable groups

In Bangladesh, Colombia, Syria and the Philippines, communities generally said that aid was correctly targeted at specific vulnerable groups, including those with disabilities. Perceptions were not consistent, however, and persons with disabilities who directly participated in FGDs in Bangladesh noted that the assistance they received was insufficient and not always provided in ways that took their different forms of disability into account. This was echoed by some relief providers, who said that risk communication activities were not always inclusive and tailored to the specific needs of persons with disabilities e.g., the hard of hearing; and distributions of assistance sometimes excluded those with disabilities.

“Yes, we saw the elderly person, person with disabilities received assistance first and they got priority. Humanitarian worker always provide them assistance first.” female FGD participant, Bangladesh

“There was no special service for disabled person they went to the distribution point by their own.” female FGD participant, Bangladesh

In Colombia, while most FGD participants perceived that assistance was directed to those most in need, there were also some people who said that political and social factors influenced the targeting of assistance, and noted tensions between Colombians and migrant populations regarding aid delivery.

“The problem is also that the targeting is very different depending on the political or social leadership in the neighbourhoods. They are the ones who help to distribute the aid, but there are many differences. In politics, sometimes the aid goes to friends and not to the most needy.” male FGD participant, Colombia

In Sierra Leone, FGD participants were confident that the elderly and persons with disabilities were targeted for community-provided assistance, but did not consider that external assistance had adequately targeted these groups. This is despite the provision of a COVID-19 ‘lockdown handout’ in the form of cash and in-kind assistance for persons with disabilities through the government’s own social protection programme (part-funded by the World Bank).

“Even the cash transfers did not benefit the right people, the aged and disabled persons.” male FGD participant, Sierra Leone

8 Adapting the response

Summary findings

- Considerable efforts were made to produce COVID-19-specific information products and guidance to strengthen the relevance and effectiveness of the operational response and advocacy over time. Available evidence suggests that they were useful but required frequent updating to keep up with the pace of the pandemic and its impacts (section 8.1).
- IASC members quickly and creatively adapted programmes to respond to new needs related to COVID-19 and continued providing assistance and services in challenging operational environments. Innovations generated during the pandemic can inform continuing efforts to reach communities in hard-to-reach areas (sections 8.2.1).
- There were several positive examples of humanitarian actors shifting to remote ways of working, but it was more effective in contexts where the necessary enabling conditions for the use of technology and digital platforms were already in place. Where these conditions did not prevail, some vulnerable groups were excluded. For protection services, in particular, remote service delivery had limitations due to the need for proximity and trust building (section 8.2.2).
- COVID-19 led to an increase in the delivery of cash, including digital cash, though with the risk of excluding some already marginalized groups with little ‘digital capacity’. The link between humanitarian cash and national social protection systems was also strengthened during the pandemic (section 8.2.3).
- Adaptions and shifts in focus to respond to urgent COVID-19-related priorities overshadowed some pre-existing needs and over-stretched funding in some instances, including in the areas of routine vaccinations and resilience-oriented work. It is too early to tell whether the balance will be recalibrated, or whether COVID-19 will have a long-lasting impact on resilience and development efforts (section 8.2.4).

175. This section of the report seeks to examine the performance of the collective humanitarian system in understanding and adapting the COVID-19 response to maintain its relevance to those in greatest need of assistance and protection.

8.1 The generation and use of inter-agency information and guidance to support collective decision-making

176. Information Management products and guidance materials provided evidence and analysis that was used for the specific purpose of strengthening the relevance or effectiveness of COVID-19 programming and advocacy (see Table 6).

Table 6: Good practice examples of thematic guidance and analysis that was specific to the COVID-19 response

Guidance & analysis product	Description
Analysis to strengthen thematic response and learn lessons	<u>WHO COVID-19 Information Notes</u> : A series of COVID-19 Information Notes were released by WHO in Somalia during 2020 and 2021. The focus of these was on specific operational and epidemiological issues with a focus on generating and disseminating emerging knowledge and lessons on the pandemic and the response to it. ²⁴⁵ While this evaluation cannot determine the extent of their use, they provided relevant analysis of the pandemic as it unfolded.
COVID-19 Projections to inform country-level preparedness and response planning	Reports from several of the case study countries were available which summarized the COVID-19 modelling results and were used by the humanitarian community in support of government to prepare for potential pandemic scenarios. ²⁴⁶ The use of these types of reports is explored in greater detail in Section 2.3 on needs assessment.
Analysis of government measures to contain the pandemic in support of advocacy for humanitarian access	<u>OCHA analysis of Government measures/overview of COVID-19 directives</u> : Information and analysis about government measures and their impact on the COVID-19 response was undertaken across many of the case studies. ²⁴⁷ ACAPS maintained a web dashboard that was updated weekly throughout the first year of the pandemic. ²⁴⁸ In several of the case study countries, including the Rohingya Refugee Response and Somalia, the monitoring of government measures informed United Nations advocacy with the respective governments and played an important role in allowing humanitarian agencies to continue their life-saving work.
Tips and good practices to improve the relevance and effectiveness of the COVID-19 response	<u>UNHCR's age, gender and diversity considerations in the COVID-19 response</u> : In March 2020, UNHCR prepared a 'tip sheet' for age, gender and diversity considerations for COVID-19 programming. This is one of many good practice guidance notes that were written and circulated in the early stages of the pandemic. It is not possible for this evaluation to gauge the use of these guidance notes, and there were valid concerns about a glut of guidance, but interviews also found that practitioners and front-line workers did actively seek out guidance to ensure that response was relevant to the changed context.
Use of secondary data analysis and perceptions studies to inform operational response	<u>ACAPS Country and Thematic Notes</u> : Over the first 15 months of the pandemic, ACAPS developed two global datasets (government measures and secondary impacts of COVID-19) and published over 30 analytical products. ²⁴⁹ These products were evidence-based and data-rich. While they primarily focused on secondary data, in some contexts (most notably the Rohingya refugee response), ACAPS, drew extensively from refugees' own perceptions of their situation which provided particularly compelling evidence on the situation of different groups from within refugee communities, including women, elderly people and disabled people. The reports received widespread praise from practitioners who found them both timely and relevant.
Support for global advocacy on refugee and IDP protection	<u>UNHCR's COVID-19 Platform</u> : At a global level, UNHCR developed the COVID-19 Platform to provide near real-time evidence of the impact that the COVID-19 pandemic is having on aspects of the protection environment for forcibly displaced people worldwide. ²⁵⁰ Its purpose was to support Governments' efforts in meeting their responsibilities to protect the rights of refugees and IDPs.

²⁴⁵ See, for example, WHO Somalia (2021) COVID-19 Information Note 12: A Key COVID-19 Lesson – Context-Specific health research, policies and practice are needed, May 2021.

²⁴⁶ See, for example, OCHA Centre for Humanitarian Data and Johns Hopkins University Applied Physics Laboratory (2021) *COVID-19 Projections: Somalia*, February 2021.

²⁴⁷ See, for example, Site Management Sector Cox's Bazar, Shelter/NFI Sector Cox's Bazar and ACAPS NPM (2020) *Impact of the Monsoon and COVID Containment Measures. Flash Report*. 20 August.

²⁴⁸ <https://www.acaps.org/projects/covid19/data>.

²⁴⁹ <https://www.acaps.org/projects/covid-19>.

²⁵⁰ <https://data.unhcr.org/en/dataviz/127?sv=52&geo=0>.

177. It is not possible for this evaluation to determine in any detail the uptake and use of the specific analyses, lessons, dashboards, and good practice guidance that were prepared and disseminated during the COVID-19 response. While standards of Information Management products were variable and users were often required to show a level of discernment in what they chose to use and what they chose to ignore, it is important to acknowledge the efforts that were made to generate evidence and analysis to strengthen the relevance and effectiveness of the operational response over time.
178. Interviews with aid workers at field level did reveal some concerns about the frequent shifts that were made in guidance. It is the view of this evaluation, however, that an approach that ‘*learned*’ and then ‘*unlearned*’ was not only justified but was necessary and far better than slavishly working with guidance that was outdated or which had been superseded as a consequence of rapid shifts in context. Knowledge and understanding of the pandemic and its transmission improved with time, as did the guidance.

8.2 Adapting the response

179. Lockdowns, movement restrictions and government measures on physical distancing to slow down or contain transmission of the virus meant that the humanitarian system had to quickly and radically adapt so as to continue delivering vital humanitarian assistance to PiN. Overall, the evaluation found IASC members to be rapid, innovative and risk tolerant in the way that they adapted their programmes to respond to new needs related to COVID-19 and to continue providing assistance and services in response to ongoing humanitarian needs during the pandemic.
180. Adaptations to the delivery of humanitarian assistance can be categorized under several headings as follows, each of which is explored in more detail and illustrated with examples in this section or elsewhere in the report:
- Adapted partnerships – a heavier reliance on local organizations, local staff of international organizations and volunteers. This is covered in section 9 on localization.
 - Adapted in-kind assistance – ways in which organizations supplemented and modified how in-kind assistance was procured and provided to navigate COVID-19 restrictions and limit the risk of further transmission of the virus.
 - Adapted ways of working – working remotely and using new and existing technologies to provide assistance and services to PiN (covered in section 2.1 on needs assessment).
 - Adapted modalities – the accelerated use of cash – digital cash in particular – and linking humanitarian cash to national social protection systems.
 - Adapted focus – recalibrating to respond to needs in new geographic areas, particularly in urban areas; and changes to ongoing programmes that were either not feasible or no longer considered a priority during the pandemic.
181. It is not possible to offer in-depth explanations under all of these headings and so examples will be used for illustrative purposes.

8.2.1 Adapted in-kind assistance

182. There is already extensive evidence of numerous and diverse adaptations to in-kind humanitarian assistance, captured in agency-specific evaluations, reviews and good practice notes and shared with the evaluation during interviews in the case-study countries. The primary adaptation that organizations implemented was the integration of biosecurity measures to protect staff, partners and affected communities from the transmission of the virus. This included the procurement and use of masks and PPE, body temperature checks, handwashing facilities, testing kits and social distancing measures at project sites. For the most part, these initial adaptations happened swiftly with the support of donors by

repurposing existing funding to make existing programmes safer. Beyond these initiatives, other illustrative examples of programme adaptations are summarized in Table 7. Remote programme adaptations are captured separately in Table 8.

Table 7: Examples of adaptations to in-kind humanitarian programmes and services during COVID-19

Cluster/Sector	Examples of programme adaptations
Food security and Livelihoods	<p>In many contexts, food rations and transfer values were increased and distributions were reduced in frequency.</p> <p>At-home distributions were provided to the most vulnerable and those isolating or receiving treatment for COVID-19, such as in Colombia, where agencies supported the Government’s C-19 PRASS self-isolation scheme by delivering food at home for those self-isolating.</p> <p>In Somalia, school feeding programmes were adapted to provide children with take-home rations.</p> <p>In Syria, communal asset creation was converted to the household level.²⁵¹</p> <p>In Colombia, a community kitchen programme for migrants was converted to a voucher programme enabling beneficiaries to collect food at local retailers, in respect of social distancing rules.²⁵²</p>
Health	<p>In the Philippines, modular tents were provided for use in health facilities and evacuation to maintain physical distancing requirements for infection and prevention control for COVID-19.</p> <p>In Colombia, mobile response teams were established in collaboration with local hospitals, bringing SRH services directly to PiN, including the migrant populations.²⁵³</p> <p>In the Rohingya refugee response, volunteers and staff were redeployed from sectors where activities were limited, such as education and protection, to sectors that could operate, such as health, as well as awareness-raising activities to maintain service provision.</p> <p>In North West Syria, health services were provided house-to-house to avoid people visiting busy health centers. Other contexts also provided mobile health services.</p> <p>In Turkey, the increased engagement of local organizations particularly in improving medical and diagnostic services for HIV.²⁵⁴</p>
WASH	<p>In many countries, WASH items were distributed, including soap, sanitizer, water containers and hygiene kits.</p> <p>Local solutions were supported, including ‘<i>Tippy Taps</i>’ in Sierra Leone, built from basic, locally sourced components including sticks, string, soap and a water container to encourage effective hand-washing behaviour.</p>
Protection	<p>In DRC, the introduction of a ‘<i>ligne verte</i>’ hotline for reporting of protection incidents.</p> <p>In Colombia, GBV/PSEA services and mental health support were provided remotely.</p> <p>In some contexts, including Turkey, mobile protection services were provided to vulnerable groups, including physical rehabilitation for persons with disabilities and support with assistive devices.</p> <p>In the Rohingya Refugee Response, support for social workers to provide door-to-door counselling services to children and young people.²⁵⁵</p>

²⁵¹ WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022.

²⁵² WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022.

²⁵³ UN OCHA (2020) Global Humanitarian Response Plan COVID-19 Progress Report, Fourth Edition, 17 November 2020.

²⁵⁴ Itad and Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final Report, May 2022.

²⁵⁵ UNICEF (2021) Real Time Assessment of the UNICEF South Asia Response to COVID-19, January 2021.

	In Bangladesh , training of adolescents and youth ambassadors to provide their peers with mental health and psychosocial messages and support. ²⁵⁶
Education	<p>In many countries, organizations supported governments with a shift to remote learning via radio, television and the internet. In some contexts, including Sierra Leone, radio learning was supported by community organizers who encouraged and supported children to gather for radio broadcasts and follow the curriculum.</p> <p>In the Philippines, longer, more in-depth training on Education in Emergency were provided for teachers which also incorporated the latest guidance in the response to COVID-19.</p> <p>In Syria, aid agencies supported the reopening of schools with cleaning items as part of a broader disinfection campaign.</p> <p>In the Philippines, Filipino sign language and audio resources were included in learning resources.</p>
Shelter and non-food items	<p>In many contexts, emergency shelters and isolation and quarantine areas were established.</p> <p>In Bangladesh, the addition of mezzanines to shelters was piloted to provide families with more space without using more land.²⁵⁷</p>
Camp coordination and camp management	<p>In many contexts, camps were improved and camp sanitation was more regularly conducted, handwashing facilities were installed and risk messaging was adapted.</p> <p>In high-risk and congested areas, mapping of space/structures was done for use as isolation centers.</p>
Nutrition	<p>In the Rohingya refugee response, Somalia, the Philippines and elsewhere, mothers and other caregivers were oriented on how to measure their children for acute malnutrition using mid-upper arm circumference tapes and were issued with these tapes to identify and self-refer acutely malnourished children.</p> <p>In many countries, agencies procured and provided ready-to-use therapeutic foods to supplement government supplies.</p> <p>In the Rohingya Refugee Response, door-to-door Vitamin A supplementation (VAS) and nutrition screening campaigns combined with messaging on infant and young child feeding.²⁵⁸</p>
Logistics	<p>In Colombia, essential food and non-food items were airlifted to reach largely indigenous communities in very remote areas.²⁵⁹</p> <p>In Somalia and DRC, the United Nations Humanitarian Air Service (UNHAS) continued to operate as far as movement restrictions permitted.²⁶⁰</p> <p>In many contexts, Logistics Clusters facilitated cargo airlifts with medical and other supplies in support of government-led responses to the pandemic.</p> <p>In DRC and elsewhere, Logistics Clusters facilitated the storage of COVID-19 items on behalf of the Ministry of Health and WHO.</p> <p>In Syria, the Logistics Cluster facilitated access to free-to-user air and land transport.²⁶¹</p>

183. The timely delivery of supplies posed a problem for many organizations, including COVID-19-related supplies to keep personnel and affected people safe. Worldwide shortages hampered procurement efforts, though there is evidence to suggest that IASC organizations worked together and collaborated to source

²⁵⁶ UNICEF (2021) Real Time Assessment of the UNICEF South Asia Response to COVID-19, January 2021.

²⁵⁷ UNHCR (2022) UNHCR's Response to the COVID-19 Pandemic, Synthesis of Evaluative Evidence, Final Synthesis Report, June 2022.

²⁵⁸ UNICEF (2021) Real Time Assessment of the UNICEF South Asia Response to COVID-19, January 2021.

²⁵⁹ UN OCHA (2020) Global Humanitarian Response Plan COVID-19 Progress Report, Fourth Edition, 17 November 2020.

²⁶⁰ Global Logistics Cluster Situation Update, November 2020.

²⁶¹ Global Logistics Cluster Situation Update, September 2020.

supplies and organize their delivery (see section 6.6 on common services).²⁶² Shortages also pushed organizations to seek alternative sources, however, and the evaluation heard of several instances in which supplies had been procured locally, with the added impact of stimulating local economies. In Bangladesh, Sierra Leone and DRC, for example, masks sewn by local women were purchased and distributed, simultaneously boosting informal incomes and providing additional livelihood skills.

8.2.2 Adapted ways of working

184. IASC actors and others adapted quickly and innovatively to working remotely in order to continue providing remote humanitarian assistance and services. There were many positive examples of remote programming across different sectors and clusters, the majority of which were facilitated through the greater use of technology and digital platforms. Table 8 provides a snapshot of some of the most striking remote adaptations that the evaluation encountered in the case-study countries.

Table 8: Snapshot of remote programming approaches in the COVID-19 response in case-study countries

Purpose of remote approaches	Description
Livelihood support	In Somalia , WFP scaled up its pilot e-Shop initiative during the pandemic in Somalia. E-Shop creates a virtual market that allows recipients of WFP’s vouchers to shop online using an app that connects users to retailers and allows goods to be delivered at home. Sales via the app increased from an initial \$60,000 to just under \$1.5 million between March and July 2020.
Telemedicine	In Turkey , WHO, UNFPA and UNHCR with MPTF funding shifted to provide telemedicine, which acted as a substitute for face-to-face care during periods of lockdown, providing women with access to health information, consultations and disease diagnosis. In Colombia , Telephone support lines were established for both refugees and migrants who requested HIV prevention and diagnostic services and other essential sexual and reproductive health services. ²⁶³
Best Interests determination	In Turkey , UNHCR and UNICEF moved their Best Interests Determination panel meetings online to ensure decision-making procedures continued, particularly for cases involving unaccompanied and separated children. ²⁶⁴
Behaviour change	In Syria , Oxfam reached nearly 7 million people across Syria with behaviour change messages disseminated across multiple channels such as Radio, SMS, billboards, and social media. Messaging included wearing facemasks, handwashing, caring for the elderly, stigma prevention, social distancing, and self-isolation. ²⁶⁵
Emergency cash assistance	In the Rohingya refugee camps in Bangladesh , UNHCR and its partners were able to support vulnerable families in host communities with emergency cash assistance using mobile money, in partnership with bKash and Nagad. ²⁶⁶
Rumour analysis	In Colombia , UNICEF conducted a community media initiative using Kobo-Toolbox to track and analyze rumours circulating among people on the move from Venezuela regarding COVID-19 vaccinations. Vaccine hesitancy was evident among more than 43 percent of those that they interviewed. The information was used to inform behaviour change activities to promote vaccine acceptance. ²⁶⁷

²⁶² UNICEF (2021) Real Time Assessment of the UNICEF South Asia Response to COVID-19, January 2021.

²⁶³ Itad and Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final Report, May 2022.

²⁶⁴ Itad and Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final Report, May 2022.

²⁶⁵ Oxfam (2021) *HBCC Final Report*, Oxfam Syria, November 2021.

²⁶⁶ UNHCR (2020) UNHCR provide emergency COVID-19 cash assistance to the Host Community of Cox’s Bazar, Bangladesh, 15 September 2020.

²⁶⁷ UNICEF (2022) Children on the move, including Venezuelans and communities affected by COVID-19, Humanitarian Situation Report, Reporting period: mid-year 2022.

Remote learning	Humanitarian organizations supported the Ministry of Education in the <u>DRC</u> to provide remote learning during periods of school closures through radio broadcasts (and educational television for students mainly living in urban areas). Remote learning was complicated for multiple reasons, including a shortage of radios, poor transmission, network, etc. Education partners supported by promoting distance learning tools, creating listening clubs, and other initiatives. ²⁶⁸ In Sierra Leone , UNICEF worked with the Ministry of Health and other partners to ensure a rapid shift to radio-based education which had been piloted during EVD. Positive feedback at national level, although at the district level there was some concern over access to radios. In some Chiefdoms, organizations sought to maximize the benefit of distance learning by radio through the use of community-level facilitators.
GBV reporting	UNFPA worked with GBV survivors and the Coalition Against Trafficking of Women in Asia Pacific to design ‘HerVoice’, a mobile application for GBV reporting used in Syria . ‘HerVoice’ notifies users of local GBV service providers and responders. For more urgent cases, the application can track the location of the survivor and alert the nearest responders. As of June 2021, ‘HerVoice’ had been downloaded more than 5,000 times. ²⁶⁹

185. While shifting to remote ways of working was necessary, it worked better for some programme areas than others, and was more effective in contexts where the conditions were already in place to support digital tools and remote service provision.²⁷⁰ Limited internet connectivity, poor mobile phone coverage and intermittent or limited electricity supply were limiting factors in some contexts, particularly in remote geographic areas, as was access to and familiarity with virtual technology, both within institutions and communities. This had the effect of excluding some vulnerable groups,²⁷¹ including some of those most at risk to the impacts of the pandemic such as the poorest and most marginalized groups, older women and men, those with intellectual disabilities, and others.
186. For certain sectors and programme areas, in-person services continued to be critical. The Joint Evaluation of the Protection of the Rights of Refugees During COVID-19 found that ‘*while adaptation and innovation to support refugees’ ongoing access to services during restricted movement is important, it is equally important to recognize the limitations of remote delivery, especially for survivors of GBV, for children at-risk and their caregivers, and others with specific protection needs*’.²⁷² This sentiment was echoed by interviewees for this evaluation at country level who stressed the importance of proximity for building trust and ensuring confidentiality for protection and other services, such as mental health and psychosocial support. This view was also shared by many community members, who articulated a preference for face-to-face engagement for some services.
187. An increase in remote monitoring approaches led to real and perceived implications and trade-offs for the quality of programmes. However, in instances where a decline in programme quality had been identified, these had generally been addressed by the time of the evaluation, or there were commitments to take corrective actions as soon as conditions allowed. There was an overriding sense from interviewees that remote programming and remote monitoring of those programmes was ‘*good enough*’ to enable the response to continue, which was imperative under the circumstances.

