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

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Evaluation Team [KonTerra Group/Itad]

Andy Featherstone, Team Leader
Tasneem Mowjee, Senior Evaluator
Terrence Jantzi, Senior Evaluator
Charlotte Lattimer, Evaluator
Véronique De Clerck, Evaluator
Rebecca Kindler, Evaluator
Pierre Townsend, Evaluator
Betsie Lewis, Senior Research Assistant
Flovia Selmani, Data Analyst
David Fleming, Quality Assurance Advisor

The KonTerra Group
Menno Wiebe, Managing Director
Belén Díaz, Project Manager
Mélanie Romat, Project Manager

Itad Ltd.
David Fleming, Partner, Fragile and Conflict Affected Environments

Evaluation Management

IAHE Steering Group Chair
Kelly David (OCHA)

Evaluation Manager
Ali Buzurukov (OCHA)

Evaluation Officer
Maria Isabel Castro Velasco (OCHA)

Evaluation Management Group
Anand Sivasankara Kurup (WHO)
Aya Shneerson/Mari Honjo (WFP)
David Rider Smith (UNHCR)
Elma Balic (IOM)
Gareth Price-Jones (SCHR)
Hicham Daoudi (UNFPA)
Jane Mwangi (UNICEF)
Susanna Morrison-Métois (ALNAP)
Volker Hüls (DRC, on behalf of the ICVA)

Global Evaluation Advisory Group
Anusanthee Pillay (Action Aid)
Colum Wilson (FCDO)
Fouad Mohamed Fouad (AUB)
Gopal Mitra (UN)
Jeremy Konyndyk (USAID)
Joanne Liu (McGill University)
Meg Sattler (Ground Truth Solutions)
Najeeba Wazefedost (Asia Pacific Network of Refugees)
Ruth Hill (World Bank)
Smruti Patel (GMI)
Thomas Zahneisen (German Federal Foreign Office)
Violet Kakyomya (United Nations Resident Coordinator, Chad)

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Acronyms

AAP	Accountability to Affected Populations
ALNAP	Active Learning Network for Accountability and Performance
CBPF	Country-Based Pooled Fund
CEPI	Coalition for Epidemic Preparedness Innovations
CERF	Central Emergency Response Fund
COVAX	COVID-19 Vaccines Global Access
ERC	Emergency Relief Coordinator
ERP	Emergency Response Preparedness
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GHRP	Global Humanitarian Response Plan
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
INGO	International Non-Governmental Organization
L/NA	Local/National Actors
NGO	Non-Governmental Organization
OCHA	Office for the Coordination of Humanitarian Affairs
OPAG	Operational Policy & Advocacy Group
PHEIC	Public Health Emergency of International Concern
RC	Resident Coordinator
RCO	Regional Coordinator's Office
RCCE	Risk Communication & Community Engagement
SARS- CoV-2	Severe Acute Respiratory Syndrome Coronavirus 2
SERP	Socio-Economic Recovery Plan
SPRP	Strategic Preparedness & Response Plan
UN	United Nations

1 Introduction and approach

1. The Inter-Agency Evaluation of the COVID-19 Humanitarian Response is an independent assessment of the collective efforts of the Inter-Agency Standing Committee (IASC) member organizations in support of people, and with government and local actors, in meeting the needs and priorities of the world's most vulnerable people in the context of COVID-19.

2. The objectives of this evaluation are threefold. First, it provides an independent assessment of IASC member agencies' collective preparedness and response to the pandemic over a two-year period from 2020. Second, the evaluation assesses the results that were achieved in support of affected people. Third, it identifies best practices, opportunities and lessons learned that will help to improve ongoing and future humanitarian responses.

