Independent Commission for Aid Impact

The UK's humanitarian response to COVID-19

Literature review

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1. Introduction

This literature review forms part of the ICAI review *The UK's humanitarian response to COVID-19*, which aims to assess how well the UK government has responded to humanitarian needs created or exacerbated by the COVID-19 pandemic.

As a major humanitarian donor, the UK has played a significant role in the international response to COVID-19. ICAI's review considers how well UK aid responded both to the direct effects of the pandemic (deaths and illness associated with the COVID-19 virus) and to the indirect humanitarian effects, including impacts on livelihoods from public health measures, the effects of disruption to public services and the increased incidence of violence against women, girls and vulnerable people.

The scope, research questions and methodology for this literature review were developed as part of the methodology for the ICAI review (see *The UK's humanitarian response to COVID-19: approach paper*).[1] The literature review supports the review in three ways:

1. By contextualising Department for International Development (DFID) / Foreign, Commonwealth and Development Office (FCDO) actions within the broader humanitarian response, the literature review highlights key issues that arose in the course of the global pandemic response and so identifies areas of enquiry for the review.
2. By outlining good practice in humanitarian response to epidemics and in areas where DFID / FCDO had made prior commitments to improvement, the literature review provides a benchmark for assessing the performance of DFID / FCDO in response to the pandemic.
3. By assessing the strengths and weaknesses of the global humanitarian response, the literature review allows a comparison of DFID / FCDO actions with those of other humanitarian actors involved in the response.

The literature review is composed of three sections.

The first section outlines the situation at the onset of the pandemic. It considers:

1. The global humanitarian situation at the end of 2019.
2. What was already known about good practice in humanitarian responses to epidemics.
3. What was known about good practice in humanitarian programming more generally, with specific reference to two reform initiatives where DFID / FCDO had made specific commitments.

The second section outlines the course of the pandemic. It describes:

4. Developments in humanitarian needs (unrelated to COVID-19) over 2020 and the first part of 2021.
5. The development of the pandemic in terms of morbidity and mortality over the period from January 2020 to August 2021.
6. Key steps in the international community's response to the pandemic.
7. The responses of three major humanitarian donors (the US, Germany and the EU).

The third section assesses the overall performance of the global humanitarian response to the pandemic. It considers:

8. How well the international humanitarian 'system' (both donors and operational agencies) performed in terms of:
    a. reaching everyone in need
    b. giving aid relevant to needs (and particularly the needs of marginalised groups)
    c. coordinating with one another
    d. supporting the resilience of governments and populations to address future pandemics
    e. responding to an unprecedented global emergency.

[1] Specifically out of scope for the literature review were: vaccine development and distribution and associated science (covered by the review *The UK aid response to COVID-19*); macroeconomic issues and long-term economic recovery (it is too early to have sufficient data to review this).

Method

The literature review builds on the annotated bibliography completed as part of the *ICAI rapid review on the UK aid response to COVID-19*. The documents summarised in the annotated bibliography were reviewed against the questions set for this literature review. The review team then conducted 'snowball' searches: reviewing any resources that were cited in this initial set of documents and that were of relevance to the research questions. In a further step, the review team used Google Scholar, consultations with key informants and their own knowledge of the topic to identify five to ten additional documents for each question. They reviewed these documents and then conducted 'snowball' searches on these documents to identify further documents for review. Finally, the team conducted searches of the ALNAP HELP database of evaluations using the search terms: "COVID-19", "Ebola", "SARS", "triple nexus" and "Grand Bargain" and reviewed evaluative and 'lessons learned' documents that included a statement of methodology. In total, the team reviewed over 198 documents.

The date ranges of documents reviewed differed from one question to another. Most documents were from the period from 2019 to 2021. For questions related to knowledge and best practice from previous humanitarian action, documents published in the period from 2010 to 2021 were considered. All documents reviewed were written in English. The review considered both published and grey literature. Analytical documents (such as academic reports, literature reviews and evaluations) were only included where they had either been peer-reviewed, or where the document had a clear statement of methodology. Descriptive documents (such as situation reports) were included where they came from a reliable source, such as a UN or government agency.

The literature review was not a systematic review and did not aim to be comprehensive. Rather, the approach aimed to identify and analyse the key English-language documents related to each of the review questions. The review used the principle of 'saturation': when additional documents were not providing any new information on a specific question, the team considered that question complete.

The review was conducted while the pandemic was ongoing, and before most humanitarian organisations had conducted evaluations of their response. As a result, it offers only an incomplete account of the course of the pandemic, the successes and failures of the international community, and the lessons that will help humanitarians respond to future pandemics.

2. The situation at the onset of the pandemic

What was the global humanitarian situation before the pandemic?

Humanitarian needs

At the beginning of 2020, before planning began for the response to the pandemic, it was projected that nearly 168 million people globally would need humanitarian assistance and protection (United Nations Office for the Coordination of Humanitarian Affairs (OCHA), 2019). The number of people assessed as being in need of humanitarian assistance has risen fairly steadily over the past two decades,[2] and the 2020 figure was the highest recorded to date. Most of these people were affected by large and long-running humanitarian crises in countries such as Syria, Yemen and Afghanistan. At the same time, 2019 had seen several new humanitarian crises, notably in Madagascar, Mozambique, Venezuela and Zimbabwe. These crises demonstrated some of the interrelated long- and short-term trends that had driven humanitarian need to levels not seen for many decades.

The rise and detrimental effects of violent conflict: Over the decade 2010-19, the number of armed conflicts globally more than doubled from 59 to 121 (Palik et al., 2020). These conflicts took a heavy direct toll on civilian populations, with recorded civilian casualties, deaths and injuries standing at 19,401 in 2019 (Action on Armed Violence (AOAV), 2019). Conflict also had indirect humanitarian consequences: it was an important cause of distress migration and made a significant contribution to hunger crises.

[2] The period for which comparable data are available.