²⁶⁸ GPE Blog: Democratic Republic of Congo: Increasing Alternatives to Ensure Learning Continuity during the COVID-19 Pandemic, 16 December 2021: <https://www.globalpartnership.org/blog/democratic-republic-congo-increasing-alternatives-ensure-learning-continuity-during-covid-19>.

²⁶⁹ UN OCHA Philippines COVID-19 Humanitarian Response Plan, Final Progress Report, June 2021.

²⁷⁰ The COVID-19 Global Evaluation Coalition (2021) The COVID-19 Pandemic: How are Humanitarian and Development Co-operation Actors Doing so Far? How Could we do Better. Synthesis of early lessons and emerging evidence on the initial COVID-19 pandemic response and recovery efforts, June 2021.

²⁷¹ ILO (2022), COVID-19 one year on: What have we learned about ILO’s influence & results in rebuilding the world of work. A synthesis review of evaluative evidence, First published 2021.

²⁷² Itad and Valid Evaluations (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, Final Report, May 2022.

8.2.3 Adapted modalities

188. The use of humanitarian cash continued an already upward trend and was further accelerated by the conditions created by COVID-19. A mapping of IASC coordination structures at country level in 2020 showed that cash and voucher assistance (CVA) was used across all 28 operations and accounted for an average of 24 percent of the total response.²⁷³ Global data on CVA shows that the volume transferred to recipients continued to rise during the pandemic, reaching a total of \$5.3 billion in 2021 – between 19 and 21 percent of total humanitarian assistance.²⁷⁴ The majority of organizations that provided data for analysis of global spending on humanitarian CVA claimed that the response to COVID-19 had led to either a consolidation or an increase in their respective volumes of CVA transferred to recipients in 2020.²⁷⁵ Across multiple contexts, ‘CVA emerged as an effective mode of assistance, lending itself to more remote delivery and supporting recipients in addressing varied needs’.²⁷⁶
189. In many humanitarian contexts, including those used as case-study countries for this evaluation, affected populations expressed a preference for cash – both in general and specifically in response to the pandemic. During FGDs, when asked about the relevance and the adequacy of the support they had received, community members often cited cash as having more of a positive impact than other forms of assistance (see Box 13).

Box 13: Feedback from communities on the provision of cash assistance during COVID-19

FGDs with communities suggested that cash assistance was one of the highest priorities amongst communities and perceived to have the most impact. In DRC, whilst people expressed appreciation for the little assistance they received e.g., facemasks, they claimed that this support did not make a significant difference to their lives, especially for those already in dire need prior to the pandemic. Cash assistance was valued more highly, allowing people to prioritize their own needs, including paying for food, school supplies, and other urgent commodities. Similarly in Sierra Leone, several groups expressed a preference for cash, food and medicines.

“We needed money and food assistance because we were unemployed at the time due to lockdown.” Male FGD participant, Bangladesh

“With cash assistance I bought medicines for my children. So it saved my children’s life.” Female FGD participant, Bangladesh

“Monetary assistance is more needed compared to other assistance because if we have money, we can buy what we need and can manage it based on our situation” Female FGD participant, Philippines

²⁷³ UN OCHA (2021) Note on IASC coordination structures at country level in 2020 – Final version – 16 July 2021.

²⁷⁴ Development Initiatives (2022) *Global Humanitarian Assistance Report 2022*, August 2022.

²⁷⁵ Development Initiatives (2022) *Global Humanitarian Assistance Report 2022*, August 2022.

²⁷⁶ Lawson-McDowall et al. (2021) The use of cash assistance in the Covid-19 humanitarian response: accelerating trends and missed opportunities, Disasters, 2021, 45 (S1): S216-S239, ODI.

190. Movement restrictions and other government measures imposed during the pandemic led to an increased use of e-cash, e-vouchers and mobile money during the response to COVID-19. Digital payments reduced the need for physical contact and therefore lent themselves to a perceived decrease in the risk of transmission of the virus.²⁷⁷ As such, there was an acceleration in the use of new digital platforms, tools and processes for CVA delivery during the pandemic. This was evident in Somalia at the time of the evaluation, which reached ‘*tipping point*’ with the use of mobile money during COVID-19, utilizing various different payment options, including cash mobile (through mobile phones), e-Cash (electronic card) and e-Voucher (for goods and services through an electronic card). The digital shift was possible in Somalia due to pre-existing financial systems and infrastructures (more than 88 percent of Somalis over the age of 16 own a SIM card and 83 percent of SIM card owners use mobile money). Somalia has a strong and influential remittance culture.²⁷⁸ In DRC on the other hand, while the use of physical cash had increased significantly during the timeframe of the pandemic – the number of beneficiaries receiving multi-purpose cash in DRC had increased from 1.2 million people in 2019 to 3.4 million in 2021²⁷⁹ – the transition to mobile money was slow due to significant and persistent operational challenges.
191. As with other forms of remote programming, digital cash carries very real risks of exclusion – particularly for ‘*people at the bottom of the digital pyramid with the least digital capacity*’²⁸⁰ – these fears hindered its acceleration during the pandemic in a number of contexts. Questions of data risks and responsibilities were also noted as limiting factors in contexts where conditions are not yet in place to enable a smooth digital transition.
192. Another area of acceleration during COVID-19 was the linking of humanitarian CVA to national social protection systems. The evaluation found several instances of national social safety nets that had been supported by international humanitarian and development actors to deliver emergency, shock-responsive assistance to vulnerable populations during the pandemic. Other (IASC agency-specific) evaluations provide more extensive evidence of support to governments to scale up or adapt existing social protection measures in response to COVID-19 – including direct delivery of cash, as well as governance, capacity and coordination support.²⁸¹ These and other experiences offer lessons on the role that humanitarian organizations can play in supporting countries to build more shock-response and adaptive social protection systems for future crises.

²⁷⁷ Lawson-McDowall et al. (2021) The use of cash assistance in the Covid-19 humanitarian response: accelerating trends and missed opportunities, Disasters, 2021, 45 (S1): S216-S239, ODI.

²⁷⁸ Magheru, M. (2020) Country mapping – large scale cash transfers for COVID-19 response, Somalia, September 2020, UN OCHA.

²⁷⁹ Data extracted from updates by the Cash Working Group – national (CWG-n) in DRC.

²⁸⁰ Lawson-McDowall et al. (2021) The use of cash assistance in the Covid-19 humanitarian response: accelerating trends and missed opportunities, Disasters, 2021, 45 (S1): S216-S239, ODI; citing Mukherjee, A. (2020) *Digital Cash Transfers for Stranded Migrants: Lessons from Bihar’s Covid-19 Assistance Program*. CGD Note. October 2020.

²⁸¹ See for example: WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022; UNDP Lessons from Evaluations: UNDP Support to Social Protection, undated; Oxfam (2021) Oxfam’s Humanitarian Social Protection Approaches in the context of COVID-19, September 2021; UNICEF (2021) Rapid Review of Global Social Protection Responses to the COVID-19 Pandemic, August 2021.

Box 14: Linking humanitarian CVA to national social protection systems to respond to COVID-19

In **Turkey**, the pre-existing Emergency Social Safety Net (ESSN) and Conditional Cash Transfers for Education – which already provided vital support to Syrian refugees in Turkey – were expanded and adapted to respond to additional needs generated by COVID-19.

In **Somalia**, the EU-supported ‘SAGAL’ social protection programme targeted elderly people at risk from COVID-19. This and the World Bank-funded ‘BAXNAANO’ social protection programme, which was used to respond to desert locusts but not COVID-19, form the nascent foundations of a social safety net in Somalia.

In **Sierra Leone**, additional cash and in-kind assistance was delivered through the existing government social protection programme, part-funded by World Bank. Coverage was extended to new beneficiaries through existing and new programmes, including persons with disabilities who received a lockdown handout, and later disbursements as part of an emergency urban cash transfer and a COVID-19 social safety net.

In **Syria**, members of the Cash Working Group supported the Ministry of Social Affairs to implement a two-month national social protection programme in response to COVID in 2020. The programme was not continued due to a likely shortage of government resources.

8.2.4 Adapted focus

193. While programmes were being modified and adapted to respond to needs in fast-changing and challenging contexts, so was the overall focus of governments and organizations as COVID-19 overshadowed previous priorities and stretched funding and capacities beyond their limits. Programmes were expanded and adapted to meet new needs, including in dense urban environments, requiring new ways of targeting, delivering and monitoring.²⁸² In DRC, for example, humanitarian organizations shifted their focus to respond to the impact of COVID-19 among vulnerable populations in the urban area of Kinshasa, which up to that point had not been considered a major target area for emergency relief.
194. With such rapid and challenging programme expansion, it was not always possible to sustain ongoing humanitarian and development programmes, either because resources were stretched too thin or the restricted operating conditions of the pandemic prevented their progress. Routine immunization programmes were heavily constrained, for example. As of June 2020, an update on the GHRP noted that nearly 100 countries had reported delays or suspensions of immunization campaigns for diseases such as measles, polio, typhoid and cholera.²⁸³ By July 2022, WHO and UNICEF reported that vaccination coverage had continued to decline in 2021, fuelled by COVID-19, and 25 million children risked missing out on lifesaving vaccines.²⁸⁴
195. As the demand and funding for emergency response accelerated there was also a notable pivoting away from resilience-oriented work in the midst of the COVID-19 response.²⁸⁵ Interviewees indicated that the shift in focus was temporary and that the balance between emergency, resilience and development priorities would be recalibrated once operational conditions allowed. It is too early to say whether that will indeed be the case, or whether COVID-19 will have a long-lasting impact on efforts to build resilience and address the root causes of crises.

²⁸² WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022.

²⁸³ UN OCHA (2020) Global Humanitarian Response Plan COVID-19 Progress Report, June 2020.

²⁸⁴ UNICEF Press Release, 14 July 2022: <https://www.unicef.org/press-releases/WUENIC2022release>.

²⁸⁵ WFP (2022) Evaluation of the WFP Response to the COVID-19 Pandemic, Centralized Evaluation Report – Volume I, January 2022.

9 Localization

Summary findings

- Across the case studies, governments played a leading role in the COVID-19 response, putting in place preventive measures and developing national response plans. Where the government was particularly strong, IASC members, especially United Nations agencies, filled gaps in the response (section 9.1.1).
- L/NNGOs, however, had almost no role in leadership, despite IASC guidance. They faced a range of barriers to participating in HCTs and co-leading clusters, including language. Although L/NNGOs participated more in coordination mechanisms during the pandemic, international actors retained leadership roles and decision-making, so L/NNGOs lacked the power to influence the COVID-19 response (sections 9.1.2 and 9.2).
- There was a significant increase in humanitarian funding to governments in 2020 but this fell to below 2019 levels in 2021. Overall, direct humanitarian funding to L/NNGOs remained a very small percentage of total humanitarian funding – after a small increase in 2020, there was a decline in 2021. Evidence suggests that this is due to donor risk aversion and a lack of capacity to manage small grants (section 9.3.2).
- Pooled Funding provided an important source of income for L/NNGOs during the COVID-19 response. In 2020, the L/NNGO share of total CBPF funding increased to 36 percent, with some Funds channelling higher percentages to L/NNGOs (section 9.3.4). CBPFs introduced a set of flexibility measures in response to COVID-19. While not all the measures were implemented across the funds, given the largely positive experience of stakeholders, the measures have been incorporated into CBPF global guidance for all funding (section 9.4.1).
- CERF undertook an innovative initiative to fund NGOs working on the frontline. While it was not designed to fund L/NNGOs specifically, and they struggled to meet the eligibility criteria, they received 20 percent of the funding and it was an unprecedented step by the pooled fund. A CERF grant of £25 million was targeted at L/NNGOs (and women-led organizations specifically). While there were challenges with the funding process, valuable lessons were learned (section 9.3.5).
- Across the board, donors provided flexibility to reprogramme funds at the start of the pandemic which was useful for frontline NGOs. Overall, however, NGOs did not feel that there had been a significant or long-term increase in funding flexibility (section 9.4.2).
- Despite the limited additional funding for L/NAs, they played a greater role in the provision of assistance across a range of contexts, reaching affected communities when international actors could not and providing protection services. Community volunteers and Civil Society Organizations (CSOs) also had a greater role in the response. However, L/NAs argued that, with the lifting of COVID-19 restrictions, there was a reversion to the pre-pandemic status quo (section 9.5).
- There were few examples encountered of capacity strengthening for L/NAs during the pandemic, partly due to the practical challenges with delivering capacity strengthening and partly due to a view a global crisis was not considered to be an appropriate time for capacity strengthening (section 9.6).

196. Within the humanitarian response to COVID-19, there was an early recognition that international actors were impeded by travel and movement restrictions while local actors were on the ground and able to maintain, and possibly scale-up, humanitarian response. This was reflected in the IASC’s interim guidance on localization, issued in May 2020.²⁸⁶ The guidance recognized the ‘*advantages*’ of direct funding to local actors but acknowledged that the GHRP did not ‘*offer an effective conduit for this modality*’.²⁸⁷ Therefore, the IASC’s guidance focused on partnership and key messages on aspects of localization. One of these was the need to support systematic local participation in coordination mechanisms and decision-making processes at both national and sub-national levels, with HCs including local actors in HCTs on an equal basis.
197. This section will seek to determine the extent to which this guidance was implemented in practice as part of a broader analysis of the role played by local and national actors in the COVID-19 response.

9.1 Government and L/NA leadership

9.1.1 The role of governments in leading the response to COVID-19

198. The scope, scale and progression of the COVID-19 pandemic and the multi-dimensional nature of its impact required governments to be at the forefront of the response and take decisive action. Governments were also the only ones able to introduce and implement the measures necessary to address both the health and socio-economic effects. Across the eight case studies, governments implemented measures to prevent the spread of COVID-19, including lockdowns and border closures. The one exception was North-West Syria where there was no entity with the authority to introduce and enforce lockdown measures.
199. The cases of Turkey and Sierra Leone are particularly instructive because, in both cases, the government played a clear leadership role with the IASC, coordinated by the UN, filling gaps that they identified in the response (Box 15).

²⁸⁶ Inter-Agency Standing Committee (2020) *Localisation and COVID-19 Response: Interim Guidance*, IFRC and UNICEF in collaboration with IASC Results Group 1 on Operational Response Sub-Group on Localization.

²⁸⁷ Inter-Agency Standing Committee (2020) *Localisation and COVID-19 Response: Interim Guidance*, IFRC and UNICEF in collaboration with IASC Results Group 1 on Operational Response Sub-Group on Localization, pg. 1.

Box 15: Examples of strong government leadership in the COVID-19 response: Turkey and Sierra Leone

The **Turkish** government's response benefitted from a WHO-backed health emergency initiative called the Pandemic Influenza Preparedness Framework for which it had published a national plan. The government activated its preparedness/contingency plans on 6 January 2020, the day that WHO shared its Rapid Risk Assessment relating to COVID-19 with countries in the European region. The Ministry of Health established a Coronavirus Scientific Advisory Board on 10 January 2020. On 11 March 2020, the first positive case of COVID-19 was confirmed and the government activated its National Response for Pandemics. It put in place lockdown measures during March.

The government continued to provide basic services (health and education) to the refugee populations that it hosts during the pandemic and included them in its vaccination campaign. In 2021, the government also provided additional cash to refugees that are part of the ESSN program that is funded by the European Union and implemented by IFRC. At the sub-national level, municipalities such as Gaziantep, provided assistance to both refugees and host communities, with support from international agencies. This included the distribution of food and hygiene kits.

In view of the high level of government capacity, the United Nations used its planning for the pandemic response to identify its niche and how best to complement the government's work and focused on refugees and vulnerable groups at risk of being left behind.

In **Sierra Leone**, the government played a leading role in the response at both national and district levels. It established a National COVID-19 Emergency Response Centre (NOACOVERC) and similar structures at district level (DICOVERCs). The government developed the National COVID-19 Preparedness and Response Plan based on scientific evidence, modelling of COVID-19 transmission in China and experience of the 2014-16 Ebola response. It also developed a Quick Action Economic Response Programme (QAERP) by March 2020. In the same month, the Ministry of Health and Sanitation supported community perception surveys of COVID-19. Also in March, the government declared a 12-month state of emergency.

There were restrictions on gatherings, border closures, the closure of schools and places of worship, and a ban on inter-district travel. Humanitarian coordination was undertaken through government structures (see below). The government was the second largest recipient of humanitarian funding, receiving over 23.5 percent as direct funding. Its response to COVID-19 involved the use of isolation and quarantine facilities, which was similar to the approach taken for EVD, but with treatment provided in District Hospitals, which was more sustainable than the standalone facilities developed for the EVD response.

As in Turkey, the United Nations complemented the government's response by focusing on particularly vulnerable groups. This included the Socio-Economic Response Plan that was completely aligned with the QAERP but focused on vulnerable groups that were not visibly prioritized in the QAERP.

200. Governments in the case study contexts developed national response plans, usually with WHO's support and based on the SPRP pillars. The Sierra Leone government had finalized and adopted its national plan by February 2020 while Turkey, Bangladesh, Somalia and Syria completed their plans in March 2020. In the DRC, however, the government did not issue its emergency, multi-sector COVID-19 response plan until May 2020. The Philippines government outlined a contingency plan in March 2020 before going on to develop evolving response plans.

9.1.2 The role of L/NNGOs in country-level leadership of the response

201. Despite an explicit commitment to strengthening local leadership and decision-making as part of the Grand Bargain,²⁸⁸ there has been limited progress made towards achieving this. In June 2020, a study by the International Council of Voluntary Agencies (ICVA) on the participation of national NGOs in HCTs outlined serious deficiencies.²⁸⁹ The IASC subsequently issued specific guidance on strengthening the participation, representation and leadership of L/NNGOs in coordination mechanisms in July 2021.²⁹⁰
202. The revision of the GHRP was accompanied by a shift in focus from the global level to the country level which, in theory, permitted greater L/NNGO input, albeit for those that were members of HCTs. On this point, it is noteworthy, therefore, that L/NNGO membership of HCTs remained static at 79 seats during the pandemic even though the total number of HCT seats increased by 90 between 2019 and 2020. As a result, the proportion of L/NNGOs participating in HCTs actually fell from 7 percent to 6 percent.²⁹¹
203. This evaluation found that L/NNGOs faced a range of barriers to their participation in HCTs during the COVID-19 response, including language barriers, but the most pronounced challenge was the lack of power and the ability to influence the humanitarian response.²⁹² A Somali NGO representative argued that *“it’s not about the numbers [of L/NAs on the HCT], it’s about the person who participates and how vocal they are. We’re very active, we speak up and make contributions and we feel heard. There are also good people representing the INGOs who are real champions of localization and women’s empowerment.”*
204. In the Philippines, the evaluation identified good practice by the HCT, which has adopted a localization road map and developed a scorecard as a practical and contextualized monitoring tool to articulate and track the progress of the HCT members and observers on localization. The scorecard is intended to provide a baseline indication of collective localization results to date and the eventual impact of those results on the quality of humanitarian action. Currently, HCT members are expected to complete it every second year.²⁹³

²⁸⁸ Grand Bargain Workstream 2 (Localization), Commitment 3.

²⁸⁹ LSE and ICVA (2020) Participation of National NGOs and NGO Fora Within Humanitarian Country Teams, April 2020.

²⁹⁰ Inter-Agency Standing Committee (2021) Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms, IASC Results Group 1 on Operational Response, July 2021.

²⁹¹ OCHA (2020) Note on IASC Coordination Structures at Country Level, Prepared by the Inter-Agency Support Branch (IASB) OCHA, 23 March 2020; OCHA and GCCG (2021) Note on IASC Coordination Structures at Country Level in 2020, OCHA with support from the Global Cluster Coordination Group, February 2021

²⁹² LSE and ICVA (2020) Participation of National NGOs and NGO Fora Within Humanitarian Country Teams, April 2020.

²⁹³ OCHA (2022). Philippines HCT Scorecard on Localization.