3. The evaluation draws on a mix of primary and secondary data. Primary data included eight case study country visits and one regional visit.[1] Interviews were conducted with 640 global, regional and country key informants. 169 focus group discussions with 510 men and 593 women were undertaken across the case study countries. Secondary data analysis included a review of over 3,500 documents as well as an analysis of several quantitative datasets. Outputs from this evaluation include this report and two stand-alone learning papers that provide a detailed examination of two issues associated with the COVID-19 response; the Global Humanitarian Response Plan (GHRP) process and the contribution made by the response to localization.

2 Context

4. On 30 January 2020, World Health Organization (WHO) declared a Public Health Emergency of International Concern (PHEIC)[2] due to the outbreak of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). WHO declared COVID-19 as a global pandemic on 11 March 2020.

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 IASC 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.[3]

- The increase in the scale and geographic spread of needs was significant; by December 2020, 243.8 million people across 75 countries needed humanitarian assistance, an increase of 45% from pre-

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[1] The case study visits comprised Bangladesh (Rohingya refugee response), Colombia, Democratic Republic of Congo, Philippines, Sierra Leone, Somalia, Syria and Turkey (refugee response). A Regional Office visit was undertaken in Kenya.

[2] 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.

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

pandemic projections.[4] 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.

6. COVID-19 brought to the fore and accentuated issues that have long been debated, including: i) the role of local actors; ii) the differential impact of the pandemic on different population groups; and iii) sectoral integration and integration across the humanitarian-development-peacebuilding to address the multi-layered effects of the pandemic in both the immediate- and longer-term. The pandemic also presented new challenges and pushed humanitarian actors to rethink and adapt traditional ways of working as it threatened to overwhelm the capacity of the existing system to respond adequately.

7. 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 provided assistance, requiring them to find different approaches to overcome restrictions on movement and in-person contact. It is in this most challenging of contexts that the members of the IASC came together to design and deliver the collective humanitarian response to COVID-19.

3 Evaluation findings

3.1 Preparedness

The humanitarian system failed to learn lessons and be sufficiently prepared for a pandemic.

8. The implementation of lessons learned from the responses to SARS and Ebola Virus Disease shows that collective memory on infectious diseases is short. Some operational lessons were incorporated into humanitarian practice and the WHO has made incremental improvements to its International Health Regulations monitoring and evaluation tools to promote stronger national capacities. This, along with the self-organization of specialist consortia such as the Vaccine Alliance (GAVI),[5] Coalition for Epidemic Preparedness Innovations (CEPI),[6] laboratory and surveillance partnerships, and a strengthened IASC protocol have improved infectious disease event response capacity. However, the changes made to pandemic preparedness have not satisfactorily resolved the global governance and equity issues inherent in global public health security which sets an important agenda for the future.

9. Within the humanitarian system, while the global nature of the pandemic was unprecedented, preparedness for COVID-19 by the collective members of the IASC was weak and the contingency plans that existed were of limited relevance. There were some exceptions to this, such as in countries that had experienced previous epidemics, but even in these contexts, lessons had not been institutionalized and were drawn upon only once the alarm had been raised.

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[4]   United Nations Office for the Coordination of Humanitarian Affairs (2021) *Global Humanitarian Overview, 2022*. United Nations.
[5]   Gavi is a global alliance to protect people's health by increasing equity in immunization.
[6]   CEPI is an alliance to finance and coordinate the development of new vaccines to prevent and contain infectious disease epidemics.

Once WHO declared a pandemic, the IASC acted swiftly at a global level but, at country level, early action was driven by individual agencies or influential humanitarian leaders.

10. Once the PHEIC had been declared as a pandemic, despite the lack of readiness and the absence of a blueprint for a global response, the IASC acted swiftly and effectively at the global level to launch the GHRP as a preparedness and response framework within two weeks. This mobilized the global humanitarian community.

11. Post-declaration preparedness at country-level was more mixed and often less decisive. At a collective level, the IASC generally performed poorly in the GHRP countries as it did not have applicable guidance or tools in place. Emergency Response Preparedness (ERP)[7] was generally not used and once the alert had been given, there was an initial reliance on ad-hoc planning with preparedness being driven by one or more agencies that were better prepared, or by influential humanitarian leaders who stepped up to the task of organizing the humanitarian community.