Increasing hunger and food insecurity: The 2020 report on Global Food Crises recorded 135 million people in 53 countries as being in food crisis (Food Security Information Network (FSIN), 2020). This reflected a trend of increased global food insecurity, caused by climatic factors, conflict and economic shocks (FSIN, 2020). At the end of 2019, Yemen remained the world's worst food crisis, with 15.9 million people – more than half of its population – in critical need of food (OCHA, 2020a). Women were disproportionately affected by hunger (OCHA, 2021a).

The impacts of climate change: Climate change is a key driver of humanitarian need: increasing the severity and frequency of natural disasters, compounding the humanitarian effects of conflict and contributing to displacement and migration (Knox Clarke, 2021). Fragile states are both particularly at risk of climate change effects and particularly vulnerable when they occur (Grayson et al., 2019; Knox Clarke, 2021). By 2019, climate change was a contributing factor in the world's eight worst food crises (OCHA, 2019).

Increased displacement and distress migration: At the end of 2019, 79.5 million people were forcibly displaced from their homes worldwide as a result of conflict, persecution, violence, human rights violations, disasters or disruptive events. Of these, 26 million were refugees living outside their country of origin (United Nations High Commissioner for Refugees (UNHCR), 2020). As with other humanitarian trends, the numbers of people forced to flee their homes had been steadily rising over the decade (UNHCR, 2019): the total number of refugees, for example, had doubled since 2010 (OCHA, 2020a).

Increasing risks of infectious diseases: Humanitarian actors were becoming increasingly concerned about infectious diseases before the COVID-19 pandemic (OCHA, 2019). Weak health systems, poor water, sanitation and hygiene (WASH) and lack of access to vaccinations combined with active conflict or protracted crises appeared to be increasing the prevalence of infectious disease in humanitarian contexts, while making them harder to contain and control (OCHA, 2019).

Humanitarian finance

While needs increased, the funds required to meet these needs were decreasing. In 2019, funding for international humanitarian assistance fell by 5% to $29.6 billion (OCHA, 2019). This was the first fall in funding since 2012 (OCHA, 2019). At the outset of the pandemic, most humanitarian appeals were underfunded, although the degree of underfunding differed significantly from one country to another. Haiti and Venezuela, for example, had received less than 30% of required funding, while the appeals for Ethiopia, Iraq, Madagascar and Myanmar were funded at between 70 and 80% of their requirements (OCHA, 2019). On average, 64% of appeal requirements were met in 2019 (OCHA, 2019).

The largest donors of international humanitarian assistance in 2019 were the US, Germany and the UK (OCHA, 2019). These three donors accounted for 58% of all international humanitarian assistance from public donors. Against a general background of decreasing financial support for humanitarian assistance, in 2019 the UK increased its proportion of humanitarian assistance in terms of GNI from 0.09% in 2018 to 0.11% in 2019 (OCHA, 2019). Combined bilateral contributions from EU institutions and European governments also increased in 2019. The UK was also part of a small group of donors who contributed the major share of UN pooled funds: in 2019, the UK tripled its contribution to the UN's Central Emergency Response Fund (CERF).

What was known at the outset[3] about humanitarian needs and responses in pandemics?

Against this challenging humanitarian background, the international community was faced at the start of 2020 with the threat of COVID-19, which would cause additional needs in existing humanitarian contexts, disrupt humanitarian programming globally and – potentially – require humanitarian action in countries that were not experiencing conflicts or other disasters. While the specific challenge of COVID-19 was new, the humanitarian system had experience of responding to epidemics, and several 'lessons learned' and 'best practice' guides were

[3] Although COVID-19 was officially declared a pandemic in March 2020, response planning was occurring in many organisations from January 2020 onwards. Accordingly, when this document refers to the 'outset' of the pandemic, it refers to the period from – roughly – December 2019 to April 2020.

available. This section outlines the key lessons that were available to DFID / FCDO on the basis of previous epidemics.

Humanitarian needs in pandemics

In addition to the mortality directly caused by COVID-19, the experience of previous epidemics – particularly the West Africa Ebola epidemic (2014-16) and the swine flu outbreak (2009-10) – made it clear that the pandemic would indirectly lead to a range of humanitarian needs. These needs had been outlined in reports and lessons papers published in the decade 2010-20, and were reiterated in a number of publications produced in the first three months of the pandemic. Areas of concern included:

Additional health needs: Over-stretched healthcare services, and reluctance to use healthcare services for fear of coming into contact with infection, could be expected to lead to increased suffering and mortality from other diseases and medical conditions (Amara et al., 2017; ACAPS, 2020c). Areas of particular concern mentioned in the literature included: maternal and child health (see below), mental health services (Rohwerder, 2020) and vaccination programmes (Gaythorpe et al., 2021).

Economic and livelihood effects: Previous disease outbreaks and government attempts to control them had resulted in negative impacts on the economy, particularly on sectors like agriculture, manufacturing, and services (Amara et al., 2017). Generally, the most economically vulnerable groups had borne the brunt of these impacts (Madhav et al., 2018; Rohwerder, 2020).

Food security and nutrition: The economic disruption caused by previous epidemics had led to shortages and increased prices of resources and food, placing financial stress on poorer people reliant on the market for access to food (Ayanlade and Radeny, 2020; Mahajan and Tomar, 2020; Rohwerder, 2020; Swinnen and McDermott, 2020). Sharing food between households also became more difficult during quarantines (Rohwerder, 2020).

In addition, there were concerns around threats to education and protection for certain vulnerable groups (see the section below).