Box 16: Learning from challenges with L/NA participation in HCTs: North-West Syria²⁹⁴

As discussed at an OPAG meeting in November 2021, the humanitarian response is delivered by Syrians working for national and international organizations. Although Syrian NGOs are members of the equivalent of the HCT, decisions are made largely ‘by men, and by foreigners, in meetings held in English’. The Deputy Regional Humanitarian Coordinator is making a concerted effort to change this and L/NA members described the HCT as ‘a platform where everyone could speak’. However, the challenge lies with influencing the way in which the humanitarian response is delivered. Syrians working on the ground were unable to get the HCT or the COVID-19 Task Force to recognize that RCCE was not working because it was not adapted to the context (“you can’t go to the local community thinking that you’re in Geneva” as one interviewee put it, referring to messaging around face masks and social distancing). They also struggled to emphasize the importance of meeting the basic needs of communities affected by multiple crises, without which communities were not going to be receptive to COVID-19 messaging and mitigation measures. In addition, they highlighted the practical challenge of not being able to secure funding for internet costs to be able to participate in online meetings even though this is a necessity, not ‘a luxury’.

205. A study on the impact of COVID-19 on localization in the Pacific highlighted that the reduced presence of international aid workers had strengthened the leadership role of national and local NGOs, who reported more influence over decision-making and a greater sense of empowerment.²⁹⁵ However, this finding was not reflected in the evidence collected from the case studies for this evaluation.

9.2 L/NA participation in collective coordination mechanisms

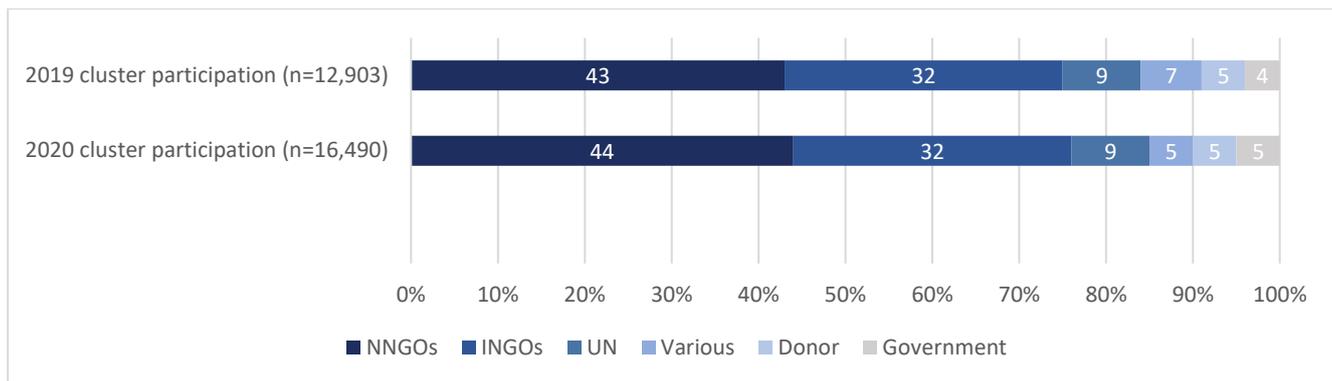
206. Findings from the case studies and data on IASC coordination structures show that in 2020, governments held 19 percent of 298 cluster/sector leadership or co-leadership positions at the national level (no L/NNGOs performed this function).²⁹⁶ Evidence collected during the case studies showed that the role and engagement of governments varied considerably. For example, in Sierra Leone, the lack of IASC coordination structures meant that humanitarian actors coordinated primarily through government structures, but in countries with IASC coordination structures, government engagement was much more variable.
207. Although COVID-19 did not change L/NAs representation in HCTs, there is strong evidence that their participation in cluster/sector coordination increased. Figure 15 indicates that the number of L/NNGO cluster/sector members increased by over 1,700 between 2019 and 2020 (the 2020 data is from 28 operations compared with 26 operations in 2019 but the numbers suggest an increase). This is borne out by interview data. L/NAs participation in cluster meetings increased considerably once these meetings were online because organizations based outside capitals or coordination hubs did not have to spend time and money travelling to the meetings (as long as they had sufficient internet connection). This was particularly true in Turkey where organizations responding to the needs of Syrian refugees are based in numerous locations across the country.

²⁹⁴ <https://interagencystandingcommittee.org/system/files/2022-06/Summary%20Record%2C%20IASC%20OPAG%20Meeting%2C%2023%20November%202021.pdf>.

²⁹⁵ Australian Red Cross, Humanitarian Advisory Group and Institute for Human Security and Social Change, La Trobe University (2020) *A Window of Opportunity: Learning from COVID-19 to Progress Locally Led Response and Development Think Piece*.

²⁹⁶ OCHA and GCCG (2021) *Note on IASC Coordination Structures at Country Level in 2020*, OCHA with support from the Global Cluster Coordination Group, February 2021.

Figure 15: Cluster/sector membership in 2019 and 2020²⁹⁷



208. To promote L/NA's engagement, a number of sectors introduced simultaneous translation to address the language barrier, which facilitated the participation of L/NAs. In the DRC, remote or 'hybrid' meetings had facilitated the participation of local partners based outside Kinshasa in national cluster meetings but several interviewees highlighted significant problems with internet connections. In Syria, aware of internet connection challenges as well as the unreliable electricity supply, one sector coordinator shared meeting discussions with members by email as soon as possible to keep them informed. This is an example of good practice. According to interviewees across case study contexts, the increased participation was positive but the depth and quality of discussions often decreased and it was not possible to make decisions in meetings with such large numbers of participants. As a result, coordination meetings were more likely to be used to share information, with decisions taken in smaller fora such as a Strategic Advisory Group.
209. Although L/NA participation in coordination mechanisms increased, COVID-19 did not change the power imbalance between international and national humanitarian actors in these structures, with international actors retaining leadership roles and decision-making power.²⁹⁸ As Somali NGOs explained, 'Local NGOs didn't have a greater voice as such. There was no great shift in the relative power of local and international NGOs...We need to see big policy changes around more equitable partnerships and more investment in institutional capacity-building but those things take time and COVID wasn't the accelerant that some hoped it would be.' 'At a strategic level, it didn't make that much difference and the system has gone back to how it was before COVID-19.'

9.3 Funding to frontline responders

210. The IASC interim guidance on localization highlighted flexible and simplified funding to front-line local actors, provided as directly as possible, and the importance of being able to re-programme existing funding. The guidance also underlined the important role of pooled funds, including CBPFs, for funding to local actors.

²⁹⁷ Sources: OCHA (2020) *Note on IASC Coordination Structures at Country Level*, Prepared by the Inter-Agency Support Branch (IASB) OCHA, 23 March 2020; OCHA and GCCG (2021) *Note on IASC Coordination Structures at Country Level in 2020*, OCHA with support from the Global Cluster Coordination Group, February 2021. Note, various includes members of the Red Cross/Red Crescent Movement, academia, private sector, IFIs and other organizations.

²⁹⁸ DA Global (2021) *Is Aid Really Changing? What the COVID-19 response tells us about localisation, decolonisation and the humanitarian system*. Commissioned by the British Red Cross; Ullah, Z., S. Ullah Khan, and E. Wijewickrama (2021) *COVID-19: Implications for Localisation. A case study of Afghanistan and Pakistan*. HPG working paper, ODI; Wijewickrama, E., N. Rose and T. Tun (2020) *Two Steps Forward, One Step Back: Assessing the implications of COVID-19 on locally-led humanitarian response in Myanmar*, Myanmar Development Network, Trocaire, IrishAid and Humanitarian Advisory Group; Barbelet, V, J. Bryant and A. Spencer (2021) *Local Humanitarian Action During COVID-19: Findings from a diary study*, Humanitarian Policy Group, Overseas Development Institute.

9.3.1 Engagement of L/NNGOs in the GHRP process

211. L/NNGOs had limited opportunity to engage in the development of the GHRP at the global level.²⁹⁹ This was partly due to the speed with which the first iteration was prepared and partly because there was no mechanism to channel their input. Inception phase interviews highlighted that there are no local actors represented in key IASC bodies that focus on the operational aspects of humanitarian response – the Principals, the EDG and the Deputies Forum. Even OPAG only has three L/NNGO representatives³⁰⁰ although other bodies such as the Localization Task Force and the newly established Cash Advisory Group have more L/NNGO members. This suggests there is a need to consider a shift in power and influence over humanitarian response at the global level as well as at the country level.
212. In seeking to address the lack of L/NNGO input into the GHRP, an EDG meeting on 16 April 2020 highlighted the need to ensure the inclusion of NGOs in the revision of COVID-19 response plans and appeals at regional and country level and by 21 April 2020, the ERC had written to all RC/HCs to emphasize the inclusion of NGOs within existing coordination mechanisms and HRP revision planning processes to reflect their COVID-related funding requirements. Despite this emphasis, there was limited evidence of significant efforts taken to ensure the inclusion of L/NNGOs, in particular, in the revision of COVID-19-related appeals and plans. In Syria, for example, neither international nor Syrian NGOs were consulted about the development of the COVID-19 Operational Response Plan.

9.3.2 Direct funding to front-line responders

213. At their April 2020 meetings, the IASC Principals discussed the importance of getting funding to NGOs quickly because of their capacity to deliver humanitarian assistance but they had limited resources. On 17 April 2020, several participants in the Principals’ meeting raised concerns about the slow pace of funding reaching NGOs working at the frontline. This resulted in IASC guidance on addressing inconsistencies in ‘unlocking’ and disbursing funding to NGOs. The guidance was in the form of proposals to be developed further, with the guidance document making it clear that the proposals required follow-up discussion and action at both global and country levels to ensure progress and system-wide support. The guidance made four proposals:³⁰¹
- Strengthen L/NA involvement in planning and coordination processes (see above);
 - Capitalize on pooled funding mechanisms and consider efficiency and effectiveness measures to improve funding to NGOs. This included the option of funding NGO networks (such as the START Fund COVID-19) directly and expanding the use of the United Nations Partner Portal;
 - Increase funding via United Nations agencies, including simplifying procedures and offering greater flexibility;
 - Ensure timely and disaggregated reporting of funding flows from United Nations agencies to NGOs.
214. Figure 16 presents data on direct funding to national and local actors in the 63 GHRP countries from 2019-2021. This shows that there was a significant increase in direct humanitarian funding to governments in 2020. This is expected since the COVID-19 response was led by governments. It is noteworthy, however, that this funding fell dramatically in 2021, to far below the 2019 level. There was a lack of evidence on the

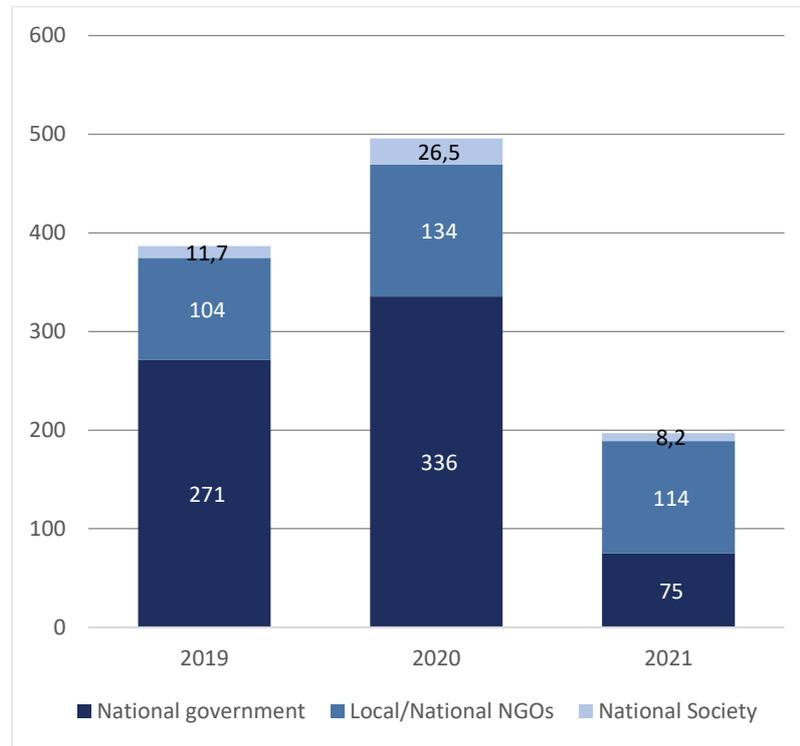
²⁹⁹ KonTerra (2022) *COVID-19 Global Humanitarian Response Plan: Learning Paper*, Commissioned by the Inter-Agency Humanitarian Evaluation Steering Committee.

³⁰⁰ <https://interagencystandingcommittee.org/system/files/2022-06/IASC%20OPAG.pdf>.

³⁰¹ IASC (2020) *Guidance: Proposals to Address the Inconsistency in Unlocking and Disbursing Funds to NGOs in COVID-19 Response*, IASC Results Group 5 on Humanitarian Financing, June 2020.

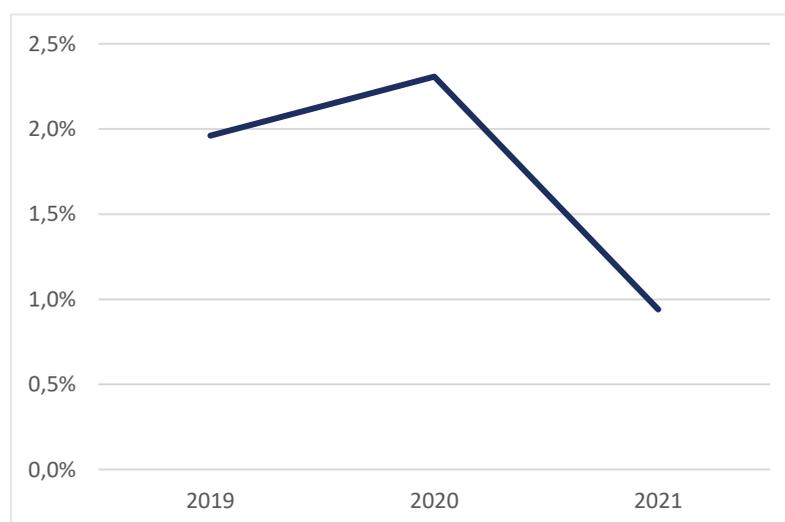
reasons for this but it could be related to the more prominent role of governments in the COVID-19 response since there was a similar pattern for L/NNGOs, albeit not so pronounced as for governments.³⁰²

Figure 16: Direct funding to national and local actors in GHRP countries: 2019-2021



215. Overall, direct humanitarian funding to L/NNGOs remained a very small percentage of total humanitarian funding to the 63 GHRP countries (see Figure 17).³⁰³ Direct funding to L/NNGOs across all countries receiving humanitarian assistance was slightly higher, at 3 percent of total humanitarian funding in 2020 before declining to 1.2 percent in 2021. The difference between GHRP and non-GHRP countries is due to a higher level of funding to governments in non-GHRP countries.³⁰⁴

Figure 17: Direct funding to national and local actors as a percentage of total humanitarian funding



³⁰² Source: Development Initiatives, based on data for the *Global Humanitarian Assistance Report 2022*.

³⁰³ Source: Development Initiatives, based on data for the *Global Humanitarian Assistance Report 2022*.

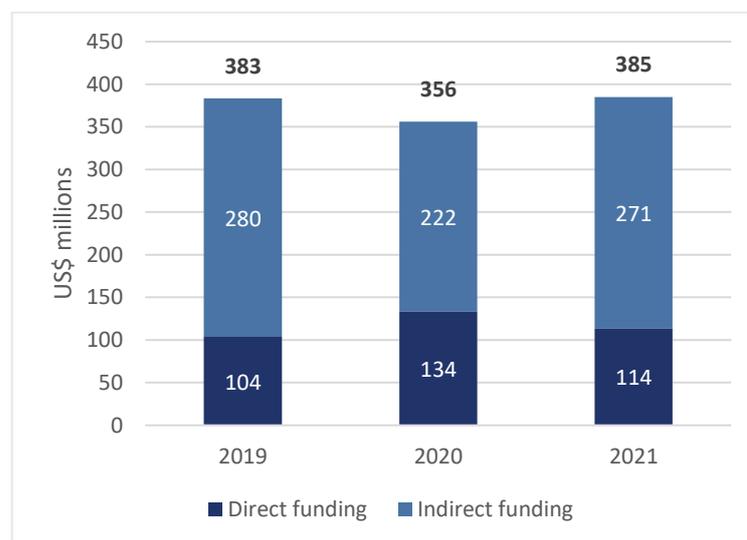
³⁰⁴ Development Initiatives (2022) *Global Humanitarian Assistance Report 2022*.

216. The challenge with delivering on the Grand Bargain commitment on direct funding to L/NNGOs is illustrated by the UK government’s response to a review that criticized it for the lack of a strategy to support localization in its humanitarian response to COVID-19 and only limited support through L/NNGOs and CSOs. The government’s justification was a lack of willingness to take on the additional risks associated with localization and the lack of capacity to manage small grants to local responders. At country level, the UK teams focused on adapting existing delivery mechanisms for the COVID-19 response rather than creating new ones.³⁰⁵ The UK example is part of a broader trend outlined in an independent funding review which concluded that the percentage of global funds allocated directly to local actors (as reported to the FTS) had essentially remained unchanged over the five years of the Grand Bargain.³⁰⁶ Ultimately, and as documented in a number of recent studies, United Nations agencies and donors continue to be averse to financial risk, which disincentivises partnerships.³⁰⁷ This is despite the fact that L/NNGOs stepped up to take on additional responsibilities and deliver assistance to affected communities when international humanitarian actors could not do so.

9.3.3 Indirect funding to front-line responders

217. While L/NNGOs receive very limited funding directly from donor governments, they are able to access a significant proportion of their funding indirectly, from CBPFs and as partners of United Nations agencies and INGOs. Figure 18 shows direct and indirect funding to L/NNGOs in the GHRP countries.³⁰⁸ This shows that, despite the rhetoric around localization and funding to frontline responders, total funding to L/NNGOs fell in 2020 before recovering to about the same level as 2019 funding. One possible explanation for this is that, in case study interviews (particularly in Somalia and Turkey), L/NNGOs generally said that they did not receive additional funding for the COVID-19 response but rather, had the flexibility to re-programme existing funding. This is supported by findings from a study that some large, well-established L/NNGOs benefitted from funding re-purposed for the COVID-19 response but the majority of them received little additional funding or funding from new sources.³⁰⁹

Figure 18: Direct and indirect funding to national and local NGOs in GHRP countries: 2019-2021



³⁰⁵ ICAI (2022) *The UK’s Humanitarian Response to COVID-19: A review*, Independent Commission on Aid Impact, July 2022.

³⁰⁶ Metcalfe-Hough, V., W. Fenton, B. Willitts-King and A. Spencer (2021) *The Grand Bargain at Five Years: An independent review*, Humanitarian Policy Group, Overseas Development Institute.

³⁰⁷ See, for example, InterAction and Humanitarian Outcomes (2019), *NGOs and Risk – Managing Uncertainty in Local-International Partnerships*, March 2019.

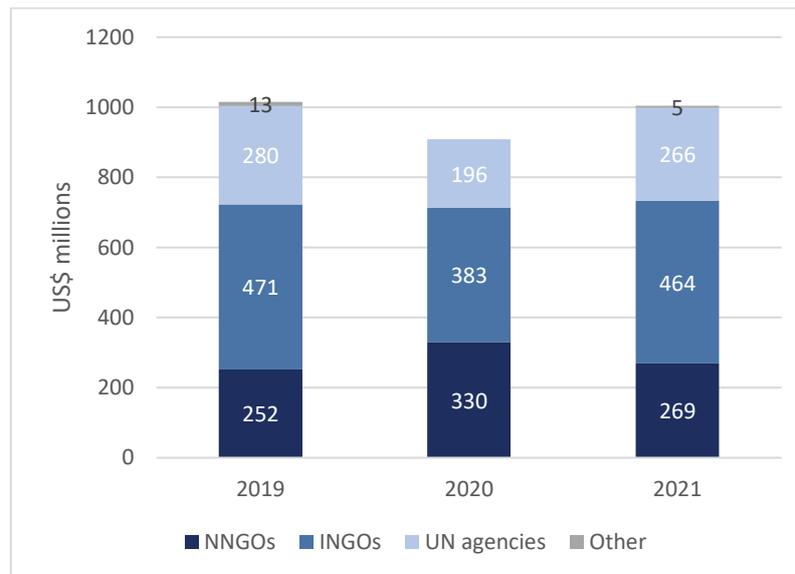
³⁰⁸ Source: Development Initiatives, based on data for the *Global Humanitarian Assistance Report 2022*.

³⁰⁹ Barbelet, V, J. Bryant and A. Spencer (2021) *Local Humanitarian Action During COVID-19: Findings from a diary study*, Humanitarian Policy Group, Overseas Development Institute.

9.3.4 The important contribution of CBPFs to front-line responders

218. CBPFs are an important source of indirect funding to L/NNGOs, as evidenced by Figure 19.³¹⁰ In 2020, CBPF funding to L/NNGOs increased considerably (to 36 percent of total CBPF funding) while funding to INGOs and United Nations agencies decreased. In the case of funding specifically for COVID-19, CBPFs allocated 32 percent of the \$252 million for the COVID-19 response to L/NNGOs. Although funding levels by partner type reverted to the 2019 pattern in 2021, funding to United Nations agencies and INGOs remained slightly lower than in 2019 whereas funding to L/NNGOs was slightly higher (\$269 million in 2021 compared with \$252 million in 2019).