3.2 Needs assessments

Movement restrictions meant needs assessments were initially based on remote methodologies and assumptions which had implications for their quality and effectiveness.

12. Needs assessments were particularly challenging due to restricted access as a consequence of COVID-19 preventive measures, a lack of methodological clarity, and pressure to respond. Data gaps compromised analysis, decision-making and response planning which may have had serious implications for the lives of vulnerable people. Instead of strong data, humanitarian actors experimented with forecasting and the use of predictive models to anticipate the trajectory of the pandemic. This anticipatory work has not yet demonstrated proof of concept but did generate significant learning and was perceived by many as worthy of continued investment.

13. Despite operational constraints, a number of collective needs assessments were conducted which highlighted the impact of COVID-19 on particularly vulnerable populations. Assessments often relied on local organizations and remote data collection to overcome access challenges. While remote data collection was necessary, it compromised the quality and inclusiveness of needs assessments, due to the lack of connectivity and access to mobile phones, particularly for women.

14. There was evidence that assessments and analysis examined the needs of particularly vulnerable groups, including women and girls and persons with disabilities. However, there were few examples of needs assessments and analyses that specifically targeted vulnerable groups or which applied a systematic protection, gender and/or inclusion lens. 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.

15. After an initial focus on the impact of COVID-19 on vulnerable populations in the first half of 2020, the effects of the pandemic began to be incorporated into broader assessments and analysis of humanitarian needs in many contexts, and HNOs and HRPs from 2021 onwards, generally included COVID-19 as one of many risk factors. This rightly acknowledged the multitude of natural and man-made risks faced by people

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[7] Emergency Response Preparedness (ERP) are a set of activities that every UN Country Team or Humanitarian Country Team must implement to establish a minimum level of emergency preparedness within a country.

living in humanitarian contexts and situated COVID-19 as a compounding factor alongside other hazards generating and exacerbating humanitarian needs.

3.3 Strategic planning

The GHRP was a rapidly developed plan that was unprecedented in its scope and delivered on its objective of framing the humanitarian response. The trade-off was that it failed to adequately consult with the IASCs collective membership or draw on its coordination structures.

16. The IASC rose to the challenge of rapidly preparing the GHRP as a coherent, collective response plan, which benefitted from strong support from OCHA in particular. The GHRP was the humanitarian community's first-ever event-specific global appeal and covered countries with existing or multi-country/sub-regional response plans as well as non-appeal countries that had requested international assistance. As such, its scope and level of ambition were without precedent, and it was developed without the benefit of previous experience.

17. The first iteration of the GHRP served as a legitimate '*place-holder'*, staking out the basic parameters of the humanitarian preparedness and response effort while leaving space for more evidence-based and bottom-up approach in subsequent iterations. The GHRP largely achieved its purpose of providing strategic direction to the response. However, the orientation of the initial plan around United Nations agencies rather than clusters/sectors limited its inclusiveness and had a damaging effect on UN-non-governmental organization (NGO) relationships. The decision not to make the protection of women and girls a standalone objective, despite evidence of a likely uptick in Gender-Based Violence (GBV) and other significant protection risks, was also a failure of the plan.

At a global level, the aid system designed the response on the basis of existing structures and interests rather than addressing the intertwined impacts of the pandemic.

18. Despite the recognition that COVID-19 would have significant socio-economic impacts, as the Ebola Virus Disease did before it, the international aid system went about planning the response in a siloed manner, with separate plans for health, humanitarian and development programs. Even if it had been expedient to have separate response plans, the development of collective outcomes, in line with IASC guidance, was a missed opportunity. These would have strengthened the coherence of the response by clarifying how the health, humanitarian and development responses could work together to achieve common objectives.

At country level, despite some challenges, greater efforts were made to develop strategic plans that cut across the global frameworks.