Vulnerable population groups

The experience of previous humanitarian emergencies, and particularly of previous epidemics, suggested that specific population groups might be particularly vulnerable to the humanitarian consequences of COVID-19. These groups, identified in the first Global Humanitarian Response Plan (OCHA, 2020b), included:

Women and girls: While the impacts of epidemics on girls and women are shaped by the specific gender dynamics in their context and by their social position (Ripoll et al., 2018), previous experience of epidemics suggested several general vulnerabilities including:

- **Impacts on health.** Diversion of resources from sexual and reproductive healthcare, and avoidance of health services for fear of contracting disease, led to increased maternal mortality in the West Africa Ebola epidemic of 2014-16 (Fuhrman et al., 2020). In addition, women and girls were vulnerable to a number of other health effects including unwanted pregnancies and unsupervised abortions (ACAPS, 2020b; Laouan, 2020; Rohwerder, 2020; Wenham et al., 2020).
- **Impacts on livelihoods.** It was expected that women would be particularly affected by the economic impacts of COVID-19, as a result of their over-representation in sectors of the economy impacted by containment measures, requirement to provide increased (unpaid) labour in caregiving, and insecurity of land tenure (ACAPS, 2020a; Fuhrman et al., 2020; Laouan, 2020; Wenham et al., 2020).
- **Vulnerability to domestic violence.** Domestic violence against women and girls had increased during previous epidemics and was expected to increase again during the COVID-19 pandemic (Bandiera et al., 2018; ACAPS, 2020b; Fuhrman et al., 2020; Laouan, 2020; Wenham et al., 2020).

Displaced people, refugees and migrants: Populations which had been forced to move were also expected to be disproportionately affected by the pandemic and by actions taken in response to the pandemic (ACAPS, 2020c). Risks included:

- **High risk of infection.** At the outset of the pandemic, there was an expectation that these populations would have particularly high rates of COVID-19 as a result of living conditions characterised by high population density and limited access to sanitation, safe water, nutritious food and healthcare (ACAPS, 2020a; ACAPS, 2020c; Khouzam and Verma, 2020; Rohwerder, 2020; San Lau et al., 2020). To date, however, refugees do not seem to have experienced particularly high infection rates (Egeland, 2020).
- **Stigmatisation and exclusion.** Displaced people and migrants had been stigmatised in previous epidemics, and blamed for spreading the disease (Madhav et al., 2018; Carter et al., 2020). There was concern that this might lead to further social exclusion and aggression against these groups (Vishwanath et al., 2020).
- **Impacts on livelihoods.** Displaced and migrant populations are often employed in the informal economy. This left them particularly vulnerable to the economic impacts of the pandemic, while also effectively excluding them from many social protection systems. This area of vulnerability was not as strongly highlighted at the outset of the pandemic (although see UNHCR, 2020a) but became more evident over 2020 (Danish Refugee Council, 2021; Vishwanath et al., 2020).

Frontline health staff: The Ebola pandemic, in particular, had seen high disease morbidity and mortality among frontline health staff (Grunewald, 2020). This group was seen as being particularly vulnerable to:

- high risk of infection
- other health impacts, particularly on mental health (Piot et al., 2019)
- stigmatisation, as potential carriers of the disease (Mabula et al., 2018; Lamoure and Juillard, 2020) and violence directed against healthcare workers (Insecurity Insight, 2020).

People with disabilities: People with disabilities were seen to be at risk because of potential difficulties in accessing healthcare and health communications (Handicap International, 2020). They were also seen as being vulnerable to neglect (OCHA, 2020b). As a result, the Global Humanitarian Response Plan (GHRP) outlined specific measures to be taken to include people with disabilities in assessment and programming.

Older people: Older people were initially seen as being vulnerable to infection by COVID-19 (UN, 2020b), but less attention was given to the other ways in which the pandemic might make them vulnerable. However, in the May 2020 update of the GHRP, they were added as an 'affected population group', and it was recognised that they were particularly vulnerable to:

- high risk of infection and mortality from COVID-19 (OCHA, 2020c)
- other health impacts, as a result of difficulties obtaining treatment for ongoing conditions (OCHA, 2020c)
- stigmatisation, as a result of COVID-19 being seen as an 'old peoples' disease' (OCHA, 2020c)
- increased risks through failure of care/neglect (ACAPS, 2020c; OCHA, 2020c).

Children: In addition to the specific vulnerabilities of girls, outlined above, children were also expected to be particularly affected by:

- Lack of access to education as a result of school closures, decreased state expenditure on education and increased requirements for child labour to earn income and care for other family members (Bandiera et al., 2018; Ripoll et al., 2018; Rohwerder, 2020).
- Poor nutrition, stunting and wasting as a result of lack of food and lack of access to healthcare (World Bank Independent Evaluation Group, 2021).

The literature on previous epidemics differed on how to address the specific and heightened vulnerabilities of particular groups. Some argued for a 'whole society' approach (Alcayna-Stevens, 2018) to ensure that the needs of those affected by the outbreak and other health needs of the wider community are cared for. However, this broad-based approach was hindered by limited available resources, including financial resources and trained staff. An alternative strategy was to target specific vulnerable groups (Leach et al., 2020). It was important, however, not to assume that certain groups would be vulnerable, but to understand needs and vulnerabilities in a specific social context (Kelly, 2020).

Geographical vulnerability

Evidence from previous epidemics suggested that **informal urban settlements, other urban areas with high population densities and limited provision of services, and camps for refugees/internally displaced people (IDPs) were particularly vulnerable** to rapid disease transmission and posed specific challenges for response (Ripoll et al., 2018; ACAPS, 2020c; Grunewald and Maury, 2020; Lamoure and Juillard, 2020).

Areas affected by conflict, where people might have poorer health and nutritional status, and where healthcare services would be limited, had also proved to be particularly vulnerable to the spread of epidemics, and in a poor position to respond (Khouzam and Verma, 2020).