Figure 19: CBPF funding by type of partner: 2019-2021



219. CBPFs have a policy of financing the partners “*best placed to respond in a timely, efficient and accountable manner*”³¹¹ and some Funds provide a significant amount of their funding to L/NNGOs. For example, in 2020, the Syria Cross-Border Humanitarian Fund channelled 56 percent of its total funding to L/NNGOs (\$104.1 million). This is because Syrian NGOs and the Syrian staff of international organizations play a critical role in the delivery of assistance to North-West Syria. Similarly, the Somalia Humanitarian Fund provided 54 percent of its 2020 allocations to L/NNGOs (this was \$19.7 million).

9.3.5 Innovation in CERF funding to support front-line responders

220. An initiative taken to increase funds to front-line organizations was a CERF allocation of \$25 million for NGOs which was allocated in June 2020. Since CERF is unable to fund NGOs directly, the money was channelled via IOM to 24 NGOs in six countries – Bangladesh, Central African Republic (CAR), Haiti, Libya, South Sudan and Sudan.³¹² The CERF secretariat selected IOM as the grant manager because of its level of flexibility. An independent review was very positive about the way in which the CERF secretariat and IOM managed the process and found that ‘*the allocation met its primary objective of moving money to frontline responding NGOs to enable them to deliver life-saving activities*’.³¹³

221. One challenge that the review identified was that national and local NGOs struggled to meet the eligibility criteria for the funding, including the ability to absorb funds and scale up. There was also a limit on the

³¹⁰ Source: United Nations (2020) Country-Based Pooled Funds: 2019 in Review; United Nations (2021) Country-Based Pooled Funds: 2020 in Review; United Nations (2022) Country-Based Pooled Funds: 2021 in Review.

³¹¹ United Nations (2021) Country-Based Pooled Funds: 2020 in Review, pg. 20.

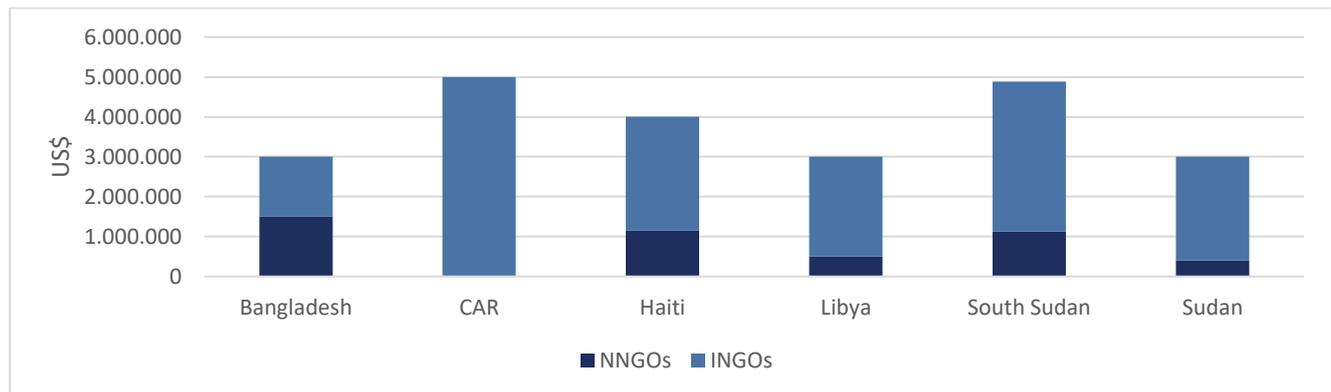
³¹² CERF (2020) CERF COVID-19 Allocations, CERF Advisory Group Meeting, November 2020.

³¹³ Poole, L. (2021) Independent review Central Emergency Response Fund (CERF) COVID-19 NGO allocation, 11 October 2021, pg. i.

number of NGO partners per country. However, in Bangladesh and Haiti, the teams involved in the allocation process made a concerted effort to include L/NNGOs, even if that meant not following the guidance fully.³¹⁴

222. Overall, eight out of the 24 NGOs that received CERF funding were L/NNGOs. Figure 20 shows funding to INGOs and L/NNGOs by country.³¹⁵ Although one-third of the recipient organizations were L/NNGOs, they only received about 20 percent of the funding because the grant amounts were smaller. Bangladesh was the only country where L/NNGOs received very slightly more funding than INGOs, while in CAR, no L/NNGO received funding.

Figure 20: CERF funding allocation to L/NAs and INGOs by country



223. Both the independent review and global interviews highlighted that the goal of the CERF’s NGO allocation was not to support localization but to ensure a timely response to COVID-19 by getting funds quickly to NGOs that could respond at scale, regardless of whether they were international or national. An allocation that was more explicitly targeted at frontline responders was CERF’s allocation of \$17 million to UNFPA and \$8 million to United Nations Women (a total of \$25 million) to support GBV programming in response to COVID-19. The grant, to be implemented over two years, was made in November 2020 and distributed to countries in February 2021. CERF requested that at least 30 percent of this funding should be channelled to women-led organizations working on GBV.³¹⁶
224. A review of the grants to UNFPA and UN Women found that setting a requirement for a percentage of funding to be implemented by women-led organizations was considered innovative and good practice that could be applied to other GBV-specific allocations. However, it also identified challenges with the funding process. CERF’s short timeframe for developing the proposal made it challenging to identify and establish partnerships with women-led organizations in time. United Nations agencies could do more preparatory work by mapping stakeholders and including women-led organizations in decision-making on funding. Also, CERF’s life-saving criteria meant that funding could not be used to support capacity-building and made it more difficult to include more organizations.³¹⁷
225. Although there were challenges with funding national and local actors through both the NGO and GBV allocations, it is encouraging that the CERF secretariat has invested in learning from the experiences. This means that there is an understanding of what could be done differently should CERF be used to fund L/NNGOs/women-led organizations as frontline responders in the future.

³¹⁴ Poole, L. (2021) Independent review Central Emergency Response Fund (CERF) COVID-19 NGO allocation, 11 October 2021.

³¹⁵ Source: Poole, L. (2021) Independent review Central Emergency Response Fund (CERF) COVID-19 NGO allocation, 11 October 2021.

³¹⁶ Ward, J. (2021) OCHA Support to Gender and Gender-Based Violence Programming: Rapid review of recent Central Emergency Response Fund (CERF) allocations targeting GBV prevention and response in humanitarian action, Commissioned by CERF Secretariat.

³¹⁷ Ward, J. (2021) OCHA Support to Gender and Gender-Based Violence Programming: Rapid review of recent Central Emergency Response Fund (CERF) allocations targeting GBV prevention and response in humanitarian action, Commissioned by CERF Secretariat.

9.4 Flexibility of funding to frontline responders

226. Following discussions at meetings of the Principals in March and April 2020, the IASC developed key messages on flexible funding for the COVID-19 response. The main messages were that existing funding should be flexible enough to reprogramme, that there should be fast-track provisions for both new funding and to reprogramme existing funding, and that there should be simplified procedures for due diligence, budgeting, reporting, evaluation and audit processes that would enable humanitarian agencies to work effectively *‘with partners on the ground which are best placed to respond’*.³¹⁸

9.4.1 Flexibility measures adopted by pooled funds

227. In April 2020, CBPFs introduced flexibility measures for their partners *‘allowing first-line responders to adapt to new needs’*.³¹⁹ These were based on the IASC’s key messages and included measures related to the following:

- Risk management framework;
- Operational modalities – partner and project ceilings, monitoring and financial spot-checks, audits, and the use of electronic signatures;
- Reprogramming of projects;
- Budgeting – cost extensions, eligibility of costs, staff categories, budget lines, and contingency budget line;
- No-cost extensions.³²⁰

228. A study found that CBPFs had largely implemented the flexibility measures, particularly reprogramming of projects, because this was viewed as strengthening the relevance and effectiveness of CBPFs. It was helpful that the process for approving reprogramming requests was fast-tracked in the online Grant Management System. However, there was limited implementation of the measures that had implications for financial risk management. Based on the mainly positive experience of NGO partners and fund managers, the CBPFs decided to incorporate many of the flexibility measures into their global guidance and apply them to non-COVID funding. This should enable partners to respond more easily to unforeseen needs or changes in the context.³²¹

9.4.2 Flexibility measures adopted by bilateral donors and United Nations agencies

229. Interviews with NGOs, in particular, across the case studies show that the ability to reprogramme funding was important, enabling the NGOs to procure PPE and to deliver programmes in a COVID-safe way. It also enabled them to switch from activities that they were no longer able to do due to COVID-19 preventive measures to COVID-19-specific activities. Some organizations made savings, on items like travel costs or the cost of organizing in-person meetings, that they were able to direct to other activities. For example, in Bangladesh, an L/NGO was not able to continue with education activities in the Rohingya refugee camps because the government had suspended these as part of COVID-19 prevention measures. It used the money saved to provide assistance to host communities that had greater needs because of the preventive measures. In Syria, an INGO reprioritized existing funding to distribute hygiene kits and provide more cash assistance. However, during interviews, the evaluation found little evidence of bilateral donors introducing fast-track provisions for new funding or simplified accountability requirements.

³¹⁸ United Nations (2021) Country-Based Pooled Funds: 2020 in Review; IASC (2020) Interim Key Messages: Flexible Funding for Humanitarian Response and COVID-19, IASC Results Group 5 on Humanitarian Financing, March 2020, pg. 2.

³¹⁹ CBPF (2020) Country Based Pooled Funds: On the front line of the COVID-19 response, June 2020, pg 1.

³²⁰ OCHA (2020) Flexibility Guidance: Country-Based Pooled Funds in the context of COVID-19 pandemic, CBPF Section, 20 April 2020.

³²¹ Featherstone, A. and T. Mowjee (2021) *Enhancing Programming Effectiveness of CBPFs*, unpublished.

230. Based on the discussions of the IASC Principals, several United Nations agencies also introduced simplified administrative requirements for their NGO partners. In April 2020, UNHCR addressed a letter to NGO partners, detailing measures taken to increase their discretion and latitude in the use of budget allocations.³²² In September 2021, UNICEF issued a comprehensive internal guidance note on localization, in which it addressed the need for funding flexibility for its local partners, among other requirements.³²³ An assessment of UNICEF’s response to COVID-19 found that, while the agency itself benefited from donor flexibility, there was mixed evidence on the extent to which it allowed partners flexibility in reallocating or reprogramming funds. In some cases, the agency was less flexible about proposed adaptations as needs evolved.³²⁴
231. From the perspective of NGOs, United Nations agencies provided more flexible funding than donor governments. This was because the latter had not made significant or long-lasting changes to simplify processes or increase the flexibility of funding as a result of COVID-19.³²⁵

9.5 Delivery of humanitarian assistance

232. Across the case study countries, this evaluation found strong evidence that L/NNGOs, Community-Based Organizations (CBOs) and affected communities themselves played a crucial role in delivering humanitarian assistance to affected people during the pandemic. This was because they were often able to reach affected communities when international actors could not and they also had sufficient proximity to provide in-person protection services (see Table 9).

³²² UNHCR, Filippo Grandi letter to Members of the International Council of Voluntary Agencies, InterAction, and the Steering Committee for Humanitarian Response, 3 April 2020.

³²³ UNICEF (2021) Technical Note – Localisation in Humanitarian Action for Children, Humanitarian Policy Section, Office of Emergency Programmes, 10 September 2021.

³²⁴ UNICEF (2021) Real-Time Assessment of the UNICEF Response to COVID-19: Global synthesis report, June 2021

³²⁵ Somalia NGO Consortium (2020) Flexible Funding for Humanitarian Response and COVID-19: A Scorecard from Somalia; <https://interagencystandingcommittee.org/system/files/2020-08/Summary%20Record%20of%20adhoc%20Principals%20Meeting%2010%20July%202020.pdf>

Table 9: Key features of L/NA response to COVID-19 in the case study countries

Feature	Assistance delivered by national and local actors and affected people
Greater access to affected people	<p>In Colombia, the United Nations imposed strict movement restrictions on its own staff and relied on local responders (NGOs, CBOs and local authorities) to deliver humanitarian assistance, e.g., delivering food parcels to communities in rural areas through churches, community leaders and indigenous organizations. A key feature of the COVID-19 response was the role of indigenous CBOs in the planning and implementation of the COVID-19 response in the remote Amazonas region because aid agencies did not have a prior presence in the area.</p> <p>Although local NGOs largely delivered humanitarian assistance in Somalia even before the pandemic, the reduced international presence meant there was a greater onus on them. Being based in communities meant that many were not affected by movement restrictions. They were also able to raise awareness of COVID-19 in local languages and dialects.</p> <p>In Bangladesh, due to the very limited access that agencies had to the refugee camps, international and Bangladeshi organizations worked through refugee volunteers who had been trained before the pandemic. The volunteers covered the gamut of activities from awareness raising to identifying and referring protection cases to supporting vulnerable people like the elderly and widows to raising problems with Camps in Charge and helping to resolve them.</p> <p>Unlike international actors which were constrained by the extensive lockdown, L/NNGOs in the Philippines were able to continue working because they secured clearance from the government. Some local NGOs were also able to assist hard-to-reach and indigenous communities through local networks and community volunteers.</p> <p>In Syria, L/NNGOs played a significant role in the provision of humanitarian assistance even before the pandemic because the government has placed restrictions on the work of international humanitarian actors.</p>
Access to information on the needs of affected people	<p>L/NNGOs in Somalia were an important source of information about the needs of affected people for different stakeholders, raising awareness at community level and providing updates for health cluster bulletins.</p>
Presence and proximity for protection monitoring and service provision	<p>In the DRC, international organizations highlighted that local partners, community networks and volunteers served as the eyes and ears of the community on GBV. When the movement of international actors was restricted, local partners played an essential role in monitoring human rights violations.</p> <p>In Somalia as well, L/NNGOs and community groups were described during interviews as the ‘eyes and ears on the ground’, enabling protection work to continue. Some self-funded the purchase of PPE and activities to address the socio-economic impact of COVID-19.</p> <p>In Syria, community volunteers came to the fore during the COVID-19 response, undertaking protection activities and supporting vulnerable groups. CBOs working in hard-to-reach areas also continued to provide protection services to communities when restrictions prevented international humanitarian actors from travelling. The valuable community-based protection activities have continued, particularly in areas where international actors have limited access.</p>

233. In addition to evidence from the case study countries outlined above, there are documented examples of the increase in assistance provided by national and local humanitarian actors across a range of different contexts.³²⁶ While discussions on localization focus on NGOs, the COVID-19 response also highlighted how affected communities helped each other and the important role played by volunteers in helping their own communities.³²⁷
234. L/NNGO interviewees reported that, once COVID-19-related restrictions were lifted, the situation went back to how it was before, lamenting the fact that it did not result in a major change. Rather than representing a *'shift in power'* many of the changes were short-term in nature and the return to the previous status quo has been comparatively swift. Ultimately, the change in roles during COVID-19 was expedient and exploited L/NNGOs' greater risk tolerance and scope to move during lockdowns.

9.6 Strengthening local/national actor capacity

235. The case studies identified a few examples of how international actors tried to strengthen the capacity of L/NAs. In Colombia, there was an example of an INGO conducting workshops to share information on protection, GBV and access to justice with a variety of local people including hospital staff and community leaders. It considered that strengthening community leaders' capacities was a means of strengthening the quality of services. In Bangladesh, United Nations agencies focused capacity-strengthening efforts on government entities in Cox's Bazar, which was much appreciated.
236. COVID-19 restrictions also posed additional challenges, with planned training having to be conducted online. There were numerous examples given of agencies and clusters offering web-based training, some of which were very innovative and proved extremely beneficial, but they were also challenging to deliver successfully. There are also challenges in understanding how effective online training is. Apart from remote training activities, capacity-strengthening initiatives were de-prioritized with interviews revealing a generally held view that the COVID-19 response was not the time to strengthen capacity as the focus should be on delivery.

³²⁶ <https://covid19-tracking-local-humanitarian-action.odi.digital/>; Wijewickrama, E., N. Rose and T. Tun (2020) Two Steps Forward, One Step Back: Assessing the implications of COVID-19 on locally-led humanitarian response in Myanmar, Myanmar Development Network, Trocaire, IrishAid and Humanitarian Advisory Group; Australian Red Cross (2020) Local response in a global pandemic: a case study of the Red Cross response to Tropical Cyclone Harold during COVID-19 in Vanuatu and Fiji, November 2020; Ullah, Z., S. Ullah Khan, and E. Wijewickrama (2021) COVID-19: Implications for Localisation. A case study of Afghanistan and Pakistan. HPG working paper, ODI.

³²⁷ UN Volunteers (2021) Coordinating Humanitarian Response in the COVID-19 context: <https://www.unv.org/Success-stories/coordinating-humanitarian-response-covid-19-context>; UNICEF (2021) Young Volunteers Help Protect the Community from COVID-19: <https://www.unicef.org/kosovoprogramme/stories/young-volunteers-help-protect-community-covid-19>.

10 Operational coherence and complementarity

Summary findings

- There was considerable evidence from the case studies of international actors working with governments on the development of response plans and aligning with national priorities (section 10.1).
- In some case study contexts, efforts to work across the nexus had started before the pandemic. There were a couple of positive examples of progress on the nexus during the COVID-19 response but there were also several barriers to operationalizing the nexus. These included a lack of funding for development activities, an adverse policy environment and a lack of coordination mechanisms (section 10.2).
- Despite recognition of the need for a holistic response to COVID-19, the evidence shows that COVID-19 did not significantly change existing levels of collaboration and coordination between humanitarian, development and peace actors and there were no new nexus approaches in case study countries as a result of COVID-19. This may be a consequence of structural barriers which will re-quire a fundamental shift in the aid architecture and incentives to overcome (section 10.2.1).
- Under the peace component of the COVID-19 response, there was a limited response to the Secretary General’s call for a global ceasefire and evidence suggests that there was no significant change in levels of violence (section 10.2.2).

237. As outlined in section 3 of this report, the frameworks developed to guide the international COVID-19 response recognized the intertwined impacts of the pandemic at an early stage and emphasized the need for coherence across the health, humanitarian and development response. The Secretary General’s call for a global ceasefire also highlighted the peace dimension. This section presents findings on the extent to which international humanitarian actors aligned their response with national priorities and also the extent to which humanitarian, development and peace actors collaborated in their responses to COVID-19.

10.1 Alignment of humanitarian plans and response with national priorities

238. Despite the challenges posed by the lack of time for adequate engagement with all the stakeholders working on the COVID-19 response at country level, the evaluation gathered significant evidence across the case studies of the complementarity between international and national response planning (see Table 10 below).

Table 10: Alignment of humanitarian plans with national priorities in the country case studies

Context	Humanitarian plans/activities aligning with/complementing national priorities
Bangladesh	The COVID-19 addendum to the JRP ³²⁸ was aligned explicitly with the strategy and response pillars of the Bangladesh Country Preparedness and Response Plan (adapted from the SPRP). It outlined the health sector as well as multi-sectoral activities under the response pillars.
Colombia	There was close alignment between the United Nations' position and the government's strategic goals for the public health response. However, it took time to cement UN-government coordination and operational processes.
DRC	Plans developed by the United Nations and partners for the COVID-19 response ³²⁹ generally aligned with the national government's plan. ³³⁰ However, the government plan was focused predominantly on the health response so both the revised HRP and the SERP took a broader approach.
North-West Syria	There is no official government in North-West Syria but rather de facto governments so there was no one structure to take responsibility for the COVID-19 response. In the absence of other actors, WHO stepped in to provide leadership on norms, standards, guidelines and the development of a response plan. It also set up and chaired the COVID-19 Task Force.
Philippines	The overall goal of the HRP was to assist national and local government to contain the spread of COVID-19. There were also efforts to examine how the HRP could complement the government's response by filling critical gaps. The United Nations Country Team (UNCT) reviewed and updated the UN-Philippines Partnership for Sustainable Development 2019-2023 to ensure that it was aligned with the updated Philippines Development Plan. This was published as the Socio-Economic and Peacebuilding Framework for COVID-19 Recovery. ³³¹
Sierra Leone	The United Nations SERP was launched in October 2020, several months after the government's plans, but it was completely aligned with the Quick Action Economic Response Plan. It sought to complement the government's response by focusing on vulnerable groups, including women and Persons with Disabilities, that were not visibly prioritized in the Response Plan. There were questions raised about whether the United Nations could have done more to influence the government's plans to ensure the inclusion of vulnerable groups rather than seeking to supplement them.
Somalia	There was broad alignment between the re-prioritized HRP and the federal government's response plans [with the Ministry of Humanitarian Affairs and Disaster Management providing positive feedback on both the degree of alignment and engagement with the United Nations system]. However, the federal government and the MoH, in particular, had very limited response capacity. In addition, the government was in a state of political paralysis at the time. These factors limited the extent to which humanitarian actors could engage with the government.
Syria	WHO and the MoH jointly developed a national response plan, which was completed in early March 2020. In the same month, the RC/HC and UNCT members met with the MoH and other ministries to discuss the establishment of a Government of Syria-United Nations technical working group to ensure a coordinated approach to United Nations support of the government's response to COVID-19. The MoH looked to the United Nations for guidance and technical help with different aspects of the response from planning to the procurement of medical equipment.
Turkey	As described earlier in this report, the Turkish government led and responded to the main aspects of the COVID-19 response so there was a limited role for international actors. However, the COVID-19 appeal as part of the 3RP mentions that activities will be aligned with the government's response framework. ³³²

³²⁸ ISCG (2020) 2020 COVID-19 Response Plan, Addendum to the Joint Response Plan 2020, Rohingya Humanitarian Crisis, April - December 2020.