19. At country level, it proved difficult for the United Nations to make sense of the overlaps and complementarities between the three global strategic frameworks which were perceived as being artificial, and they were translated into context-specific plans in different configurations. In some cases, the plans were developed to satisfy headquarters requests, rather than to meet country-level needs. Where international humanitarian actors were more successful was in ensuring alignment between humanitarian response and national government plans and priorities.

3.4 Leadership and coordination

The importance of a coherent response to the pandemic required that international humanitarian actors work closely with governments and the evaluation found that IASC leaders generally performed fairly well in convening and coordinating collective humanitarian action in support of government priorities.

20. Prior investments in strengthening the IASC at a global level had solidified relationships between IASC members and improved the quality and rigor of their work, positioning the IASC advantageously as it embarked on the COVID-19 response.

21. At country level, governments most frequently played a leadership role due to the need for regulations and action, and the Resident Coordinator (RC)/Humanitarian Coordinators (HC), Humanitarian Country Teams (HCT), and Regional Coordinator's Offices (RCO), played a pivotal role in priority setting and leading IASC collective action in support of government and local actors. While individual HC/RCs varied in their ability to convene the disparate members of the humanitarian ecosystem and ensure the relevance and effectiveness of the response, it is commendable that, over the two years under evaluation, IASC country-level structures have shown significant resilience and determination in supporting national governments and humanitarian actors to deliver complex responses across a third of the globe.

22. In many of the case study countries, the necessity for international and government actors to work 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 collective 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.

Clusters/sectors at both the global and country level generally performed well under difficult circumstances and scaled up the provision of technical guidance and support, despite pre-existing challenges.

23. Strong sectoral coordination was essential during the response, and clusters/sectors broadly performed well in providing strategic technical direction and offering relevant guidance and support. Global clusters played a key role in providing essential support to country-level mechanisms. Rather than highlighting an optimal model of coordination for response to infectious disease response, the evaluation concluded that the priority is that coordination works optimally – in whatever form it exists.

24. The response did highlight the scope for continued room for improvements, largely in aspects of the response that are known to be areas of weakness; namely inter-cluster coordination, incorporation of cross-cutting issues and sub-national coordination. While there were signs of improvement, particularly in seeking to work across cluster siloes, there is still a need for solutions to these most persistent problems.

3.5 Funding

Donors made un-earmarked funding commitments early in the response and offered agencies the flexibility required to re-program existing funds. This flexibility was reduced with time and earmarking returned to pre-pandemic levels.

25. Donors were engaged actively with the development of the GHRP and it provided them with a framework against which funds could be released early in the pandemic. This early injection of funding was important for scaling up the health response. It was also helpful that most donors, and pooled funds, provided partners with the flexibility to reprogram existing funding at the start of the pandemic. This enabled them

to adapt programming and to respond to new needs more quickly than if they had to go through funding approval processes. Donors also provided considerable un-earmarked funding at the start of the pandemic, in line with Grand Bargain commitments. However, this flexibility was reduced after the initial phase – often reverting to pre-pandemic levels of earmarking – because of a perceived unmet need for accountability for the use of funds and a lack of clarity about future priorities.

26.   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 was significantly reduced by the time of the larger COVID waves.

Pooled funds played an important role in providing targeted and timely funding, particularly to frontline actors.

27.   The Central Emergency Response Fund (CERF) and Country-Based Pooled Funds (CBPF) provided timely and flexible funding to a range of humanitarian actors. The CERF made an early, fast-tracked provision of completely flexible, global funding to nine United Nations agencies, which was counter to the traditionally country-driven nature of CERF allocations, and which caused reporting challenges later on. The CERF also trialed a range of other innovative funding allocations, including to NGOs and to women-led organizations responding to gender-based violence, which offered considerable scope for learning.