Lessons related to epidemic control

At the outset of the pandemic, a number of lessons and good practices for responding to and controlling epidemic diseases were available to humanitarian practitioners. Many of these lessons related to preparedness activities that should take place before epidemics occur, with **an emphasis on preventing, rather than responding to crises** (Heymann et al., 2015; Moon et al., 2015). This includes:

- **The creation of systems** to conduct epidemiological assessments, real-time surveillance and contact tracing in order to intervene early and control the spread of disease (Wilson et al., 2010; Grunewald and Maury, 2020).
- **Ensuring systems strengthening for healthcare is focused on resilience.** Experience showed that systems strengthening should aim for resilient systems that can respond to epidemics and still address the everyday health needs of local populations (Gostin and Friedman, 2015).
- **Recognising healthcare workers as central to effective epidemic response.** In preparing healthcare systems to respond to epidemics, the literature highlights the importance of ensuring that there are enough frontline healthcare workers, that they are trained to respond to emergency situations, that they are adequately compensated and supported (a key failure in the Ebola epidemic), and that they have adequate personal protective equipment (PPE) (Heymann et al., 2015; Piot, et al., 2019; Lamoure and Juillard, 2020),

With respect to epidemic response, a key lesson that had emerged from the humanitarian experience of Ebola was **the need for community engagement, and understanding local contexts and cultures, in combating the disease**. This was a notable failure of the Ebola responses, which initially prioritised top-down approaches rather than recognising the important role of relatives and neighbours as first responders to epidemics (Lamoure and Juillard, 2020). Community engagement involves working with communities to understand local cultural, social, political and economic factors that relate to the disease (Heymann et al., 2015; Piot et al., 2019), and building relationships with, and trust in, health authorities (Carter et al., 2020; Kelly, 2020; Lamoure and Juillard, 2020).

WASH activities are also vital for an effective response (Blanchet et al., 2017; Lamoure and Juillard, 2020). In particular, WASH activities that involve messages on how the disease is spread and how transmission can be prevented, should be a priority (Grunewald and Maury, 2020).

It is also important to **develop 'humanitarian corridors', as per the World Health Organisation (WHO) guidance** (Grunewald and Maury, 2020) in order to transport medicines, equipment and test kits in a situation where movement of goods is restricted, and without overwhelming existing logistical arrangements required for continuation of other healthcare services.

Lessons related to addressing 'secondary' humanitarian needs caused by an epidemic

In previous epidemics, and in the West Africa Ebola epidemic in particular, humanitarian actors had been slow to recognise and respond to the 'secondary' humanitarian impacts related to the disease: impacts on areas such as provision of health services, nutrition, livelihoods and education (DuBois et al., 2015; Knox Clarke, 2018). In 2019-20 there was much greater recognition of these threats, as well as a number of lessons and good practices on how to address them.

One key lesson **was the importance of maintaining essential health services to provide coverage for non-COVID-19 health needs** (Kelly, 2020; San Lau et al., 2020; Kutalek et al., 2015; McQuilkin et al., 2017). Specific interventions might include targeted funding, specifically for local-level health services (Kelly, 2020) and for specific conditions such as HIV, malaria and tuberculosis (San Lau et al., 2020).

It is important to recognise and respond to the economic impact of the pandemic on vulnerable households. This requires identification of those people who have been disproportionately impacted, such as workers in the informal sector and agriculture (Lamoure and Juillard, 2020). Cash and voucher assistance is an effective approach to providing short-term economic support (Lamoure and Juillard, 2020). There should also be a focus on long-term income-generating activities through micro-grants and providing training to support livelihood recovery (Momoh et al., 2016).

A number of authors highlight the importance of focusing on gender-based violence (GBV) – an area that was comparatively neglected in previous epidemics (Stark et al., 2020). This includes ensuring support for GBV-specific services such as safe spaces and crisis centres for victims in such a way as to prevent the spread of the disease, and providing information and health services that meet victims' specific needs (John et al., 2020).

Good coordination between organisations is vital for an effective, multisectoral response (Leach et al., 2020). Experience of previous epidemics did not demonstrate one single best coordination system (Lamoure and Juillard, 2020), but did show the importance of ensuring clear roles and responsibilities (Mobula et al., 2018) and ensuring that resources – particularly skilled and experienced human resources – for coordination were available (United Nations Children's Fund (UNICEF), 2017; Cook et al., 2018).

What lessons/good practices were available on operationalisation of the triple nexus that might have been relevant to DFID / FCDO in the COVID-19 humanitarian response?

The triple nexus or 'the new way of working' is a programmatic approach that aims to strengthen interconnections between humanitarian, development and peace actions (OECD, 2022) in order to address both the immediate and the longer-term needs of vulnerable and crisis-affected populations (Centre on International Cooperation (CIC), 2019; Hövelmann, 2020; Nguya and Siddiqui, 2020; Oxfam, 2019; International Council of Voluntary Agencies (ICVA), 2018; Südhoff et al., 2020; Swiss Agency for Development and Cooperation (SDC), 2019; Pedersen and Copenhagen, 2020; Alcayna, 2019).

The approach was instigated as a UN reform initiative at the World Humanitarian Summit in 2016 and taken forward through an interagency process called the Agenda for Humanity. The UK was a stakeholder in the Agenda for Humanity and made a number of commitments towards the new way of working.

The COVID-19 pandemic required a response that provided both immediate humanitarian support and longer-term developmental assistance for health systems and economic recovery. As such, it was well suited to a new way of working that more closely aligns humanitarian and development programming.

In the period from 2016 to 2020, a number of reviews and assessments of triple nexus programming were conducted. These provided lessons and guidance which were available for DFID / FCDO to use in planning its humanitarian activities. Key learning is highlighted below.

The importance of flexible funding

A number of observers suggested that the rigid distinctions between humanitarian, development and peace-building sectors are artificially created by separate funding streams, which make it difficult to work across the three areas (Debarre, 2018; ICVA, 2018; International Committee of the Red Cross (ICRC) and Red Cross EU Office, 2018; Nguya and Siddiqui, 2020). Humanitarian funding, in particular, is generally strictly reserved for certain pre-identified activities over short periods of time. While there can be good reasons for this, it makes it more difficult to adapt to changes in the operating context, to meet new or newly identified needs, and to ensure coherence

with longer-term development programmes (Hövelmann, 2020; Nguya and Siddiqui, 2020; Oxfam, 2019; Alcayna, 2019; SDC, 2019; Pedersen and Copenhagen, 2020).

In 2019, the Organisation for Economic Cooperation and Development's Development Assistance Committee (OECD-DAC) suggested that members adjust the way they fund humanitarian programmes to make the triple nexus a policy priority (OECD, 2022; Hövelmann, 2020). In particular they recommended:

- financing activities that coordinate development, peace and humanitarian assessments and programming
- increasing financial support for prevention activities
- ensuring funding flows that allow humanitarian activities to be adaptive.