³²⁹ OCHA (2020) Plan de Réponse Humanitaire 2020 RDC Révisé, Juin 2020.

³³⁰ Gouvernement RDC (2020) Programme multisectoriel d'urgence d'atténuation des effets du Covid-19 en République démocratique du Congo.

³³¹ RCO (2020) UN Socioeconomic and Peacebuilding Framework for COVID-19 Recovery in the Philippines 2020-2023, Published by the Resident Coordinator's Office.

³³² UNHCR and UNDP (2020) 3RP Regional Refugee and Resilience Plan: 3RP Partner Support to Turkey's Response to COVID-19.

239. As Table 10 shows, the case study countries provided ample evidence of United Nations agencies, particularly WHO, working with governments on the development of response plans. RC/HCs, United Nations agencies and INGOs also engaged with governments through a variety of mechanisms, such as clusters/sectors as well as bilaterally. In instances where there was a lack of established mechanisms for structured coordination within the government, such as in Turkey, the evaluation found examples of United Nations agencies working closely with municipalities or local government to provide assistance.

10.2 Coherence and complementarity in the COVID-19 response

240. Efforts were underway to work across the humanitarian-development-peace nexus before the pandemic in some of the case study countries, including Colombia, DRC and Somalia (see Table 11).³³³

Table 11: Pre-pandemic efforts to work coherently across the nexus in case study countries

Case study country	Progress made towards working across the nexus
Colombia	There are three strategies for responding to needs arising from armed conflict and violence from illegal activities, forced displacement, the Venezuelan refugee crisis, and extreme poverty. During the COVID-19 response, interviewees reported integration between the health and humanitarian aspects of the response. They cited the MoH's co-leadership of the health cluster as an enabling factor.
DRC	Humanitarian, development and peace actors are all operating in the DRC to respond to needs arising from protracted armed conflict, disease outbreaks, chronic under-development and political instability. Discussions to improve coherence across different funding flows and actors started in 2018. Based on a shared risk and vulnerability analysis, key stakeholders agreed on four collective outcomes in October 2019 and are piloting the nexus approach in Greater Kasai and Tanganyika Provinces but the case study found that this had been disrupted by COVID-19.
Somalia	The 2016-17 drought response saw the development of good practices under the leadership of the DSRSG/RC/HC, including the development of collective outcomes. ³³⁴ In August 2020, the United Nations established the Taskforce on the Operationalization of the Nexus since both the HCT and the UNCT had committed to delivering on the nexus in Somalia. Also, there was an opportunity to capitalize on the alignment of the planning processes for the United Nations Cooperation Framework and the HPC. ³³⁵ The collective outcomes were revised in 2020 and included in both the HRP and the UNSDCF 2021-2025. Also in 2020, the government established a new Somalia Aid Architecture and the Prime Minister approved the establishment of a high-level Triple Nexus Steering Committee led by the DSRSG/RC/HC.

241. The evaluation identified only a few examples of progress on the nexus during the COVID-19 response. Notwithstanding a political impasse in Somalia (see Table 12), work on linking humanitarian cash programming with social safety nets was accelerated during the pandemic, an example being the EU 'SAGAL' social protection programme targeting elderly people at risk of COVID-19. In Bangladesh, the 2020 JRP had leveraged grant contributions from the World Bank and Asian Development Bank for Rohingya refugees as part of the New Way of Working.³³⁶ During the COVID-19 response, the World Bank pivoted its support to health services and was able to reprogramme \$35 million of its funding and finance a range of activities from setting up a laboratory to supporting ambulance services and SARI ITCs, funding medical supply procurement and supporting community awareness raising.

³³³ IASC Results Group 4 (2021) Mapping Good Practice in the Implementation of Humanitarian-Development-Peace Nexus Approaches: Synthesis Report, September 2021.

³³⁴ IASC Results Group 4 (2021) Country Brief on the Humanitarian-Development- Peace Nexus: Somalia

³³⁵ Somalia HCT (2020) Discussion Paper: The Humanitarian - Development - Peace Nexus: A Framework for Somalia, September 2020.

³³⁶ ISCG (2020) 2020 Joint Response Plan, Rohingya Humanitarian Crisis, January - December 2020.

10.3 Challenges encountered in facilitating work across the nexus

242. Despite groundwork being laid to facilitate collaboration across the nexus in some of the case study countries, there were several challenges with operationalizing these during the COVID-19 response, such as a lack of funding for development activities, an adverse policy environment in some countries and a lack of mechanisms for coordination between different sets of actors (see Table 12).

Table 12: Challenges faced by case study countries in working across the nexus in the COVID-19 response

Challenges encountered	Examples from the country case studies
Overlapping COVID-19 response frameworks	Colombia: There was an overlap between the HRP and the SERP, which resulted in a lack of clarity about how to distinguish between interventions under the two plans. An example that was given was of cash transfers to households affected by COVID-19 or capacity-building to local authorities which could be reported under either plan.
Inadequate funding	DRC: Although there is a Nexus Donor Group, development funding is not available at scale so COVID-19 activities were supported mainly with humanitarian funding, despite clear evidence of longer-term impacts on already poor and under-served populations. The case study highlighted the need for development and dual-mandated organizations to do more to communicate the longer-term implications of shocks such as COVID-19 to development donors to obtain the funds they need to operationalize the nexus. Somalia: Despite the progress in planning and the establishment of coordination structures in Somalia, implementation has been a challenge, at least partly due to the lack of availability of development funding for key areas like basic services as well as the slow disbursement of development funding. ³³⁷
Political instability	Somalia: The implementation of development activities in support of the COVID-19 response was particularly challenging because of the political impasse so humanitarian actors and funding were predominant.
Adverse policy environment	Syria: There are sanctions against the Syrian government and a donor policy of not providing bilateral development funding. Some donors, like Germany and Sweden, fund partners from development budget lines but are strict about ensuring that it does not benefit the government in any way. Despite this, long-term assistance is needed now more than ever because COVID-19 has compounded the economic crisis and increased needs considerably. The absence of development funding leaves humanitarian actors to address the growing needs and vulnerability. Bangladesh: The government's policy is that Rohingya refugees should only benefit from humanitarian assistance, not long-term development activities because its objective is to repatriate the refugees as soon as conditions permit. Therefore, skills and livelihood activities, for example, must have the aim of equipping refugees to sustain themselves on their return to Myanmar.
Lack of coordination mechanisms	Colombia: An interviewee noted that <i>'We talk about the nexus a lot but there are no mechanisms to work together in practice'</i> . DRC: Despite work on the triple nexus described above, there were problems with coordination and dialogue between humanitarian, development and peace actors (even though coordination mechanisms existed for each pillar at least at the national level). ³³⁸

243. While the case study analysis identified difficulties that are external to the humanitarian and development communities, such as adverse policy environments and political instability, two particular issues have been long-term challenges to working in the nexus. These are outlined and discussed below.

³³⁷ IASC Results Group 4 (2021) Country Brief on the Humanitarian-Development- Peace Nexus: Somalia.

³³⁸ IASC Results Group 4 (2021) Country Brief on the Humanitarian-Development- Peace Nexus: Democratic Republic of the Congo.

Challenges in obtaining adequate funding for the socio-economic response

244. In some contexts, despite the development of SERPs and growing acknowledgment of the deprivations suffered as a consequence of the secondary impacts of the pandemic, interviewees highlighted a tendency to focus on the immediate health and humanitarian response. One reason is that there was limited funding for the socio-economic response, at least initially. A study identified that development funding for COVID-19 from international financial institutions was committed and disbursed faster than in previous crises. However, if budget support is taken out of the equation, only 13 percent of funding was disbursed within the first four months of COVID-19. By contrast, 33 percent of the humanitarian funding provided through the United Nations was disbursed within the first four months.³³⁹
245. When funding was made available for the socio-economic response, budgets were often modest in size; in Turkey, United Nations agencies had an opportunity to apply for funding from the COVID-19 Response and Recovery Fund in late August 2020. They developed detailed concept notes for three programmes and the UNCT decided to put forward one to the Fund, with two others as ‘*pipeline*’ programmes if more funding was available. Ultimately, only one programme with a budget of \$1 million received support, possibly because the Fund was only able to mobilize a modest \$86 million in total.³⁴⁰
246. Interviewees also highlighted the risk of focusing available funding on short-term COVID-19 health needs at the expense of other health needs, such as routine immunization, or longer-term needs, such as mental health. At the time that the Somalia case study was undertaken, there was widespread concern about the significant challenge of addressing the break in routine immunization which had occurred across the country during the pandemic which is a stark reminder of the long-term challenges that lay ahead.

Challenges in the coordination of humanitarian and development actors

247. Links between humanitarian and development actors on the socio-economic response were problematic due to a lack of coordination mechanisms.³⁴¹ In the case study countries, there was frequently close collaboration between the health and humanitarian response, facilitated through the HCT (with WHO sharing information regularly) and existing inter-cluster coordination groups that brought together the health and other clusters. However, a similar forum for humanitarian and development actors rarely existed. Turkey offered one of the few positive examples of coordination across the nexus, largely as a consequence of UNHCR and UNDP co-leading the 3RP and collaborating closely, which made it easier to coordinate and collaborate on the inclusion of 3RP COVID-19 activities in the socio-economic response offer and avoid duplication.
248. Despite the COVID-19 response frameworks recognizing the need for a holistic response to the pandemic’s intertwined impacts, the response did not change the level of coordination and collaboration between humanitarian, development and peace actors. Where the nexus approach was being implemented pre-COVID-19, this continued, and there was no evidence of new nexus approaches in other case study contexts as a result of COVID-19. One potential reason for this is that the barriers to progress on the nexus are structural³⁴² and the response to COVID-19 was unable to achieve a breakthrough in addressing these. It has also been argued that the problem with implementing the triple nexus is not the lack of linkages between the three ‘*siloes*’ in international crisis response but the existence of the siloes in the first place,

³³⁹ Yang, Y., D. Patel, R. V. Hill and M. Plichta (2021) *Funding COVID-19 Response: Tracking Global Humanitarian and Development Funding to Meet Crisis Needs*, Centre for Disaster Protection Working Paper 5, April 2021.

³⁴⁰ <https://mptf.undp.org/fund/cov00>.

³⁴¹ At a meeting of IASC Principals on 27 July 2020, it was reported that 42 countries had developed SERPs but humanitarian actors had only engaged in 13 of these.

³⁴² A background document for a joint HCT-UNCT discussion of the nexus in Somalia identifies a set of ‘*bottlenecks*’ to progress, all of which are structural or systemic. See United Nations Somalia (2020) *Nexus Discussion*, HCT-UNCT Meeting, 28 July 2020.

given the multi-dimensional nature of crises.³⁴³ Overcoming this will require a fundamental shift in the underlying architecture and incentive structures in the aid system.³⁴⁴

10.4 The Global Ceasefire

249. The response to COVID-19 had a specific peace component beyond the ongoing nexus approaches; this was the Secretary General's call for a global ceasefire on 23 March 2020.³⁴⁵ The United Nations socio-economic response framework referred to the call and included an indicator on ceasefire agreements as part of monitoring the human rights implications of COVID-19. The document on the United Nations' comprehensive response to COVID-19 also included a section on a global ceasefire, with the steps being taken at global and country level. However, the evidence suggests that *'the call for a global ceasefire has largely fallen on deaf ears'*.³⁴⁶
250. Non-state armed groups in only 10 countries were reported to have *'welcomed'* the call, declaring a unilateral ceasefire or establishing a mutual ceasefire agreement. But even in these cases, progress was limited or short-lived. For example, in the Philippines, unilateral ceasefires declared by the government and the New People's Army in March 2020 did not reduce violence significantly.³⁴⁷ In Colombia, the National Liberation Army declared that it would start a month-long ceasefire from 1 April 2020 but the government did not reciprocate.
251. In some contexts, armed groups were quick to capitalize on measures to prevent the spread of COVID-19.³⁴⁸ Interviewees in Colombia noted that armed groups took advantage of the reduction in humanitarian assistance and public services in conflict-affected parts of the country to consolidate their territorial gains. More positively, a CERF allocation disbursed in November 2020 was helpful in responding to the worsening conflict dynamics in Choco and Nariño (as well as COVID-19 in neglected parts of the country) and enhanced community protection mechanisms had saved hundreds of children from forced recruitment.
252. In some countries, there were positive statements in response to the call but no commitment to action and, in others, there was an increase in rates of organized violence.³⁴⁹ For example, in Somalia, Al Shabaab launched daily attacks in May 2020, which hampered the humanitarian response to COVID-19. Overall, it was estimated that the armed group increased its activity by 33 percent compared with 2019.³⁵⁰ Studies have shown that in contexts like Afghanistan and Syria, where there was a marked decline in armed conflict in the weeks after the pandemic declaration, this was due to factors unrelated to COVID-19.³⁵¹ The evidence from research in addition to case study data suggests that COVID-19 and the Secretary General's call for a global ceasefire did not result in any significant change in global levels of violence.

³⁴³ <https://www.thenewhumanitarian.org/opinion/2020/1/7/triple-nexus-international-aid-Marc-DuBois>.

³⁴⁴ <https://www.thenewhumanitarian.org/opinion/2020/1/7/triple-nexus-international-aid-Marc-DuBois>; <https://odi.org/en/publications/constructive-deconstruction-making-sense-of-the-international-humanitarian-system/>.

³⁴⁵ <https://www.un.org/en/un-coronavirus-communications-team/fury-virus-illustrates-folly-war>.

³⁴⁶ <https://acleddata.com/2020/05/13/call-unanswered-un-appeal/>; Rustad, S. A., F. Methi, H.M. Nygård and G. Clayton (2020) *The Strategic Use of Ceasefires in the Coronavirus Crisis*, Peace Research Institute Oslo (PRIO) and Centre for Security Studies, ETH Zürich.

³⁴⁷ Kishi, R. (2021) *A Year of COVID-19: The Pandemic's Impact on Global Conflict and Demonstration Trends*, The Armed Conflict Location and Event Data Project (ACLED), April 2021.

³⁴⁸ Mustasilta, K. (2020) *From Bad to Worse? The impact(s) of COVID-19 on conflict dynamics*, European Union Institute for Security Studies, Conflict Series Brief 13, June 2020.

³⁴⁹ <https://acleddata.com/2020/05/13/call-unanswered-un-appeal/>.

³⁵⁰ Kishi, R. (2021) *A Year of COVID-19: The Pandemic's Impact on Global Conflict and Demonstration Trends*, The Armed Conflict Location and Event Data Project (ACLED), April 2021.

³⁵¹ <https://acleddata.com/2020/08/04/a-great-and-sudden-change-the-global-political-violence-landscape-before-and-after-the-covid-19-pandemic/>.

11 Monitoring and reporting of collective results

Summary findings

- The GHRP monitoring framework was the first of its kind for a global humanitarian plan and offered important potential for tracking collective results across the system. However, there were challenges in implementation which included the focus on individual agency (particularly UN) rather than cluster-wide results, weaknesses in the selection of indicators and targets, and the use of different methodologies to report against the same indicator across contexts. As a result, there was a lack of quality monitoring data and limited qualitative information at the outcome level (section 11.1).
- A broader challenge is that humanitarian reporting tends to prioritize donor needs for quantitative results, even if these are not meaningful for understanding how the affected population benefited, particularly when they are aggregated at the global level. This has led to a lack of understanding of the extent to which assistance has met the identified needs (section 11.1).
- Notwithstanding the limitations of the data, an analysis across the GHRP's three Strategic Priorities shows the extent of what was achieved during the COVID-19 response in 2020. Targets for support to contain the pandemic and reduce morbidity and mortality (Strategic Priority 1) were largely met and many of those that focused on the provision of essential services (Strategic Priority 2) were similarly achieved. Incomplete reporting against Strategic Priority 3 makes it harder to assess achievements but persons of concern received significant support and services (section 11.2).
- In 2021, the COVID-19 response was integrated into broader humanitarian response planning, which was justified, but the lack of a global COVID-19 monitoring mechanism and corresponding results report (as well as a lack of COVID-19-specific reporting at country level) means that this evaluation cannot assess the extent to which the collective COVID-19 response met the needs of affected people in 2021 (section 11.4).
- Many previous IAHEs have identified similar limitations in humanitarian results reporting, particularly the lack of attention paid to outcome measurement (section 11.5).

253. The GHRP included an integrated monitoring framework to provide '*systematic and frequent*'³⁵² information on changes in the humanitarian system and needs emanating from the pandemic. During the lifespan of the GHRP, five progress reports were published, the final one being produced in February 2021.³⁵³ The COVID-19 response was integrated into '*regular*' country-level HNOs and inter-agency coordinated plans from 2021 onwards. This section examines how the results of the COVID-19 response were monitored and what reports reveal about what it achieved.

11.1 GHRP results monitoring for 2020

254. The GHRP offered the first example of a monitoring framework for a global humanitarian plan. Annual GHOs have not previously included common, global aggregated indicators beyond estimates of PiN and people targeted by HRPs. The GHRP monitoring framework was, therefore, an important advance in tracking collective results across the system and has generated significant learning.

³⁵² United Nations (2020) Global Humanitarian Response Plan COVID-19. United Nations Coordinated Appeal, April – December 2020.

³⁵³ A short update was released in May 2020. This was followed by five progress reports which included qualitative and quantitative analyses against the three strategic priorities and a funding update. They were released in June, August, September, November 2020 and February 2021.

255. The first iteration of the GHRP in March 2020 included an initial set of indicators on situation and needs monitoring, as well as response monitoring. This was elaborated in subsequent iterations of the plan, based on inputs from participating agencies, producing a detailed set of indicators allocated to specific United Nations agencies to report back on.³⁵⁴ At the time, however, with a few notable exceptions,³⁵⁵ it was unclear whether agencies were tasked with reporting back on their own institutional results or whether reporting should reflect the collective results of all sector/cluster partners. Furthermore, in contexts without existing humanitarian sector or cluster coordination mechanisms, there was no obvious mechanism through which to gather and report on collective results of this kind. These challenges were further elaborated in the September GHRP Progress Report and have been reproduced in Box 17.

Box 17: Account, by the UN, of weaknesses associated with GHRP monitoring³⁵⁶

The first round of data collection and narrative reporting took place in June 2020, ahead of the GHRP July Update. However, a number of challenges quickly became evident: ongoing restrictions on mobility and travel limit the ability of humanitarian organizations to conduct field assessments; methodologies to report against the same indicator vary from country to country and between humanitarian organizations, so aggregation is difficult; most organizations only report on their own achievements and not on behalf of a group; and finally, the biggest challenge was the absence of humanitarian inter-agency coordination mechanisms, such as clusters or an OCHA country office in about half of the GHRP countries.

The monitoring framework does not measure the full scope of the collective response by all actors in all 63 countries. It is limited to reporting organizations and only in certain countries. Most of the reporters are United Nations agencies, though the response involves a plethora of organizations. In the absence of common methodologies to measure the same indicators, it is not possible to aggregate figures.

256. Despite the best efforts of OCHA’s monitoring team, which was brought in after the GHRP monitoring framework had already been elaborated, it was not possible to retroactively re-engineer the monitoring approach. Global clusters were hesitant to get involved and only a handful of INGOs submitted reporting on behalf of their own organizations. As a consequence, reporting on GHRP results in the July 2020 iteration of the plan and in subsequent GHRP progress updates can, for the most part, only be interpreted as partial reporting i.e., not reflecting the results of all participating organizations in all GHRP countries. Moreover, reporting generally relied on organizations sharing existing data from their own organizational monitoring systems, rather than a tailored set of data to report on progress against specific indicators within the GHRP.

257. Analysis of the GHRP progress reports by the evaluation team revealed a range of other limitations about the monitoring framework and reporting. These are organized in Table 13 below.³⁵⁷

³⁵⁴ The first iteration of the GHRP includes 13 indicators on situation and needs monitoring and 14 indicators on response monitoring. By June 2020, this had been expanded in a separate monitoring framework to accompany the GHRP containing 19 needs and situation monitoring indicators and 33 response indicators.

³⁵⁵ For example, the Child Protection Area of Responsibility is listed as the responsible entity for reporting on child protection needs and UNICEF (Nutrition Cluster) is the responsible entity for nutrition-related situation and needs monitoring.

³⁵⁶ United Nations (2020) Global Humanitarian Response Plan: COVID-19. Progress Report. Third Edition, 30 September 2020.

³⁵⁷ All of the figures used are from the February 2021 GHRP progress report.

Table 13: Critique of the GHRP monitoring

Issue	Description
Indicators	Interviewees were critical of specific GHRP indicators which proved overly subjective and thus hard to measure.
	There was limited attention given to cross-cutting issues. GBV was integrated into several of the indicators but this was not the case for disability or broader issues of inclusion. The results are not disaggregated by gender.
	While the GHRP included indicators for food security and reported over 108 million people in IPC 3, ³⁵⁸ there were no response indicators and no indication of the change in this figure at the end of the reporting period.
Targets	The initial targets were set based on global figures provided by United Nations agencies. While this was expedient given the urgency of the situation, it is not possible to determine how valid this was.
	Some of the targets changed with time, particularly as the GHRP shifted from a focus on global input from United Nations agencies to country-level input from RC/HCs. There is no accompanying narrative to justify or explain the changes. It is understood that some of the increases proposed at country-level were vetoed and that some of the targets were ‘capped’ by OCHA globally.
	Some targets were significantly over-achieved, while others were under-achieved. There is no explanation provided of the reason for the over-achievements, or implications for affected people where targets were not achieved.
Reporting	Overall, there was a heavy reliance on quantitative monitoring. As a result, in instances where significant inputs were missing from globally aggregated totals, reporting was misleading.
	The majority of reporting was undertaken by the United Nations agencies that developed the first iteration of the GHRP. Four INGOs reported their results.
	In the progress and achievements section of the report, no reference is made to local or national actors even though they delivered the majority of the front-line response. Named organizations are all international and are mostly United Nations agencies.