28.   CBPFs were an important source of funding to L/NNGOs and front-line actors. In 2020, the Funds introduced a set of flexibility measures to help frontline responders adapt to new needs. Based on the broadly positive experience of NGO partners and fund managers, the CBPFs have subsequently incorporated many of the flexibility measures into their global guidance and apply them to non-COVID contexts. The share of CBPF funding allocated to L/NNGOs in 2020 increased to 36 percent of total funding, with some Funds channeling even higher percentages.

3.6   Collective response

With movement restrictions making it harder to engage directly with communities, COVID-19 negatively impacted on the humanitarian system's accountability to affected populations (AAP).

29.   The progress made by agencies on ensuring the meaningful participation of affected people within humanitarian action had been slow before the pandemic and more ground was lost during the COVID-19 response. While adapted guidance on how to continue engaging with communities was prepared and disseminated, evidence suggests that remote forms of community engagement had negative impacts on the accountability of the response and community participation was further compromised as a result.

30.   Communities consulted for this evaluation frequently lacked awareness of ways to provide feedback to aid providers and even when they were aware of how to make complaints, they often lacked trust in the effectiveness of community feedback and complaints mechanisms, partly due to a prior lack of responsiveness from aid providers as well as a fear of repercussions in some cases. Women and girls appeared to find it particularly difficult to access systems to make complaints or request assistance.

Given the additional risks of sexual exploitation and abuse (SEA) during the pandemic, mitigating or responding to these risks was not adequately prioritized within the collective COVID-19 response.

31. 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. However, the evaluation found only limited evidence of collective efforts to strengthen SEA prevention and response in case-study countries. In instances where IASC actors did not have an active SEA collective mechanism during the COVID-19 response, this weakened the inter-agency response to SEA at a critical time, putting vulnerable people at even greater risk.

Risk Communication and Community Engagement (RCCE) was a significant part of the COVID-19 response, generating lessons for future responses although it took some time to re-learn the important need for two-way communication.

32. Built on lessons from the response to Ebola Virus Disease outbreaks, RCCE was an important aspect of the humanitarian community's collective response to COVID-19 and offered significant lessons. These included the importance of involving communities in all aspects of the response, prioritizing social as well as technical elements of the response, and the value of listening, analyzing and responding to community feedback to gain trust and tailor the response to specific and ever-evolving community perceptions.

33. The evaluation encountered multiple examples of perception studies conducted by individual organizations that shed light on community comprehension and behaviors during the COVID-19 response. However, the results of these studies were jointly analyzed and used to inform the collective response in only a few instances. The COVID-19 response demonstrated again the critical role of faith leaders, particularly in contexts where religion plays an important part in people's lives and the value for humanitarian actors of engaging with inter-religious bodies and actors to share key messages and model health-seeking behavior.

At a global level, the Common Services supported the ability of the United Nations, in particular, to '*stay and deliver*'. At country level, though, the implementation of the commitment was context and leadership-dependent.

34. Considerable collective effort was made to analyze risk and maintain access in the face of travel disruptions and government movement restrictions, in addition to pre-existing conflict dynamics. At a global level, the Common Services were a very visible manifestation of this. They are noteworthy both for what they were able to deliver, and also because they showed the potential of what is possible when agencies pool their resources and use their distinctive competencies to address a common challenge – that of providing global support to those responding to the pandemic.

35. At a country level, it was extremely challenging for humanitarian agencies to access those who were hard to reach due to conflict. While evidence was limited, in the case study countries where violent conflict restricted access of communities to protection and assistance, COVID-19 tended to further reduce this. While humanitarian leaders advocated for the continuation or resumption of humanitarian assistance when government measures risked limiting or curtailing the activities of humanitarian agencies, the commitment to '*stay and deliver*' varied between agencies and from country to country and considerable concern was expressed about a reduction in humanitarian space.

The aspirations for the Humanitarian Buffer and the COVID-19 Vaccines Global Access (COVAX) were laudable but the mechanisms failed to consistently deliver on these.