Some examples of flexible funding include:

- Ireland's Humanitarian Programme Plan (HPP), which moved funding for programmatic humanitarian responses from a two-year to a three-year funding cycle, with the aim of increasing to a five-year duration from 2022. 20% of HPP funds can also be re-targeted without seeking donor approval (Metcalfe-Hough et al., 2020; Metcalfe-Hough et al., 2021).
- Denmark's four-year partnership agreements with non-governmental organisations (NGOs) and UN agencies, where 30% of funds are unearmarked (Metcalfe-Hough et al., 2020; Metcalfe-Hough et al., 2021).
- DFID's flexible funding model, which enabled movement of funds between budget lines, to adjust budgets in line with strategy and contextual changes. DFID was unusual in this regard and did not – as is generally the case among donors – separate the budget in terms of development and humanitarian spend. This enabled DFID to be responsive, context-specific and innovative in its approaches (Development Initiatives, 2019). In contrast, other donors have found that the separation of funding hinders work that spans humanitarian and development activities (SDC, 2019; Oxfam, 2019; United Nations Evaluation Group, 2018).

In addition, the use of multi-year, country-level pooled funding has been shown to break down the sector-based silos that discourage nexus working (Nguya and Siddiqui, 2020).

The need for context-specific approaches

Successful triple nexus working is founded on an understanding of how humanitarian, developmental and conflict challenges are related in a specific context (ICRC and Red Cross EU Office, 2018; Nguya and Siddiqui, 2020). This requires investment in context-driven and highly localised analyses, which are jointly conducted by humanitarian, development and peace agencies (OCHA, 2017; Knox Clarke, 2018; Willits-King, 2018; Alcayna, 2019; CIC, 2019; Nguya and Siddiqui, 2020; Oxfam, 2019).

Before the COVID-19 pandemic, DFID had demonstrated good practice in this area. The business case approach to programming required country offices or relevant geographical or issue-centred teams to undertake a thorough context analysis and outline the activities required on the basis of the UK's comparative advantage (SDC, 2019). For example, in the DFID business case for the Somalia Health and Nutrition Programme, a five-year programme approved in 2015, the roles of both development and humanitarian assistance were considered in the health sector. The business case recognised the need to shift from humanitarian assistance into longer-term bilateral support, working more closely with government (Development Initiatives, 2019).

The centrality of intersectoral coordination: joint analyses, assessments, planning and strategies

As suggested above, a 'joined-up' approach to programming requires humanitarian, development and peace actors to work together on analysis, assessment and programme design (CIC, 2019; SDC, 2019; Development Initiatives, 2019; Oxfam, 2019; Alcayna, 2019; Nguya and Siddiqui, 2020). This allows for programming that addresses both short- and long-term needs: in parallel, in sequence, or by moving back and forth between the two (Nguya and Siddiqui, 2020; Oxfam, 2019). A key part of this is deciding on a set of collective outcomes that

are shared by all actors, but to which different organisations contribute in different ways and at different times. DFID had developed a number of approaches to support intersectoral coordination:

- DFID's focus on risk, resilience and preparedness and then protracted crises in its programming allowed for key engagement with the nexus and created the frame for coordination and joint analyses and assessments (Development Initiatives, 2019).
- DFID's Country Development Diagnostic tool acted as a basis for joint planning and programming across humanitarian, development and peace programmes (Development Initiatives, 2019).
- DFID's business case facilitated a comprehensive organisational approach to programme design and planning that gave the organisation the tools to consider nexus-related issues in the design process (Development Initiatives, 2019).

What lessons/good practices were available on the Grand Bargain that might have been relevant to DFID / FCDO in the COVID-19 humanitarian response?

In addition to its support for the triple nexus, DFID was also a signatory to the Grand Bargain, another humanitarian improvement initiative that provided lessons to inform DFID / FCDO programming. In 2016, 18 donor countries, including the UK, and 16 international aid organisations agreed a 'Grand Bargain' to improve the efficiency and effectiveness of humanitarian aid (Inter-Agency Standing Committee (IASC), 2021a). They were subsequently joined by a number of other donor states and humanitarian aid organisations. The Bargain – a 'quid pro quo' between donors and operational agencies – was composed of a series of 51 commitments organised into ten areas. It included a voluntary annual reporting mechanism and an annual independent review to monitor progress against commitments (IASC, 2021a).

Three elements of the Grand Bargain were particularly relevant to the pandemic response:

1. More support and funding tools to local and national responders.
2. Increasing the use and coordination of cash-based programming.
3. Enhanced quality funding.

Localisation (more support and funding tools to local responders)

Localisation was considered a core area of the Grand Bargain for all signatories (Metcalfe-Hough et al., 2021; Konyndyk et al., 2020). The breadth and depth of policy discourse on localisation suggests that there has been a system-wide normative shift in thinking in this area (Metcalfe-Hough, 2021). However, before the pandemic, there was a general sense that these changes at a policy level were not leading to meaningful change on the ground (Metcalfe-Hough et al., 2021; Konyndyk et al., 2020; Metcalfe-Hough et al., 2020). The pandemic provided a major opportunity to accelerate progress on localisation (Metcalfe-Hough et al., 2020; Metcalfe-Hough et al., 2021; Development Initiatives, 2020a). Travel restrictions made it difficult for international organisations to work in many places, while the importance of health communication put knowledge of local languages and belief systems at a premium. In supporting localisation, DFID / FCDO could draw on previous experience that suggested it was good practice to:

- **Include the core costs and capacity-building costs of local humanitarian organisations** in project budgets (Kraft and Smith, 2018; Metcalfe-Hough et al., 2020; Wall and Hedlund, 2016; Accelerating Localisation through Partnerships, 2019; International Rescue Committee (IRC), 2020).
- **Ensure that international agencies have clear exit and handover activities** built into programme plans, and potentially fund these agencies to fulfil a backstopping/advisory role once operational activities have ended (Els, 2018; UNHCR and UNDP, 2019; Wilkinson et al., 2020).
- **Support pooled funding mechanisms**, including country-based pooled funds (CBPFs), the Disaster Relief Emergency Fund managed by the International Federation of Red Cross and Red Crescent Societies (IFRC), Start Funds and nationally managed funds such as SAFER in the Philippines. These have increased funding to local and national actors and supported localisation objectives by increasing national NGO representation in governance and decision-making at the country level (Poole, 2018; Barbelet, 2019;

Howe and Stites, 2019; IFRC, 2019; Metcalfe-Hough et al., 2019; OCHA, 2019; UNHCR and UNDP, 2019; Bamforth et al., 2020; Featherstone and Mowjee, 2020; Metcalfe-Hough et al., 2020).