258. Key informants at the global level acknowledged the shortcomings of GHRP monitoring. They also raised an additional concern that reporting tended to prioritize donor needs for quantitative results despite these lacking meaning (particularly when they are aggregated at the global level) or being able to reveal how affected populations benefitted and whether the assistance provided was appropriate in meeting their needs. The lack of quality monitoring data and the limited availability of qualitative information at the outcome level is a finding that this evaluation shares with some other COVID-19 evaluations.³⁵⁹
259. The capacity that OCHA had to effectively monitor the GHRP also attracted comment during the evaluation, and specifically the limited level of resourcing that existed for this; it is noteworthy that significant investment has been made over time to strengthen the capacity of the humanitarian community to assess needs; however, this has not been partnered with a similar investment in monitoring results. As a consequence, there is a far better understanding of the needs of affected people than there is about the extent to which assistance has met those needs.

³⁵⁸ The IPC Acute Food Insecurity classification differentiates between different levels of severity of acute food insecurity, classifying units of analysis in five distinct phases: (1) Minimal/None, (2) Stressed, (3) Crisis, (4) Emergency, (5) Catastrophe/Famine. Each of these phases has important and distinct implications for where and how best to intervene, and therefore influences priority response objectives (<https://www.ipcinfo.org/ipcinfo-website/ipc-overview-and-classification-system/ipc-acute-food-insecurity-classification/en/>).

³⁵⁹ See, for example, IFRC (2022) Evaluation report: IFRC-wide response to the COVID-19 pandemic, March 2022; Evaluation Office of the Secretary General United Nations (2022) Interim Report: System-wide evaluation of the UNDS response to COVID-19. March 2022.

11.2 GHRP results reporting for 2020

260. Despite the flaws and limitations of the data, the progress reports that were prepared provide a snapshot of the assistance delivered to affected people during the world's first global humanitarian response. Results for each of the strategic priorities given in the final GHRP update are summarized in the three tables below alongside a short narrative.³⁶⁰

11.2.1 Strategic Priority 1: Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality³⁶¹

Table 14: Achievements against targets for Strategic Priority 1

Strategic Priority 1	Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality	No. of orgs 7 UN, 1 INGO	Target	Reporting by agencies with targets	Reporting by agencies with no targets
Ensure essential services and health systems	Number of passenger movement requests fulfilled	1	90%	97%	
	Number of cargo movement requests fulfilled	1	90%	97%	
	Number of hubs established for consolidation and onward dispatch of essential health and humanitarian supplies	1	8	8	
	Number of GHRP countries with multisectoral mental health and psychosocial support technical working groups	1	100%	83%	
	Number of caregivers of children less than 2 years old reached with messages on breastfeeding, young child feeding or healthy diets in the context of COVID-19 through national communication campaigns	1	15,225,034	17,190,093	
	Number of 3 plies/medical masks distributed against need (or request)	3	45,500,000	127,434,083	113,772,530
	Number and percentage of children and adults that have access to a safe and accessible channel to report SEA	1	20,042,480	15,855,097	
	Number of existing or newly established service points continuing to offer specialized services to victims of SEA during the COVID-19 pandemic	1	0	0	1,120 service points in 55 countries
	Number of health workers provided with PPE	3	1,408,349	1,520,801	422,719

³⁶⁰ There are a number of considerations to bear in mind when reading the achievements against targets for each of the SPs: (i) For the purpose of analysis, a household a household has been assumed to comprise 5 people; (ii) Where agencies reported in to the GHRP but were not included in the targets, their results have been reported separately in the last column of the table; (iii) Wherever possible, targets were aggregated, except when the target was 'number of countries' in which case the target number has been listed for each reporting organization; (iv) For targets with more than a single organization reporting, there is the potential for duplication between different organizations (or for all organizations if all 63 GHRP countries were targeted); (v) The final results given for SP3 were from September rather than the end of the year and hence they likely under-represent the achievements.

³⁶¹ United Nations (2020) Global Humanitarian Response Plan: COVID-19. Progress Report. Final Edition, 30 February 2021.

Learn, innovate and improve	Percentage of countries implementing sero-epidemiological investigations or studies	1	20%	16%	
Prepare and be ready	Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	1	60	60	
	Proportion of GHRP countries that have a national Infection Prevention and Control programme including water, sanitation and hygiene (WASH) standards and WASH basic services operational within all health-care facilities	1	100%	29%	
Prevent, suppress and interrupt transmission	Proportion of GHRP countries with a functional, multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	1	100%	98%	
	Number and proportion of countries with COVID-19 Risk Communication and Community Engagement Programming	1	60	59	
	Proportion of GHRP countries with COVID-19 national preparedness and response plan	1	100%	98%	

261. What the monitoring data confirms is that the first global humanitarian response was accompanied by a massive mobilization of assistance across the GHRP countries. The focus of this, in the first instance, was on containing the spread of the virus and on decreasing morbidity and mortality with an emphasis placed on the distribution of facemasks and RCCE to vulnerable communities and the distribution of PPE to health staff; the targets for each of these indicators were over-achieved.
262. The data also suggests that the humanitarian community was cognisant of and sought to respond to the risks that the pandemic presented to mental health, GBV and SEA. While the indicators and targets make it difficult to determine the effect of responses, there was significant support provided for the establishment of services, referral pathways and assistance.
263. The assistance that was provided to the government and local actors to strengthen preparedness and coordination largely met the targets that were set, except for the establishment of national prevention and control programmes, which were only achieved in one-third of the targeted countries.
264. The Common Services was considered to have achieved its objective in facilitating the IASC's collective humanitarian response through the transport of humanitarian workers and supplies. The targets associated with passenger numbers, volume of cargo delivered and the number of humanitarian hubs established were all either achieved or over-achieved.

11.2.2 Strategic Priority 2: Decrease the deterioration of human assets, rights, social cohesion and livelihoods³⁶²

Table 15: Achievements against targets for Strategic Priority 2

Strategic Priority 2	Decrease the deterioration of human assets, rights, social cohesion and livelihoods	No. of orgs 7 UN, 4 INGO	Target	Reporting by agencies with targets	Reporting by agencies with no targets
Preserve the ability of people most vulnerable to the pandemic to meet their basic needs	Number of people/households most vulnerable to/affected by COVID-19 who have received livelihood support, e.g., cash transfers, inputs and technical assistance	8	31,013,872	34,835,482	27,851,847
	Number of people/households most vulnerable to/affected by COVID-19 who benefit from increased or expanded social protection	5	109,990,000	53,740,778	2,558,780
Ensure the continuity of and safety from infection of essential services including health, water and sanitation, nutrition, shelter, protection and education for the population groups most exposed and vulnerable to the pandemic	Number of people (girls, boys, women, men) who are receiving essential health-care services	4	62,699,261	69,844,339	5,800,000
	Number of people reached with critical WASH supplies (including hygiene items) and services	6	93,672,706	101,559,440	3,469,524
	Number of children and youth supported with distance/home-based learning	3	179,536,631	129,854,484	3,469,524
	Number of children and youth in humanitarian and situations of protracted displacement enrolled in pre-primary, primary and secondary education levels	2	2,233,000	1,840,644	
	Number of people (including children, parents and primary caregivers) provided with mental health and psychosocial support services	4	21,006,744	23,544,504	625,523
	Number and proportion of countries in which minimum child protection services are operational during the COVID-19 crisis	1	60	58	
	Number of children 6-59 months admitted for treatment of severe acute malnutrition	2	7,335,186	3,047,741	
	Number of children 6-59 months admitted for treatment of moderate acute malnutrition	2	140,000	523,674	391,455
	Number of women and girls who have accessed sexual and reproductive service	3	710,000	1,180,000	18,251,831
	Number and proportion of countries where messages on gender-based violence risk and available gender-based violence services were disseminated in all targeted areas	2	56 countries 30 countries	48 countries 30 countries	

³⁶² United Nations (2020) Global Humanitarian Response Plan: COVID-19. Progress Report. Final Edition, 30 February 2021.

	Number and proportion of countries where GBV services are maintained or expanded in response to COVID-20	3	63 countries	63 countries	25 countries
	Number of people who have accessed protection services	6	12,375,147	16,525,227	6,089,769
Secure the continuity of the supply chain for essential commodities and services	Number and percentage of countries that requested consignments of reproductive health kits and other pharmaceuticals, medical devices and supplies to implement life-saving sexual reproduction and health services shipped since 1 March 2021	1	48 countries	47 consignments shipped	
			47 countries	44 consignments arrived	
			44 countries	Consignments to partners	

265. The IASC’s collective support in maintaining basic services was a secondary focus of the collective response, with analysis of the results suggesting that Strategic Priority 1 was prioritized for the first 6-9 months of the response. While there was a focus on cash and livelihood support through the GHRP, the target for which was over-achieved, the social protection target was just over 50 percent.
266. Strong results were achieved for the delivery of collective support and the continuity of essential services across all of the indicators, with targets for healthcare services, WASH, sexual and reproductive services all over-achieved. The targets for the promotion of distance learning were extremely high (179.5 million children and youth) and so it is, perhaps not surprising that these were not achieved, although the provision of services to 133 million learners is still significant.³⁶³ What these targets do not provide is an assessment of the quality of those services which interviews for this evaluation have suggested were variable.
267. The indicators focused significant attention on assisting particularly vulnerable people; The target for the provision of assistance to children presenting with Severe Acute Malnutrition was only partially met during the pandemic, although the target for assisting those with Moderate Acute Malnutrition was significantly over-achieved. The provision of GBV messages, services and the broader provision of protection services were broadly met or over-achieved. The target for the provision of life-saving assistance for sexual reproduction and health services was also met.

³⁶³ It should be borne in mind that the indicator focuses on quantity, rather than quality and the evidence strongly suggests that there were widespread limitations to online schooling.

11.2.3 Strategic Priority 3: Protect, assist and advocate for refugees, IDPs, migrants and host communities³⁶⁴

Table 16: Achievements against targets for Strategic Priority 3

Strategic Priority 3	Protect, assist and advocate for refugees, IDPs, migrants and host communities	No. of orgs 4 UN, 2 INGO	Target	Reporting by agencies with targets	Reporting by agencies with no targets
Advocate and ensure that people of concern receive COVID-19 assistance	Number of refugees, IDPs and migrants particularly vulnerable to the pandemic that receive COVID-19 assistance	4	104,465,770	75,325,620	7,629,480
Prevent, anticipate, and address risks of violence, discrimination, marginalization and xenophobia towards people of concern	Number and proportion of countries where areas inhabited by refugees, IDPs, migrants and host communities are reached by information campaigns about COVID-19 pandemic risks	5	60 countries	52 countries	
			54 countries	49 countries	
			58 countries	40 countries	
					6 countries
	Proportion of countries inhabited by IDPs, refugees and migrants with feedback and complaints mechanisms functioning	2	61	61	

268. In addition to other limitations outlined earlier in this section, it is noteworthy that for Strategic Priority 3, GHRP results were only reported up to September 2020 rather than to the end of the year. Despite this, the report shows that significant progress was made against all of the targets; although it represented a huge mobilization of support, the assistance target was 79 percent achieved. The targets for the provision of information about COVID-19 pandemic risks and the provision of functioning feedback and complaints mechanisms were both largely met. As was evident for both the other Strategic Priorities, reporting agencies placed significant emphasis on the provision of protection services, which included a specific focus on maintaining and expanding GBV services.

269. For a thorough assessment of the international response’s effectiveness in ensuring the protection of refugee rights during the pandemic, this evaluation recommends the study commissioned by the COVID-19 Global Evaluation Coalition and concluded in May 2022.³⁶⁵

11.3 Global results monitoring for 2021

270. For 2021, the COVID-19 response was integrated into broader humanitarian response planning in recognition that the pandemic’s health and non-health effects had now merged with the impacts of other shocks and stresses. As a consequence, COVID-19 analyses and responses were integrated into ‘regular’ HNOs and HRP as well as into inter-agency response plans. While it was considered that some pandemic-specific responses may still be necessary in certain contexts, in most cases COVID-19 was considered as one of the factors of various humanitarian needs, and programming reflected the combined effects with other shocks. This integration signalled the synchronization of COVID-19 and non-COVID-19 funding requirements and reporting under the regular HPC.

³⁶⁴ United Nations (2020) Global Humanitarian Response Plan: COVID-19. Progress Report. Final Edition, 30 February 2021.

³⁶⁵ COVID-19 Global Evaluation Coalition (2022) Joint Evaluation of the Protection of the Rights of Refugees During the COVID-19 Pandemic, May 2022.

271. This evaluation endorses the decision taken by the IASC to normalize the COVID-19 reporting, however, it did have important implications for the ability to assess what was achieved; from the end of 2020 there was no global reporting mechanism for COVID-19 results and at country-level, there was no means of disaggregating COVID-19 results from the results of ongoing humanitarian responses. This meant that it was no longer possible to isolate or analyze collective COVID-19 activities or outputs.
272. It is important to add that the lack of COVID-19 results is not in any way linked to a lack of capacity or willingness of country operations to report; in all of the case study countries, a review of 2021 appeal documents (HRP, RRP or 3RP) revealed COVID-19 was integrated as a cross-cutting issue, which is consistent with the guidance, and there continued to be a range of thematic reports and sitreps that sought to track the effects of the pandemic on vulnerable communities. The difference between 2020 and 2021 is that collective COVID-19-specific results were not routinely tracked.

11.4 Global results reporting for 2021

273. The lack of a global COVID-19 monitoring mechanism and corresponding results report means that this evaluation cannot assess the extent to which the collective COVID-19 response met the specific needs of affected people in 2021.
274. While the 2022 GHO provides a retrospective analysis of 2021 results into which COVID-19 responses were integrated, the report has been generated from inputs by United Nations agencies and a small number of clusters and so, as with 2020, it does not encapsulate the totality of the collective response. This fact and the fact that specific COVID-19 results were not monitored and reported mean that they are not relevant to this evaluation.
275. 11.5 The broader challenge presented by results reporting
276. A number of previous IAHEs have identified similar limitations in humanitarian results reporting; in its assessment of results, the 2015 South Sudan IAHE notes that not enough attention was paid to outcomes in response planning. As a result, response plan indicators were often weak and based on the ‘*number of people reached*’; generally, there was ‘*too much focus on outputs compared with outcomes*’ which provides an imperfect basis for determining whether programme and strategic objectives are being achieved.³⁶⁶ More recently, in 2019, the IAHE of the drought response in Ethiopia, came to a similar conclusion, reporting that ‘*The humanitarian community in Ethiopia is unable to track the collective effectiveness of its drought response due to a lack of outcome monitoring and sufficiently disaggregated information on outputs.*’³⁶⁷ Similarly, the IAHE of the Idai response in Mozambique noted ‘*the lack of a coherent framework to monitor humanitarian operations*’ which contributed to ‘*an emphasis on coverage, activity and output-based reporting*’.³⁶⁸
277. The obstacles encountered in South Sudan, Ethiopia and Mozambique described above are all relevant to the challenges faced during the COVID-19 response. While this evaluation recognizes the significant contribution to the COVID-19 response made by the collective members of the IASC and endorses the decision taken in 2021 to integrate COVID-19 with the broader humanitarian response at the country-level; however, the partiality of the 2020 results and the lack of COVID-19-specific indicators and results for 2021 and the lack of a country or global narrative on achievements means that it is not possible to offer a rigorous global analysis of its effectiveness in either year.

³⁶⁶ Valid International (2015) Report of the Inter-Agency Humanitarian Evaluation of the Response to the Crisis in South Sudan. November 2015.

³⁶⁷ GPPI (2019) Inter-Agency Humanitarian Evaluation of the Drought Response in Ethiopia, November 2019.

³⁶⁸ Baker, J. et al (2020) Inter-Agency Humanitarian Evaluation of the response to Cyclone Idai in Mozambique, July 2020.

12 Community perceptions of the COVID-19 response

Summary findings

- Many FGD participants understood how COVID-19-related assistance was targeted and felt that specific vulnerable groups were prioritized. Some expressed concerns that assistance was uneven and inconsistent and were not clear about the reasons for this, although there was an assumption that it was because of the large numbers of people requiring assistance. In two countries, there were claims that assistance had not reached those that were most vulnerable; in one of these, communities themselves redistributed it to address the problems they perceived (section 12.2.).
- Community perceptions about the timeliness of assistance were mixed; with the exception of two contexts, FGD participants said that assistance to contain the spread of the COVID-19 pandemic (GHRP Strategic Priority 1) was significantly delayed. As a result, people either tried to make do without support or felt compelled to ignore movement restrictions to seek out the assistance they required (section 12.3.).
- Communities across the case studies described how the aid they received was often focused on reducing the transmission of the virus (facemasks, soap and awareness raising). There were fewer efforts to address their broader needs to decrease the deterioration of human assets and support social cohesion and livelihoods (GHRP Strategic Priority 2). Livelihood assistance was perceived as the most relevant support that was provided and particularly cash assistance which was one of the highest priorities of affected people. This was because it offered them the greatest flexibility to prioritize their own needs (section 12.4.).
- Specific vulnerable groups, such as GBV survivors, older people and persons with disabilities reported mixed experiences with the assistance they received, particularly due to the shift from in-person services to the use of remote methodologies (section 12.5.).
- Across the case study countries, communities affected by COVID-19 were grateful for the assistance that was provided, but they stressed that it had been insufficient and had made only a modest contribution to meeting essential needs (section 12.5.).

278. In the context of the COVID-19 response, where there were significant limitations in the monitoring and reporting of results, the evaluation prioritized the collection and analysis of community feedback on the response. In each of the eight case studies, structured discussions were undertaken with affected communities in areas worst affected by COVID-19 on issues of timeliness, relevance, and effectiveness of the assistance they received during the response. Issues of targeting and access to feedback and complaints were also examined.
279. This section of the report provides a summary of the results of these discussions with affected people. These data have been complemented by other community survey work and perceptions reports where they were available and offered relevant findings.

12.1 Getting beyond the numbers – the importance of community feedback

280. The engagement of communities throughout the Humanitarian Programme Cycle - including during monitoring and evaluation - is considered essential practice and has gained greater prominence in humanitarian practice since the Grand Bargain.³⁶⁹ The challenges of achieving this important aspiration have been a fairly consistent feature of IAHEs, as exemplified by the IAHE of the Ethiopia drought, which recommended that *‘an in-person survey of affected people in a sample of locations [should be conducted] at least once per year*³⁷⁰ to supplement agency results with community feedback.
281. While the results of the community discussions cannot replace a review of monitoring and reporting of results, as they are themselves limited in their scope and scale, they do complement them and provide a *‘human face’* to the analysis of what was achieved by the COVID-19 response. Importantly, they permit testimony from affected people themselves of the extent to which the collective response met their priority needs.

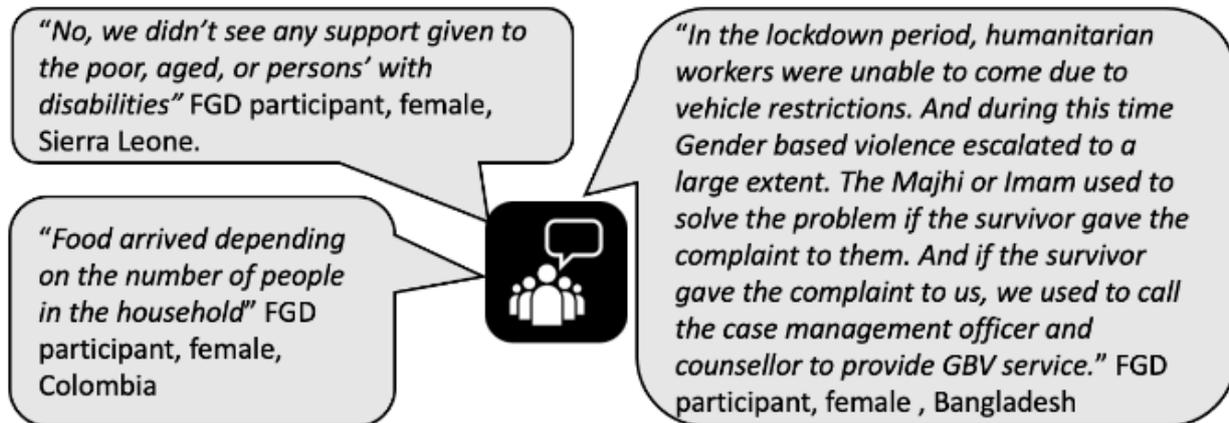
12.2 Targeting

282. In the majority of case study countries, communities had some understanding of the basis on which decisions were made about the targeting of assistance (see Figure 21). In several countries, the affected communities confirmed that specific vulnerable groups were prioritized (the poor, the elderly, pregnant women, persons with disabilities and widows). Some noted that those who had a job or access to money were least likely to be selected for aid, although there was some concern that government-provided assistance was not always targeted at the poorest community members. In Somalia, there was a particularly good understanding of targeting and broad agreement on community members that had been prioritized by NGOs during the COVID-19 response.
283. Frequent concerns were raised during FGDs with the evaluation team that assistance was uneven and inconsistent and that it was not always made clear to recipients why this was the case – although there was a general perception that it was likely due to the large number of people that required support. In North-west Syria, a very small number of children in a single community had received a tablet so they could study remotely, some others had received stationery kits, and some had received no education supplies; FGD participants did not understand the basis on which the children had been selected for the different interventions. In the IDP camps in Kismayo in Somalia, a similar pattern emerged with some camps faring better than others; while some were well-served, in others, FGD participants claimed that they had received no assistance at all. In Somalia, aid was welcomed by FGD respondents when it arrived but sorely missed when distributions were over or when camps failed to receive assistance.
284. In Syria, concerns were expressed by female members of the community about vulnerable people who missed out on receiving assistance; included in this group were affected people who did not understand how to register for assistance from NGOs, those that lived in remote areas, and those that did not have access to the internet. It was felt that more could be done to ensure that the most vulnerable received aid.