36.   A new element in the IASC collective response toolkit was the Humanitarian Buffer (HB).[8] While the concept of the Buffer is laudable, the fact that it delivered just over 3.5 million doses of the vaccine across six approved HB applications by June 2022 is disappointing. Lack of funding for vaccine delivery to hard-to-reach communities and the difficulties associated with working outside of state-based architecture remain unresolved challenges. The slow pace of decision-making was also incompatible with the agility and opportunism required to use the HB in volatile contexts. The cost of these failings has been borne by some of those made most vulnerable by the pandemic.

37.   While collective efforts to deliver COVAX were unprecedented and innovative, it was extremely challenging to consistently implement these aspirations at country-level. Many of the reasons for this are external to the humanitarian community and this evaluation recognizes the significant efforts that were made by the COVID-19 response in seeking to address vaccine hesitancy, which played an important part in the limited uptake of vaccines, particularly in the early stages of the rollout.

3.7 Responding to the needs of vulnerable groups

The challenge of scaling up the response in a way that responded to the differential needs of vulnerable people proved extremely difficult for the collective humanitarian system. Lack of funding, limited capacity for analysis, the scale of the needs and the lack of operational flexibility were all factors that affected collective performance.

38.   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. This facilitated the inclusion of refugees in national plans and encouraging coordinated efforts.

39.   The evaluation found that collective action in support of gender and GBV was extremely mixed and while there was evidence of prioritization of these aspects of the response in planning and appeal documents, this was not commensurate with the disproportionate effects suffered by vulnerable women and girls. As is often the case, funding remained an important barrier to collective aspirations to scale-up assistance.

40.   While there was evidence of progress in seeking to more routinely assess and analyze the effect of COVID-19 on other vulnerable groups, specifically people with disabilities and older people, the response fell far short of meeting the specific needs of these groups. 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.

41.   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 ongoing lack of clarity about how to put protection programming into practice, which was evidenced by an initial de-prioritization of protection in comparison with the health and WASH sectors. Consistent under-funding contributed to its lack of prioritization in the pandemic response.

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8   The Humanitarian Buffer ensures access to COVID-19 vaccines for high-risk populations in humanitarian settings. This Buffer acts as the last resort for some of the most vulnerable populations, who have the least resources to cope if they were to get sick from COVID-19. See https://www.gavi.org/vaccineswork/covax-humanitarian-buffer-explained.

3.8 Adapting the response

The humanitarian system worked hard to adapt its support and services to better respond to the complexities of the pandemic. Some of the most effective adaptations tended to be those that had already benefited from prior investments, or which represented long overdue changes.

42. COVID-19 acted as an accelerant, forcing the pace of change, making organizations and donors more open to innovation, and increasing the collective appetite for risk. In several countries, cash was described as having achieved a *'tipping point'* where it became the dominant modality to support livelihoods. Although long overdue, it constituted an important shift, particularly the use of digital and mobile cash. Where new and innovative ways of delivering humanitarian assistance have worked, there should be a commitment to sustaining the advances made.

43. Other adaptations should have a shorter lifespan because they were prompted by negative features of the pandemic such as movement restrictions; these included the increase in the uptake of remote methodologies to provide protection, assistance and quality assurance which were not ideal solutions, but were necessary in some contexts. The evaluation noted that in some of the more access-constrained environments, agencies were slow to re-establish their field presence even after the situation permitted it. 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. With this in mind, the humanitarian community must be discerning in which adaptations it chooses to continue and which should be discontinued as soon as conditions permit a normalization of the response.

3.9 Localization

Many of the intentions to progress the localization agenda and deliver on commitments that were made at the start of the pandemic did not result in significant or long-lasting change, despite the greater role played by L/NAs in the COVID-19 response.