Humanitarian cash-based assistance programming

Before the pandemic, the distribution of cash (rather than in-kind assistance or vouchers for specific products) was growing as a humanitarian assistance modality: in many cases it had become the norm in humanitarian practice (Metcalfe-Hough et al., 2021). Cash-based humanitarian assistance was of particular interest to the UK, which co-convened, with the World Food Programme (WFP), work in this area for the Grand Bargain. In general, providing humanitarian assistance in the form of cash is seen to afford greater dignity to affected populations, to increase the relevance of aid (by allowing cash recipients to decide what their own priorities are) and, often, to increase the speed and decrease the costs of providing assistance (Harvey and Bailey, 2011; Knox Clarke, 2018; Smith et al., 2018; Harvey and Pavanello, 2018; WFP, 2018; WFP, 2019; UNHCR, 2019). The pandemic, to which many states responded by expanding welfare and social protection payments, made cash programming a fundamental element of the global response, and provided the humanitarian system with an opportunity to integrate humanitarian cash into larger, state-led social protection programmes.

Before the pandemic, there had been many evaluations of cash-based humanitarian assistance (several supported by DFID). From these evaluations a broad understanding of how to programme cash effectively had been developed. Key lessons, captured by the OECD-DAC (Fabre, 2017), suggest that donors support:

- **Preparedness measures**, and particularly information-gathering around markets and economic security.
- **Coordination of cash approaches at country level** to ensure that different agencies use comparable eligibility criteria and transfer values for their cash programmes. Where possible, it may be preferable to introduce a single delivery model to replace multiple actors with multiple programmes. DFID and the European Commission Directorate General for Humanitarian Aid and Civil Protection (ECHO) had been trialling this approach in Lebanon since 2017.
- **Developing links to social protection mechanisms**. Humanitarian cash assistance can work with and through government social protection systems and safety nets, so as to strengthen those systems, standardise entitlements and payment mechanisms, deliver cash responses at speed to more people, and extend social protection to new areas or population groups.
- **Consideration of the protection implications of cash programming**. Good cash-based responses should minimise protection risks (for example, addressing any risks faced by individuals in accessing cash support). A risk analysis should be completed to ensure the most vulnerable are able to benefit from the cash-based response and do not incur additional risks as a result of this support.
- **Building financial inclusion by using cash programmes to connect people to banking services**. If cash support is paid through financial institutions, it can provide an introduction for poor and marginalised groups to complementary financial services, such as bank accounts or debit cards, that may outlast the period of emergency response.
- **Ensuring the capacity and skills of organisations (including local actors) to manage a cash-based programme.**

Flexible, multi-year funding ('enhanced quality funding')

Flexible funding is an area which is central to both the triple nexus (above) and the Grand Bargain. The specific commitments in the Grand Bargain cover an increase in multi-year humanitarian funding and planning, flexible funding and reduced earmarking of funds (Metcalfe-Hough et al., 2021; Development Initiatives, 2020b). Since 2016, many donors have increased the provision of multi-year and flexible funding, although operational agencies point out that the total proportion of funding that meets these criteria is still low (Metcalfe-Hough et al., 2020). Examples of good practice that were available to DFID / FCDO are given above on page 9.

3. The course of the pandemic

How did the global humanitarian situation evolve over the period from January 2020 to August 2021?

In countries already experiencing humanitarian crises, the COVID-19 pandemic occurred in, and exacerbated, situations where millions of people were already experiencing threats to life and livelihood as a result of conflict, weather extremes and economic failures. These conflicts and disasters continued alongside the pandemic over 2020 and 2021, and in many contexts these underlying crises posed a graver risk to vulnerable populations than the pandemic. At the onset of the pandemic, the UN advised donors to see existing humanitarian needs as "an utmost priority" (OCHA, 2020b:9). Despite this, funding to existing programmes fell as donors directed funds to meet needs caused by COVID-19 (Development Initiatives, 2021a). Existing humanitarian programming also became more difficult as a result of supply chain disruption, movement controls and evacuation of expatriate humanitarian staff. As a result, the number of programmes where it was difficult to access people in need increased significantly over the period (ACAPS, 2021).

In many countries, including South Sudan, Syria, the Central African Republic and the Sahel region, existing crises were made more severe in 2020 due to acute weather conditions, which in turn exacerbated food insecurity (UNHCR, 2020b). Globally, the number of people in food crisis increased by 20 million, to a new record of 155 million (FSIN, 2021). Threats to life also increased from other causes, including an increase in communicable diseases (OCHA, 2020a).

These trends are illustrated by the situations in countries which were already the focus of humanitarian attention at the onset of the pandemic.

In Afghanistan, the war that had lasted more than 40 years intensified over 2020 and 2021, leading to a Taliban takeover of government in August 2021. At the same time, Afghanistan was experiencing a severe drought, which had affected 80% of the country by June 2021 (IFRC, 2021b). These dual crises led to a doubling of the number of people in need of humanitarian assistance – by the end of 2021, the UN estimated that 18.4 million people needed aid, accounting for more than 47% of the country's population (OCHA, 2021a).[4] At the same time, conflict and COVID-19 made it harder for humanitarian agencies to reach people most in need (OCHA, 2020a).