³⁶⁹ See, for example <https://interagencystandingcommittee.org/a-participation-revolution-include-people-receiving-aid-in-making-the-decisions-which-affect-their-lives>.

³⁷⁰ The IAHE recommended that *‘The survey should cover what assistance individuals received and when; how satisfied they were with the different aspects of the response; and how well informed they were about the response. An analysis, disaggregated for different relevant groups should be presented to humanitarian coordination fora and relevant government bodies at federal and regional level. These bodies should agree on actions that will be taken to address concerns raised in the surveys.’* See GPPI (2019) Inter-Agency Humanitarian Evaluation of the Drought Response in Ethiopia, November 2019.

Figure 21: Community perceptions of the targeting of COVID-19 assistance

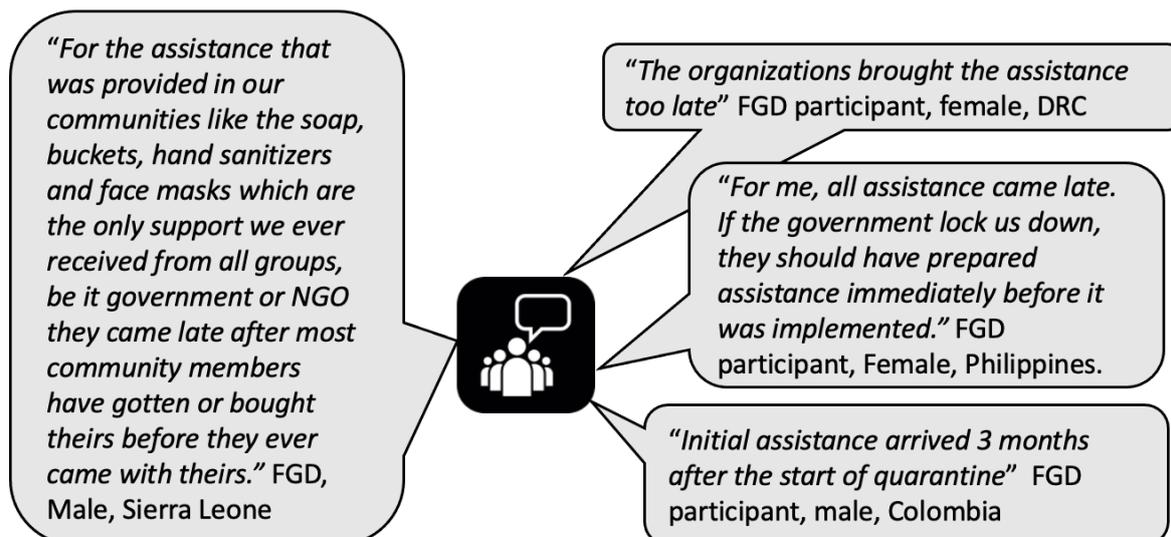


285. In one of the case study countries, aid was considered inequitable and community mechanisms were used to redistribute it; in the Philippines, communities repacked and redistributed aid according to their own perceptions of need, to ensure it was fairly distributed and that it responded to the specific needs of vulnerable groups. Efforts were taken by the community to ensure that the most vulnerable community members such as elderly persons or persons with disabilities received adequate assistance.

12.3 Timeliness

286. Data on timeliness was mixed across communities, however, there were widespread views among FGD participants that assistance to contain the spread of the COVID-19 pandemic (GHRP Strategic Priority 1) was significantly delayed (see Figure 22). It was only some communities in North-west Syria and Somalia that viewed the initial provision of hygiene items they received as timely. These items were considered important in Somalia due to the widespread fear that existed about COVID-19, but also because people were being fined by the police for not wearing masks.

Figure 22: Community perceptions of the timeliness of COVID-19 assistance



287. In Bangladesh, DRC, Syria, Somalia and Colombia FGD participants claimed there were significant delays in the assistance that they received, which in some cases took several months to arrive. In Sierra Leone, the little assistance that was received from NGOs or the government was considered to have arrived late, with communities claiming that it was their own members that mobilized in a timely manner to respond to their own immediate needs to contain the transmission of the virus. In Syria, there was a widely held view that aid had been slow to arrive (particularly medical assistance) although some items, like face masks were considered to have been timelier. In Colombia, communities felt the initial arrival of aid was timely, but distributions were inconsistent and did not respond to the changing needs of the population.
288. When communities did not receive assistance in time, they either tried to make do without support or felt compelled to ignore lockdown rules to seek out the assistance they needed. This was the case in Somalia, Sierra Leone and Colombia where members of affected communities considered it that was necessary to break government-imposed lockdowns to find food, employment, or to obtain the means to protect themselves from the virus.

12.4 Relevance

289. Overall, communities considered that the aid they received across the case study countries across contexts was focused on reducing the transmission of the virus (face masks, soap and awareness raising), but did little to address the broader needs of communities to decrease the deterioration of human assets, social cohesion and livelihoods (GHRP Strategic Priority 2) (see Figure 23).

Figure 23: Community perceptions of the relevance of COVID-19 assistance



290. Community research undertaken by Ground Truth Solutions soon after the onset of the pandemic in Somalia showed that cash transfers either decreased or stopped entirely for 80 percent of respondents³⁷¹ which had a significant effect on livelihoods, and yet in Somalia community members said that the aid they received focused on soap and face masks; these items were welcome, but the results of the FGDs showed that participants received little assistance to address their broader needs for income, food or shelter. Similar feedback was received from affected people in other case study countries; FGDs revealed that the main type of assistance received by communities in North-west Syria was awareness campaigns and some limited hygiene items. In DRC and Sierra Leone, the items that FGD participants received during the two years of the response included masks, plastic buckets, soap, plastic boots and some food items.

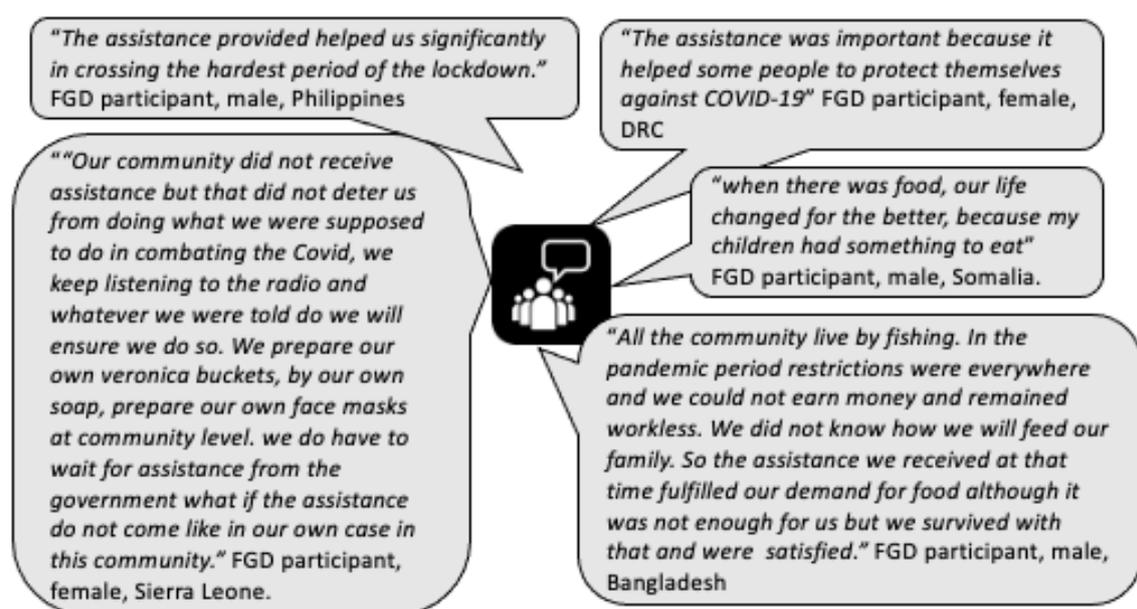
³⁷¹ Ground Truth Solutions (2021) *Perception survey of aid recipients in Somalia*, December 2021.

291. The overwhelming response from the FGDs was that they received very little livelihood support. A minority of FGD participants, however, referred to these broader needs being met. In DRC, some affected people spoke of having received cash assistance; in Bangladesh host communities received cash, in-kind food assistance in addition to hygiene items. A number of FGD participants received agricultural inputs and those with children reported that they had received school supplies. Refugees continued to receive food assistance and hygiene items as well as medical services as efforts were made in the camps to maintain a basic level of services in line GHRP Strategic Priority three. In Turkey, refugee participants received Emergency Social Safety Net support but it was reported by some as being insufficient to cover their needs.
292. In an FGD in a Rohingya refugee camp that included several persons with disabilities, participants raised concerns about the challenges they faced with the assistance they received which did not take into account their specific needs. One member was concerned that when aid was provided, he was unable to access it as there was no special service for him to reach the distribution point.
293. Evidence suggests that cash assistance – provided under GHRP Strategic Priority 2- was one of the highest priorities amongst communities affected by COVID-19. It was also perceived to offer the greatest flexibility as it allowed affected people to prioritize their own needs. In Sierra Leone, Philippines and Somalia several of the focus group members expressed a strong preference for cash and food which were in short supply. Where there were other needs, the feedback during FGDs suggested that these were rarely met. In Colombia, education, mental health, reproductive health and transportation were only addressed through isolated humanitarian responses, despite the population identifying these areas as their priority needs.

12.5 Effectiveness

294. A significant number of FGD participants across the case study countries claimed that the aid provided was not adequate to meet requirements and there were many examples given of communities across contexts supporting each other to fill gaps in the assistance they received (see Figure 24). Across all of the countries, vulnerable people affected by COVID-19 were grateful for the assistance that was provided, but they stressed that it had been insufficient and had made only a modest contribution to meeting their essential needs.

Figure 24: Community perceptions of the effectiveness of COVID-19 assistance



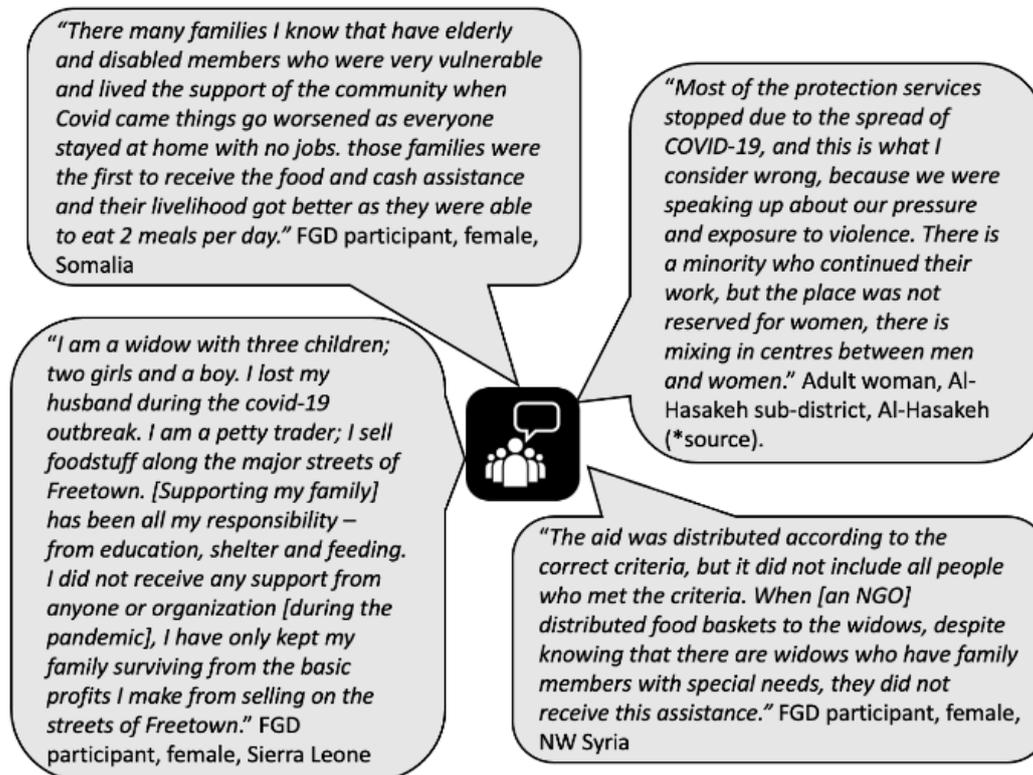
295. The research undertaken during this evaluation can only provide a snapshot of community perceptions of the assistance they received, but it is noteworthy that a perceptions survey undertaken in December 2021 in Somalia showed that the majority of respondents said they were unable to meet their most important needs with the aid they received. The survey results showed that over 50 percent of respondents had unmet needs in cash/voucher assistance, food health and education. Loss of jobs and decline in aid were the most significant reasons given for the deterioration.³⁷² This is part of a broader finding about the limited support that affected people received under the second GHRP Strategic Priority. A similar survey undertaken in Bangladesh of Rohingya refugees in January 2021³⁷³ reported that 72 percent of respondents found it more difficult to meet their basic needs once the virus had started spreading; in a separate survey, two-thirds of respondents expressed their dissatisfaction with the shelter assistance that they received, and only 10 percent were satisfied with the food assistance.³⁷⁴
296. According to the FGD data collected during the evaluation, in North West Syria overall humanitarian aid for COVID-19 was insufficient to meet needs. Community members reported that they had informed aid agencies of this repeatedly but the response had been inadequate. Of those that did receive assistance, it was often only for a short period. In DRC, while people expressed appreciation for the support received (most frequently, face masks), they felt that this support did not make a significant difference, especially for those already in need of humanitarian assistance prior to the pandemic. While assistance was often considered insufficient, it did help many people get through the hardest months of the pandemic – most frequently, the lockdowns when movement was restricted and it was extremely difficult for the most vulnerable to cope.
297. The experiences of vulnerable communities, such as GBV survivors, older people and those with disabilities, were mixed (see Figure 25). Across the case study countries, an increase in needs and a reduction in access to in-person services was addressed by a growth in the number of hotlines and online platforms for GBV survivors. Although a perception study elicited very mixed responses from would-be users, efforts to continue services were appreciated. In Sierra Leone, FGDs were conducted with vulnerable community members which included widows and women-headed households, one of whom had struggled to get her voice heard and received no assistance. In Bangladesh, a man with a physical disability was relieved to have had assistance to transport his food ration back to his house as he was unable to do so himself. Ultimately, even for the most vulnerable groups, the breadth of the needs went beyond the humanitarian assistance that was available to address them.

³⁷² Ground Truth Solutions (2021) *Perception survey of aid recipients in Somalia*, December 2021.

³⁷³ Ground Truth Solutions and IFRC (2021) COVID-19 takes social and financial toll on Cox's Bazar camp communities, January 2021.

³⁷⁴ Ground Truth Solutions (2021) *Balancing Act Between Health and Livelihoods in Cox's Bazar*, October 2021.

Figure 25: Perceptions of vulnerable people about the effectiveness of the response



*Source: GBV AoR & UNFPA (2021) *Voices from Syria 2021: Assessment findings of the Humanitarian Needs Overview.*

298. Despite the limitations of the aid that was received during the COVID-19 pandemic, it was always welcomed by communities who considered that it provided an important safety net given the limitations of their own coping mechanisms. It is important to add that FGDs included some participants who had received regular food distributions, or who had received cash grants. In these cases, the benefits were much greater and examples were given of a resumption of livelihood activities or petty trading which provided a significant benefit. Ultimately, every relief item that was provided was considered welcome, because all the community members who participated in the FGDs were poor, and most were extremely vulnerable and had very limited resources.

12.6 What does community feedback reveal about the collective COVID-19 response?

299. This evaluation has examined the significant deficiencies in the monitoring and reporting of the collective results of the COVID-19 response. The consequence of the shortcomings is that it is not possible to determine the effect of the response on the lives of the people that it sought to assist. In engaging with communities in each of the case study countries, the evaluation has gone some way to filling this gap in evidence by offering an opportunity for people to tell their own stories.

300. The outcome of these efforts and the compilation of these stories provide a very mixed picture of affected people's experiences of the humanitarian assistance they received. An analysis of the views of the 1,103 people that participated in FGDs shifts the evaluation away from the false certainty that quantitative analysis provides. In its place, it offers up a far more complicated picture, but one that is a much closer representation of reality. More importantly, it shifts the power away from those that are counting, to those that are being counted.

Conclusion

Key conclusions from the evaluation

301. The COVID-19 response demonstrated that the humanitarian system could adapt and stretch to meet the needs of a vastly larger humanitarian caseload, but it also highlighted the pre-existing and entrenched challenges that the system faces. This is disappointing, but not unexpected. Ultimately, the humanitarian system that responded to COVID-19 is the same system that has responded to other crises and the same persistent weaknesses were merely magnified during the response to the global pandemic.
302. However, COVID-19 was anything but business as usual. While it was an extreme event that was unprecedented for many different reasons, analysis suggests that it is unlikely to be a one-off anomaly. There is now growing consensus that in the future the international humanitarian system will be required to respond to an exponential increase in needs due to the overlapping challenges posed by climate change, economic crises, spiraling inequality, pandemics, disease outbreaks and violent conflict. This acceleration of humanitarian need is being compounded by an increasingly fragmented world order, weakened multilateral institutions and growing resource constraints. It is the combination of these factors that is pushing principled and needs-based assistance even further beyond the reach of those that require it most.
303. The case for re-focusing assistance on affected people and re-calibrating structures to emphasize the role of national and local actors has been made many times over. While the findings of this evaluation are numerous and cover a diverse range of issues, the COVID-19 response serves to echo these calls for long-overdue change.
 - Put affected people at the center of the response
 - Prioritize those who are in greatest need and are least visible
 - Trust, empower and resource local actors
 - Build a coherent and cohesive system
 - Learn from COVID-19 adaptations to strengthen the collective response capacity

1: Put affected people at the center of the response

In the COVID-19 response, approaches to participation, feedback and accountability were not consistently fit for purpose as all too often affected people were often either not aware of how to engage with agencies or did not trust the mechanisms that were in place.

304. The principle of humanity compels humanitarian agencies to prevent and alleviate suffering wherever it may be found; to protect life and health and to ensure respect for the human being. The COVID-19 response did not change this, but the greater distance between those in need of assistance and those providing it did compromise it. Perhaps the most significant conclusion this evaluation can make from its engagement with communities is the widespread perception that during the pandemic response, humanitarian assistance lost some of its humanity.
305. While agencies and donors sought to satisfy themselves that remote methodologies could adequately deliver impartial assistance that met quality standards, the feedback received from communities during this evaluation raises urgent questions about the compromises that were made. It highlights how the COVID-19 response failed in its effort to be people-centered – the evaluation showed that assistance failed to consistently meet the needs of those who were most vulnerable, that complaints and feedback mechanisms were either untrusted or unknown and that the assistance provided did not meet the full range of people’s needs.
306. This finding is not new or novel, but echoes evidence collected from people affected by crises across the world and replicates findings of many previous IAHEs, the report of the Tsunami Evaluation Coalition³⁷⁵ and the Joint Evaluation of Emergency Assistance to Rwanda among many others.³⁷⁶ In his opening address at the 2022 ECOSOC Humanitarian Affairs Segment, the world’s most senior humanitarian and Emergency Relief Coordinator (ERC), Martin Griffiths, outlined the urgency of change, *‘I feel very strongly that we need to be more accountable, in a fundamental way, in a paradigm shift, to the people that we serve in the humanitarian enterprise, to put their needs and priorities at the heart of everything we do. Not just to listen to them but to be instructed by them. We must genuinely change course and apply ourselves to meet the demands of people who know their own interests and needs better than we do.’*³⁷⁷ It is now time to make good on this promise.

2: Prioritize those in greatest need and who are least visible

The specific needs of people as a consequence of the intersection of factors including age, gender, sex, sexual orientation, and disability were poorly understood and rarely prioritized in the COVID-19 response. At best, it was dealt with inconsistently.