44. The volume of IASC guidance on aspects of localization at the start of COVID-19 reflects the good intentions that existed in implementing Grand Bargain commitments and the wider localization agenda. Some progress was made but, overall, the pandemic has been a missed opportunity to advance this important agenda. Any increases in funding disbursed to L/NNGOs have since been reversed and there has been little change to the power that L/NNGOs have in partnerships or their level of involvement in decision-making bodies. Moreover, with the lifting of COVID-19 restrictions, evidence suggests that there has been a return to the pre-pandemic status quo. This is all the more disappointing because of the enhanced role and responsibilities that L/NNNGOs and communities themselves took on during the COVID-19 response, particularly where international humanitarian actors withdrew. They received little recognition or recompense for taking on additional responsibilities and risks.

45. While donors were generally quick to agree to the re-purposing of their funds, they performed poorly in getting funding directly to front-line responders and the lengthy chain of partnership and sub-contracting from institutional donors to United Nations and International Non-Governmental Organizations (INGO) to front-line responders remained in place despite strong requests for change. It is difficult to shift power within the humanitarian system without money but the evaluation did not identify any significant innovations in direct funding of L/NNGOs by donors, which was a disappointing but important finding. This underlines that it is now time to ensure that the localization spotlight includes donor practices as well as the partnership practices of humanitarian agencies.

46. Concerns about risk management have been identified as one of the barriers that prevents donors from increasing direct funding to L/NNGOs. As a result, capacity development efforts are often focused on improving administrative and financial management. In some contexts, this type of capacity strengthening has been conducted for years, even decades, and yet donors and international humanitarian actors argue that L/NNGOs are not ready to handle significant amounts of direct funding. This is an area that needs to be addressed urgently because it strongly suggests that the problem is more about a lack of trust, or insufficiently flexible donor systems, than a lack of L/NNGO capacity.

3.10 Operational coherence and complementarity

Despite recognition of the need for a holistic response to COVID-19, there was no significant change in existing levels of collaboration and coordination between humanitarian, development and peace actors.

47. There were few examples of COVID-19 making a significant difference to operationalizing the nexus in the eight case study countries, even in contexts where efforts were underway before the start of the pandemic. Perhaps the best examples were in countries with only a modest pre-existing humanitarian footprint. In other contexts, operationalizing the nexus was a missed opportunity for humanitarian, development and peace actors to work together to address the intertwined impacts of the pandemic. This is in part because the socio-economic impacts of COVID-19 have proved to be as serious, if not more so, than the immediate health and humanitarian impacts, but there has been limited funding available to address them. Also, in many of the conflict-affected or fragile environments that the GHRP targeted, the greatest challenge in delivering a more coherent and connected response was not the lack of linkages between the siloed international aid architecture, but the existence of the siloes themselves. Even a multi-dimensional global crisis like COVID-19 did not generate sufficient political will and concerted effort to overcome institutional interests and address this long-term structural problem.

The Secretary-General's call for a global ceasefire did not result in any major change in global levels of violence.

48. The Secretary General's call for a global ceasefire on 23 March 2020 was referenced in the United Nations' socio-economic response framework and also in the United Nations' outline of its comprehensive response to COVID-19. There were varying levels of response to the call from armed groups but, overall, it did not lead to a major decrease in violence. Where violence was reduced during the pandemic, this did not appear to be attributable to COVID-19.

3.11 Monitoring and reporting of collective results

While the evaluation recognizes that the collective efforts of the IASC made a significant contribution to the COVID-19 response, the partiality of the 2020 results and the lack of COVID-19-specific indicators and results for 2021, means that it is not possible to offer a rigorous global analysis of its effectiveness in either year.

49. 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 several challenges with implementing this, including the focus on an individual agency (particularly the United Nations) 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 at the output level and limited qualitative information at the outcome level.

50. For these reasons, it is not possible to make a judgment on the effectiveness of the response in 2020. It is noteworthy that challenges with humanitarian response monitoring are not new to the IASC as similar issues were reported in the IAHEs for South Sudan, Ethiopia and Mozambique. This underlines the importance of now seeking to address these problems.