In Ethiopia, existing humanitarian needs caused by displacement, droughts, floods and desert locust invasions (OCHA, 2021a) were intensified by conflict that broke out in the Tigray region in November 2020. This led to over a million people becoming displaced (UNHCR, 2019). Access to basic services, food and safe water quickly became limited, and people's livelihoods were destroyed. Before the conflict, the Tigray region was already experiencing high levels of malnutrition, especially among women and children, which worsened as a result of the conflict. By the end of 2021, the UN estimated that almost 21.3 million people in Ethiopia needed humanitarian aid, accounting for almost 19% of the country's population (OCHA, 2021a).

In Yemen, conflict has led to massive disruption to livelihoods, closure of services and large-scale displacement: by the end of 2020, 3.6 million people were displaced across the country (OCHA, 2020a), and record numbers of children and pregnant and lactating women were suffering from malnutrition (OCHA, 2020a; 2020e). Outbreaks of communicable diseases such as cholera, diphtheria, polio and dengue fever devastated communities during the first half of 2020 (OCHA, 2020d). By the end of 2021, the UN estimated that 24.3 million people in Yemen needed humanitarian aid, accounting for almost 82% of the country's population (OCHA, 2021a).

In Sudan, humanitarian needs increased in response to ongoing pre-COVID-19 disease outbreaks, but also as a result of conflict, economic collapse and flooding events. Even though the conflict had somewhat calmed since 2016 due to a peace agreement between the Sudanese government and armed groups, violence continued, forcing millions to be displaced (OCHA, 2020a). In addition to unrest and displacement, in 2020 Sudan suffered from outbreaks of diseases including malaria, polio, chikungunya and viral haemorrhagic fever, as well as extreme flooding, which further increased the risk of contracting and spreading water-borne diseases and damaging

[4] The percentages in this subsection have been calculated using the number of those in humanitarian need and the total population provided by OCHA (2021a), link.

livelihoods (FSIN, 2021). By the end of 2021, the UN estimated that 13.4 million people in Sudan needed humanitarian aid, accounting for almost 31% of the country's population (OCHA, 2021a).

In Syria, a decade of war had caused displacement, civilian casualties, economic collapse and unstable health systems. Syria's forcibly displaced population is the world's largest, with 13.5 million displaced: the total displaced population represents over half of the Syrian population (UNHCR, 2020a). The number of displaced people increased by 100,000 during 2020 (UNHCR, 2020a). In the northwest region in particular, the number of child casualties between January and March 2020 reached an all-time high since the conflict began (UNICEF, 2020). In the country as a whole, poverty increased significantly in 2020 and 2021, making it even harder for people to meet minimum dietary needs (OCHA, 2020a). By the end of 2021, the UN estimated that 13 million people in Syria and a further 20 million people outside Syria were in need of humanitarian aid, accounting for more than 74% of the country's residing population (OCHA, 2021a).

In Madagascar, the Grand Sud region experienced its most severe drought in 40 years, affecting approximately 69% of the region (OCHA Madagascar report). This crisis coincided with other shocks, including sandstorms, armyworms and locusts (OCHA, 2021c), leading to agricultural losses of up to 60% across the region. As a result, the number of people experiencing food insecurity in Grand Sud roughly doubled between 2020 and 2021, to 1.14 million in July 2021 (OCHA, 2021c), as did infectious disease outbreaks (FSIN, 2021). At the end of 2021, the UN estimated that 1.6 million people were in need of humanitarian assistance in Madagascar, accounting for nearly 6% of the country's population.

These examples are by no means the only areas where humanitarian needs distinct from COVID-19 have persisted or increased during the pandemic, but they provide a snapshot of the humanitarian situation beyond the pandemic.

How did the COVID-19 pandemic evolve over the period from January 2020 to August 2021?

The SARS-CoV-2 (COVID-19) virus was initially detected in China in December 2019. By March 2020, COVID-19 was present in humanitarian contexts in the Middle East and – to a lesser degree – had been detected in the form of individual cases and clusters in Africa, Latin America and the Caribbean (OCHA, 2020b). Countries with poor universal health coverage – notably in sub-Saharan Africa, South Asia, Southeast Asia and the Pacific, were seen to be at particular risk of "massive outbreaks" (OCHA, 2020b:11). By July 2020, OCHA estimated that, without significant interventions, COVID-19 could infect up to 640 million people and kill 1.67 million of the world's most vulnerable people in 32 low-income countries (Omtzigt and Pople, 2020).

At the onset of the pandemic, the UN envisaged two possible scenarios for the growth of, and response to, COVID-19 (OCHA, 2020b). In the best-case scenario, the humanitarian community would take swift action and the virus would be largely contained by July 2020, allowing for a quick recovery (OCHA, 2020b). In the worst-case scenario, there would be rapid escalation in fragile and developing countries. In this case, it was expected that the rate of infection and spread of infection would rise considerably in developing regions, notably Africa, Asia and the Americas, leading to an extended period of limited movement and border closures. It was also expected that health systems in developing countries would be unable to respond to the outbreak, increasing the severity of the spread by another 9-12 months (OCHA, 2020b). In both scenarios, it was assumed that the pandemic would be under control by July 2021.

Data on disease morbidity and mortality are generally of poor quality or unavailable in humanitarian contexts (Knox Clarke and Darcy, 2014; Knox Clarke, 2018; Mahmood et al., 2010). This lack of data has been evident over the course of the pandemic (WHO, 2021b; Federal Ministry for Economic Cooperation and Development (BMZ), 2021). Globally, reported figures on COVID-19 mortality appear to be significantly lower than actual mortality rates (The Economist, 2021; WHO, 2021c). This has been particularly true in humanitarian contexts: "Studies in Syria, Yemen and Sudan indicate cases and mortality have been vastly underestimated" (OCHA, 2021a:4).

Nevertheless, the available data do provide an overview of the trends in infections and mortality at a regional level.

The WHO Eastern Mediterranean Region (which includes a number of countries experiencing humanitarian crisis, including Afghanistan, Somalia, Sudan, Syria and surrounding countries, and Yemen) experienced four peaks in reported cases, with the number of cases increasing at each peak. These were in June and November 2020, and April and August 2021. The August 2021 peak comprised 502,000 confirmed cases (WHO, 2021e). Large-scale community transmission was only registered in July/ August of 2020 in some countries and locations of particular concern to humanitarians, including Iraq and Syria (OCHA, 2020d). Death rates related to COVID-19 peaked in the same months as infections, although the death rate did not rise as steeply over the period as the case rate (WHO, 2021e).