307. The delivery of impartial assistance requires that decisions about the allocation of aid are based on need alone, giving priority to the most urgent cases; as such, impartiality is at the heart of a people-centered approach. Evaluations have long lamented the inability of humanitarian actors to prioritize those in greatest need of assistance and protection, to adequately ensure the participation of diverse groups, and tailor programs to their specific risks and needs. Indeed, the COVID-19 response failed to consistently

³⁷⁵ Tsunami Evaluation Coalition (2006) Joint Evaluation of the International Response to the Indian Ocean Tsunami: Synthesis Report, July 2006.

³⁷⁶ DANIDA (1996) The Joint Evaluation of Emergency Assistance to Rwanda, 1996.

³⁷⁷ United Nations (2022) United Nations Under-Secretary-General for Humanitarian Affairs, Martin Griffiths Remarks at Opening of ECOSOC Humanitarian Affairs Segment UN Headquarters, New York, 21 June 2022.

achieve this impartiality as aid agencies struggled to assess, analyze, identify and reach the most vulnerable. Movement restrictions and the consequent lack of proximity and presence compounded pre-existing challenges of access and inclusion.

308. People affected by the pandemic spoke passionately about the devastating impact that it had on their lives; many were part of very vulnerable communities that were already receiving humanitarian assistance – and were grateful for it - but the additional shock from COVID-19 was catastrophic. The pandemic exacerbated existing vulnerabilities and increased inequality, for women and girls in particular; those who were marginalized, became more so; those who struggled to access assistance found themselves further from it; and those left behind fell further out of sight.
309. In countries where access to the most vulnerable people was already constrained or denied before the pandemic, such as in Somalia, Syria or Nigeria, there was little mention and limited understanding of the needs of these acutely vulnerable communities. In the context of a spiraling caseload, resource limitations and a humanitarian algorithm that prioritizes the overall numbers of people reached over addressing those in greatest need, it was difficult to determine whether those who did receive assistance were in need, or most in need.
310. While progress has been made in strengthening guidance and ways in which the differential needs of affected people are assessed, analyzed and responded to, the pace of change has been too slow, and all too often good practice is found in small-scale pilot projects or delivered by specialist agencies. The COVID-19 response highlighted the difficulties experienced with identifying those in greatest need of assistance, and more importantly, the structural challenges that humanitarian agencies experience in routinely resourcing and meeting the specific needs of vulnerable communities once they have been identified.

3: Trust, empower and resource local actors

Despite the IASC's Guidance notes on localization which endorse the Grand Bargain commitment to strengthening local leadership and decision-making, the COVID-19 response was a missed opportunity to strengthen locally-led humanitarian action.

311. This evaluation has found that the response to the COVID-19 pandemic started with good intentions to support and strengthen locally-led humanitarian action in line with Grand Bargain commitments. However, while the response highlighted the important role of local and national actors (L/NA), two years after the launch of the GHRP, there is considerable evidence that the pandemic was a missed opportunity to advance the localization agenda. The quantity of funding disbursed to L/NNGOs is on a downward trend and there has been little lasting change to the power that L/NNGOs have in partnerships or their level of involvement in decision-making bodies such as HCTs. With the lifting of COVID-19 restrictions, the evidence from the IAHE suggests that there has been a return to the pre-pandemic status quo.
312. The lack of progress in translating IASC policy and guidance into practice and delivering on localization commitments is all the more disappointing because of the enhanced role and responsibilities that L/NAs and communities themselves took on during the COVID-19 response. In cases where international humanitarian actors withdrew, L/NAs and communities stepped up to shoulder the responsibility for delivering assistance as well as the risks associated with it.
313. The humanitarian system has failed to transfer power from the international to the national, underpinned by an apparent reluctance to transfer funding and decision-making authority to L/NAs. Without a ceding

of power from international humanitarian actors to their national and local counterparts, locally-led humanitarian response is not possible.

314. In the same address to ECOSOC in 2022, the ERC remarked that *‘it’s way beyond time to allow, and insist on, and require, and plan for, a bigger role for local NGOs, civil society and aid agencies. They are the ones on the ground, on the front line. Day in, day out, they are the ones confronting the extreme deprivations and they know the relationship with communities better than we do... We need to empower them; we need to bring them closer into our councils and we need to support them in their efforts and in their desire to extend their reach.’*³⁷⁸ It is now time to move beyond a discussion of technical fixes, and instead to focus on concerted action on empowering and resourcing the local actors on the frontline of delivering humanitarian assistance at a level that is commensurate with their critical role, which was amply demonstrated during the COVID-19 response.

4: Build a coherent and cohesive system

The IASC’s own guidance suggests that working across the humanitarian-development-peace nexus offers the most effective assistance and protection to those in greatest need. The failure to do this in the COVID-19 response showcased the shortcomings that are implicit in the way that the international aid architecture is currently organized.

315. The COVID-19 response raised important questions about how the world responds to crises. What started as an emergency response to address the pandemic quickly emerged into protracted crisis management straddling the boundaries of humanitarian, development and peace, with significant implications for governments and non-state actors.
316. The first iteration of the GHRP in April 2020 correctly foresaw many of the socio-economic impacts of domestic containment measures and warned of the potential *‘poverty traps’* that the pandemic could trigger, and the United Nations Socio-Economic Response Plan saw the United Nations Development System *‘switching to emergency mode’*. But the United Nations failed to link its own response plans at the global level, thereby missing a vital opportunity to make headway in operationalizing the nexus.
317. At an operational level, in the countries worst-affected by the pandemic, the response was more fluid. However, the existence of different planning frameworks, the lack of architecture to facilitate joint assessments, planning and response, and the continuing lack of suitable financing all served to place a spotlight on the continuing structural impediments to the delivery of a more coherent response.
318. Taking a people-centered approach requires that effective humanitarian response is done differently – in a way that not just saves lives, but anticipates crises, reduces risks, and strengthens the resilience of communities. Achieving this will ultimately require that the *‘artificial barriers’*³⁷⁹ that have hobbled coherent responses in the past are deconstructed. This is a long-term change agenda that goes beyond the scope of this evaluation, and in the short-term, robust advocacy and action as well as strong leadership will be required to create the necessary momentum at the global, national and local levels to operationalize the commitments that have been made to develop and deliver collective outcomes for crisis-affected communities.

³⁷⁸ Ibid.

³⁷⁹ Ibid.

5: Learn from COVID-19 adaptations to strengthen the collective response capacity

Learning lessons from the use of COVID-19 adaptations will offer an opportunity for future responses to build on the progress made and avoid the pitfalls encountered in the COVID-19 response.

319. The COVID-19 response was arguably the most complex response that has been embarked upon by the collective humanitarian system. It is understandable, therefore that it was considered to be a high-water mark for humanitarian innovation and adaptation. This evaluation has documented numerous new and novel initiatives, program approaches and processes which strengthened the ability of IASC members to support local and national humanitarian actors to prepare for, anticipate and respond to the pandemic.
320. This evaluation has also identified adaptations that sought to overcome the specific challenges posed by the pandemic (particularly movement-related restrictions), but which post-pandemic, will reduce the effectiveness of collective humanitarian action. For this reason, it is important that the humanitarian system is discerning in the innovations that it adopts.

Concluding comments

321. As the evaluation heard from a senior humanitarian leader, *'the response didn't meet [all the] needs and it never could do. It's always the case and so it's best to be honest about it.'* It is important to acknowledge that in seeking to respond to the COVID-19 pandemic, the humanitarian community took on a task of unprecedented scope and scale. It should therefore come as no surprise that the collective response was imperfect given the enormous scale of the needs and the exceptional complexity of contexts. But it also sets an essential agenda for the collective humanitarian community as it faces up to the challenge of responding to a world where needs are becoming ever greater and resources to meet them ever more inadequate. At this time of need, it is ever more important for humanitarian assistance and humanitarians to reclaim the space that was lost during the pandemic.
322. Notwithstanding the challenges outlined above, by providing assistance to many of those who were most vulnerable, this evaluation concludes that the humanitarian community provided a safety net for many millions of people who otherwise would have likely gone without assistance. Furthermore, in taking on this complex task and working under such difficult circumstances, humanitarian agencies, particularly national and local NGOs, showed remarkable adaptability, courage and tenacity in delivering a coordinated response at an unprecedented scale. The safety net that they provided was not without its holes and some people likely slipped through them, including some of the most vulnerable, but for the many who did receive assistance, the collective response offered a lifeline.
323. To address the deficiencies in the collective response will require the operationalization of a change agenda for IASC members and the broader humanitarian community towards a people-centered, locally-led response.
324. It is important to stress that the changes that are required are not new and most are already documented in IASC Principals Statements and IASC Operational Guidance. Many have also been outlined as recommendations in previous IAHEs. This strongly suggests that the problem is not a lack of knowledge or understanding, but a lack of leadership, commitment or capacity to making changes. In saying this, it is important to acknowledge that some of the challenges go beyond the gift of the IASC alone to address.
325. Irrespective of this, the existence of two opposing post-pandemic trends of vastly increased humanitarian needs and significantly diminished resources will almost certainly result in change. The question that this poses to the IASC is whether the system will lead change from within or resist and let the change be driven externally.

Recommendations

The recommendations below outline the key tenets of an agenda for change that draw from the lessons of the pandemic response. In forming these recommendations, the evaluation has sought to navigate two important factors:

- The IASC has already made commitments to implementing many of the changes that are required. Where this is the case, this evaluation will not propose new recommendations but will highlight the urgency in progressing commitments that have already been made, but which evidence from the evaluation suggests have not yet been implemented satisfactorily.
- The findings of the evaluation suggest the need for systemic change – going beyond the IASC and including change for donors and development partners. However, this evaluation cannot make recommendations that go beyond IASC members and structures. It should therefore be noted that these recommendations alone are insufficient to bring about the changes that are required to address the significant and far-reaching deficiencies highlighted by the evaluation.

Recommendation 1: Put affected people at the center of the response

Explanation: In the COVID-19 response, approaches to participation, feedback and accountability were not consistently fit for purpose as all too often affected people were often either not aware of how to engage with agencies or did not trust the mechanisms that were in place. The statement by the IASC Principals on AAP³⁸⁰ outlines a strong commitment to addressing the deficiencies evidenced in the COVID-19 response. Similarly, sound IASC guidance already exists on PSEA, and the new IASC strategy on PSEA and harassment sets out a clear vision for improvements.³⁸¹ However, statements and strategies on both AAP and PSEA are meaningless without a means of monitoring action and compliance.

Sub-recommendation	Action
<p>1.1. Implement existing AAP policy: At global and country level, operationalize in full the 2022 IASC Principals Statement on Accountability to Affected People in Humanitarian Action. This should include plans to increase flexible financing through pooled funds and fast-track the revision of the HPC so that coordinators can be more responsive to people's needs.</p>	<p>Global level: IASC Principals, OPAG, IASC Task Force 2 on AAP Country level: HC, HCT, IASC member agencies</p>
<p>1.2. Improve monitoring and reporting: At country level, reorient and resource collective monitoring and reporting so that it draws on, and can respond to qualitative data from the experience of affected people on the quality and effectiveness of humanitarian assistance and protection.</p>	<p>Country level: HC, HCT, OCHA</p>
<p>1.3. Strengthen Accountability for implementation: At country level, the implementation of the AAP commitments outlined in the IASC Principals Statement should be used as a metric to assess the performance of HCs and HCT members.</p>	<p>Country level: HC, HCT, OCHA</p>
<p>1.4. Prioritize PSEA: The IASC's Vision and Strategy for PSEA provides a clear framework for strengthening country-level efforts to embed sustainable and accountable PSEA actions in humanitarian contexts.³⁸² The commitments and targets should be implemented and monitored as a priority with adequate support and resourcing from relevant global actors.</p>	<p>Global level: IASC Technical Advisory Group on PSEAH Country level: HC, HCT, IASC member agencies</p>

³⁸⁰ IASC (2022) Statement by Principals of the IASC: Accountability to affected people in humanitarian action, 14 April 2022.

³⁸¹ IASC (2022) IASC Vision and Strategy: Protection from sexual exploitation, abuse and sexual harassment (PSEAH) 2022-2026.

³⁸² Ibid.

Recommendation 2: Prioritize those who are in greatest need and are least visible

Explanation: The specific needs of people as a consequence of the intersection of factors including age, gender, sex, sexual orientation, and disability was poorly understood and rarely prioritized in the COVID-19 response. At best, it was dealt with inconsistently. While some good practice was evident, all too frequently there was a lack of collective tools to assess, analyze and monitor progress on inclusion. At an individual agency level, there was a lack of relevant skills, time and resources.

Sub-recommendation	Action
<p>2.1. Implement existing policies: At global and country level, implement IASC Guidelines on the inclusion of persons with disabilities in humanitarian action³⁸³ (ii) IASC Policy on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action³⁸⁴ (iii) IASC Gender Handbook³⁸⁵ (iv) IASC Policy on Protection in Humanitarian Action³⁸⁶</p>	<p>Global level: IASC members Country level: HC, HCT, IASC member agencies</p>
<p>2.2. Re-focus response on quality and equity: Define inclusion in the context of the humanitarian principles, particularly those of humanity and impartiality, and outline operational implications including in access-constrained and/or resource-constrained contexts where decisions must be made about the relative prioritization of quantity and coverage versus quality and equity.</p>	<p>Global level: IASC Principals, EDG, OPAG</p>
<p>2.3. Strengthen accountability for implementation: At country level, HNOs already include an analysis of the landscape of needs and an internal prioritization of the most at-risk and marginalized groups. Indicators should be developed so HCTs can regularly assess their performance in prioritizing quality and equity in humanitarian response.</p>	<p>Country-level: HC, HCT</p>
<p>2.4. Prioritize and resource GBV as a core part of future public health responses: While GBV prevention and response were highlighted as a priority within COVID-19 advocacy and appeal documents, it did not result in a convincing response to protect women and girls from the additional risks associated with quarantines, lockdowns and other associated restrictions. Future pandemic and other public health responses should include GBV prevention and response as a clear priority from the start, accompanied by adequate and timely funding.</p>	<p>Global level: IASC Principals, EDG, OPAG</p>

³⁸³ IASC (2019) IASC Guidelines on inclusion of persons with disabilities in humanitarian action 2019, July 2019.

³⁸⁴ IASC (2017) IASC Policy on gender equality and the empowerment of women and girls in humanitarian action 2017, November 2017.

³⁸⁵ IASC (2018) IASC Gender handbook for humanitarian Action 2018, February 2018.

³⁸⁶ IASC (2016) IASC Policy on Protection in Humanitarian Action 2016, October 2016

Recommendation 3: Trust, empower and resource local actors

Explanation: Despite the IASC's Guidance notes on localization³⁸⁷ which endorse the Grand Bargain (GB) commitment to strengthening local leadership and decision-making, the COVID-19 response was a missed opportunity to strengthen locally led humanitarian action. While a shift in power will require fundamental changes in donor funding policies, which is outside of the scope of this evaluation, the recent GB outcomes on the role of intermediaries offers an important change agenda that is consistent with IASC commitments and relevant to IASC members.

Sub-recommendation	Action
<p>3.1. Strengthen policy: The outcomes of the Caucus on Intermediaries have significant potential to address some of the systemic blockages to strengthening locally led humanitarian action.³⁸⁸ The IASC should fully support the dissemination of the GB outcomes document and use it to develop its own policy to guide its members as intermediaries</p>	Global level: IASC Principals, OPAG
<p>3.2. Implement IASC policy and GB outcomes: At global and country level, IASC members must now ensure that their global policies and country-level practices are consistent with their policies on the provision of overheads to local and national partners. Furthermore, IASC members should seek to institutionalize and implement the policies outlined in the Intermediary Caucus Outcome document.</p>	Country-level: IASC members
<p>3.3. Review global structures: The IASC should review its global structures and processes to ensure that the membership and participation of L/NAs in these is consistent with its localization commitments.</p>	Global level: IASC Principals, OPAG
<p>3.4. Strengthen accountability for implementation: At country level, localization should be integrated into accountability mechanisms for HCT members (including in HC performance appraisals, HCT compacts, and HCT annual work plans). At every performance review, an assessment of HCT members' performance against localization indicators should be assessed, with agreements for annual incremental improvement and an agreement to act where deficiencies are highlighted.</p>	Country-level: HC, HCT, IASC members

³⁸⁷ In May 2020 the IASC endorsed guidance notes on arrangements between donors and intermediaries, gender responsive localization, coordination, capacity strengthening, financing and partnership practices. See <https://interagencystandingcommittee.org/grand-bargain-official-website/guidance-notes-localisation-may-2020>.

³⁸⁸ The Grand Bargain Intermediaries Caucus (2022) Towards Co-ownership: The role of intermediaries in supporting locally led humanitarian action, August 2022.

Recommendation 4: Build a coherent and cohesive system

Explanation: Taking a nexus approach is imperative for responding effectively to crises and protecting those who are most vulnerable. The COVID-19 response showcased the shortcomings that are implicit in the way that the international aid architecture is currently organized. While there is growing consensus that the system requires urgent change, this goes beyond the scope of this evaluation and so the recommendation hereunder focuses attention on what the IASC should do differently to promote a coherent response in the future.

Sub-recommendation	Action
<p>4.1. Strengthen policy: The IASC should use the lessons from the COVID-19 response alongside existing good practice³⁸⁹ and its own policy on Collective Outcomes³⁹⁰ as a basis for outlining an approach to responding to future global health crises in a way that is consistent with its commitments.</p>	<p>Global level: IASC Principals, OPAG</p>

Recommendation 5: Learn from Covid-19 adaptations to strengthen the collective response capacity

Explanation: The COVID-19 response was arguably the most complex response that has been embarked upon by the collective humanitarian system. It is understandable, therefore that it was considered to be a high-water mark for humanitarian innovation and adaptation. Learning lessons from the use of these adaptations will offer an opportunity for future responses to build on the progress made and avoid the pitfalls encountered in the COVID-19 response.

Sub-recommendation	Action
<p>5.1. Cash and voucher assistance (CVA) was the priority for people affected by COVID-19 and has significant potential to promote participation, choice and resilience as part of a demand-driven model of humanitarian response. During the pandemic, CVA was found to be adaptable and scalable as well as being relevant to meeting needs in access-constrained contexts. When linked to longer-term social protection systems, the modality also proved that it had significant potential as a response that spans the humanitarian-development nexus. Areas that require learning include understanding and addressing the digital divide, more attention to ensuring access to CVA for particularly marginalized groups and facilitating greater engagement and uptake by L/NAs.</p>	<p>Global level: Global Cash Advisory Group Country level: Cash Working Groups</p>
<p>5.2. An unprecedented demand for data in the humanitarian sector led to experimentation with predictive models to inform humanitarian response strategies. However, anecdotal evidence suggests that the modelling was not readily absorbed and used at the country level for operational purposes. Continued learning and investment is justified, working towards a more anticipatory approach to pandemics and other related crises, with a focus on building</p>	<p>Global level: IASC members</p>

³⁸⁹ IASC Results Group 4 (2021) Mapping good practice in the implementation of humanitarian-development-peace nexus approaches: Synthesis report, September 2021.

³⁹⁰ IASC Results Group 4 (2020) *Light guidance on collective outcomes*, June 2020.

<p>technical capacity, engaging local actors more consistently throughout the process to agree on triggers and response mechanisms, and combining predictive models with other types of analysis and evaluation.³⁹¹</p>	
<p>5.3. While the use of remote modalities permitted humanitarian agencies to retain contact with communities in the short-term, they failed to provide the presence and proximity to affected people that is fundamental to the delivery of effective protection and assistance. Furthermore, the evaluation found that humanitarian agencies were slow to re-establish their presence, particularly in fragile contexts. It is important that remote methodologies are used only where they are absolutely necessary, rather than as a substitute for humanitarian presence.</p>	<p>Global level: OPAG (as lead for the HPC) Country level: HC, HCT, IASC members</p>
<p>5.4. The GHRP provided strategic direction to the response, but its initial orientation around UN agencies rather than clusters/sectors limited its inclusiveness and had a damaging effect on UN/NGO relationships. For a collective response to be effective requires that collective structures are used to plan and implement it. For this reason, future response plans must draw on the capacities of the clusters/sectors and seek the participation of UN and NGO IASC members.</p>	<p>Global level: IASC Principals, EDG, OPAG</p>
<p>5.5. The COVID-19 Common Services (i.e., global freight management, humanitarian air services, medevac, etc.) were innovative in scope and scale, provided an important safety net for the response, and in the context of the IASC supported humanitarian business continuity at regional and country levels. They were also developed largely based on leveraging inter-agency humanitarian logistics, supply and operations support mechanisms, albeit at a much greater scale than had necessarily been imagined. This learning should inform the IASC approach to operations support and humanitarian business continuity in a manner that complements and leverages the full spectrum of inter-agency response mechanisms and reinforces/augments the IASC’s approach to coordinating operations support in a manner that is coherent with, and complementary to, non-IASC response mechanisms in case of future global crises.</p>	<p>Global level: IASC Deputies Group and relevant UN entities and partners</p>

³⁹¹ Bodanac, N. (2020) Predictive Analysis for Anticipatory Action: Challenges and Opportunities, OCHA Center for Humanitarian Data, December 2020.

Annexes (Bibliography)

Annex 1: IAHE terms of reference

Annex 2: Approach and methods

Annex 3: List of stakeholders interviewed

Annex 4: Community engagement methodology

Annex 5: Strength of evidence findings

Annex 6: Bibliography

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