51. 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.

4   Conclusions

Key conclusions from the evaluation

52. 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.

53. 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.

54. 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.**

55. 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.

56. 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.

57. 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 Coalition[9] and the Joint Evaluation of Emergency Assistance to Rwanda among many others.[10] 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.'*[11] 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.**

58. 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

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9   Tsunami Evaluation Coalition (2006) Joint Evaluation of the International Response to the Indian Ocean Tsunami: Synthesis Report, July 2006.
10 DANIDA (1996) The Joint Evaluation of Emergency Assistance to Rwanda, 1996.
11 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.

59. 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.

60. 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.

61. 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.**

62. 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.

63. 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.

64. 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.

65.   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.*'[12] 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.**

66.   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.

67.   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.

68.   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.

69.   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*'[13] 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.

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[12]   Ibid.
[13]   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.**

70.   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.

71.   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

72.   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.

73.   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.

74.   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.

75.   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.

76.   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 AAP[14] 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.[15] However, statements and strategies on both AAP and PSEA are meaningless without a means of monitoring action and compliance.	
Sub-recommendation	**Action**
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.	Global level: IASC Principals, OPAG, IASC Task Force 2 on AAP Country level: HC, HCT, IASC member agencies
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.	Country level: HC, HCT, OCHA
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.	Country level: HC, HCT, OCHA
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.[16] The commitments and targets should be implemented and monitored as a priority with adequate support and resourcing from relevant global actors.	Global level: IASC Technical Advisory Group on PSEAH Country level: HC, HCT, IASC member agencies

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14   IASC (2022) Statement by Principals of the IASC: Accountability to affected people in humanitarian action, 14 April 2022.
15   IASC (2022) IASC Vision and Strategy: Protection from sexual exploitation, abuse and sexual harassment (PSEAH) 2022-2026.
16   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**
2.1. **Implement existing policies:** At global and country level, implement IASC Guidelines on the inclusion of persons with disabilities in humanitarian action[17] (ii) IASC Policy on Gender Equality and the Empowerment of Women and Girls in Humanitarian Action[18] (iii) IASC Gender Handbook[19] (iv) IASC Policy on Protection in Humanitarian Action[20]	Global level: IASC members Country level: HC, HCT, IASC member agencies
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.	Global level: IASC Principals, EDG, OPAG
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.	Country-level: HC, HCT
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.	Global level: IASC Principals, EDG, OPAG

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[17] IASC (2019) IASC Guidelines on inclusion of persons with disabilities in humanitarian action 2019, July 2019.
[18] IASC (2017) IASC Policy on gender equality and the empowerment of women and girls in humanitarian action 2017, November 2017.
[19] IASC (2018) IASC Gender handbook for humanitarian Action 2018, February 2018.
[20] 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 localization[21] 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
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.[22] 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	Global level: IASC Principals, OPAG
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.	Country-level: IASC members
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.	Global level: IASC Principals, OPAG
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.	Country-level: HC, HCT, IASC members

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[21] 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.

[22] 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
4.1. **Strengthen policy:** The IASC should use the lessons from the COVID-19 response alongside existing good practice[23] and its own policy on Collective Outcomes[24] as a basis for outlining an approach to responding to future global health crises in a way that is consistent with its commitments.	Global level: IASC Principals, OPAG

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
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.	Global level: Global Cash Advisory Group Country level: Cash Working Groups
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	Global level: IASC members

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[23] IASC Results Group 4 (2021) Mapping good practice in the implementation of humanitarian-development-peace nexus approaches: Synthesis report, September 2021.
[24] IASC Results Group 4 (2020) *Light guidance on collective outcomes*, June 2020.

	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. [25]	
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.	Global level: OPAG (as lead for the HPC) Country level: HC, HCT, IASC members
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.	Global level: IASC Principals, EDG, OPAG
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.	Global level: IASC Deputies Group and relevant UN entities and partners

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