In the **WHO Africa region**, widespread community transmission was recorded later than in other regions (OCHA, 2020d). However, by July 2020, authorities were recording peaks in infections. Further peaks followed in January 2021 and July 2021. Each peak was higher than the last, with the July 2021 peak comprising 214,000 cases (WHO, 2021e). Death rates reflected infection rates, peaking in the same months. The relatively low recorded rates for cases and mortality in Africa are likely to be partly a result of poor reporting but also a result of the demographics of African countries, which tend to have young populations[5] (Adams et al., 2021; Lawal, 2021; Musa et al., 2021). Lower rates, particularly early in the pandemic, may also reflect the actions taken by many African governments, including early 'lockdowns' and intensive surveillance and case-finding (Ihekweazu and Agogo, 2020; Musa et al., 2021; Adams et al., 2021). The private sector also stepped up to fill gaps in public health service provision and provide care to critical patients (Ihekweazu and Agogo, 2020). There was also an increase in innovative uses of technology, including drones transporting test kits, and a boost in the local manufacturing of sanitisation and PPE (Ihekweazu and Agogo, 2020).

The WHO Western Pacific region, which includes Bangladesh,[6] the Democratic People's Republic of Korea, Myanmar and the Philippines, all of which were included in the GHRP, experienced far less dramatic peaks and troughs in confirmed cases over the period. Instead, the caseload rose gradually until June 2021, when cases started to increase rapidly, peaking at 554,000 in late August of 2021 (WHO, 2021e). As in the other two regions, peaks in reported death rates occurred in the same months as peak infection rates.

In February 2021, at the end of the last reporting period for the GHRP, there had been 29.5 million reported cases in the 52 countries covered by the plan, and 827,000 confirmed deaths, approximately 35% of global deaths at this point (OCHA, 2021b).

What was the humanitarian response to the pandemic?

United Nations roles and responsibilities in responding to the pandemic

Over the course of the pandemic, the UN's overall response (and by extension, that of most of the international community) has focused on three pillars of operation (OCHA, 2022a):

1. Delivery of a large-scale, coordinated and comprehensive health response – this element of the response has been covered by the WHO-led Strategic Preparedness and Response Plan.
2. Activities to respond to the socioeconomic, humanitarian and human rights aspects of the crisis.
3. A recovery process that builds back better.

Within these three pillars, the humanitarian effects of COVID-19, and of governments' attempts to reduce the spread of COVID-19, were addressed by the GHRP, led by OCHA. The GHRP had three strategic priorities:

1. Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality (particularly in situations which were already receiving humanitarian assistance, as well as in a small number of other contexts where governments requested specific assistance).
2. Decrease the deterioration of human assets and rights, social cohesion and livelihoods (this covered a number of areas including food security, economic support, prevention of GBV and maintenance of essential healthcare and education provision in humanitarian contexts).

5 Globally, only 16% of all deaths occur in individuals aged between 15 and 64 years old (WHO, 2021f:3).
6 The Bangladesh component of the GHRP was targeted exclusively at the Rohingya refugee population.

3. Protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic.

In responding to the humanitarian impact of COVID-19, OCHA has worked with international humanitarian partners (including DFID / FCDO) to identify urgent humanitarian needs, plan responses and determine the budgets needed to address them.

Beyond the humanitarian response outlined in the GHRP, the WHO has led or co-led key initiatives related to the health response to COVID-19, including COVAX and the COVID-19 Solidarity Response Fund. It has also been instrumental in providing governments with reliable guidance to prevent, detect and respond to the pandemic. The UN Development Programme (UNDP) and UN Development Coordination Office have coordinated the development of socioeconomic frameworks and national development plans (OCHA, 2022b).

The beginning

1 January 2020, the WHO dispatched an Incident Management Support Team to Wuhan, China, to ensure coordination of activities and response across the organisation's three levels (headquarters, regional, country) for public health emergencies (WHO, 2021d).

5 January 2020, the WHO shared information about pneumonia cases in China with an unknown source via the International Health Regulations (IHR) Event Information System, which is accessible to all member states (WHO, 2021d).

9 Jan 2020, the WHO reported that Chinese authorities had identified that the pneumonia had been caused by a novel coronavirus (WHO, 2021d).

10-12 January 2020, the WHO began publishing a comprehensive technical package of guidance documents to support national governments' efforts to manage a potential outbreak (WHO, 2021b; 2021d).

By **13 January 2020**, the virus had made its first appearance outside China, in Thailand (WHO, 2021f).

22-23 January 2020, the International Health Regulations Emergency Committee concluded that human-to-human transmission was occurring (WHO, 2020a).

30 January 2020, the WHO Director-General and the Emergency Committee declared a public health emergency of international concern over the global outbreak of novel coronavirus (WHO, 2020a; 2020b; 2020c; 2020d) and urged the international community to support low- and middle-income countries (WHO, 2020d).

4 February 2020, the WHO Director-General asked the UN Secretary-General to activate the UN crisis management team (WHO, 2020e). At this stage, the WHO still believed that there was "a window of opportunity" to avoid a pandemic if the international community acted swiftly (WHO, 2020d).

6 February 2020, the UN produced its COVID-19 Strategic Preparedness and Response Plan (SPRP), which outlined the public health measures required to prepare and respond to the pandemic in a coordinated manner (WHO, 2020a; 2020b). The SPRP did not include broader measures required to mitigate socioeconomic effects of COVID-19 (WHO, 2020a). Detailed needs and resource analyses at country level were then developed through COVID-19 Country Preparedness and Response Plans (WHO, 2020a).

February 2020, governments across the world began implementing a variety of domestic and international movement-restricting measures to mitigate the spread of the virus.

February 2020, CBPFs and the CERF began making funding allocations to humanitarian agencies to fund the COVID-19 response (CERF, 2020).

11 March 2020, the WHO declared COVID-19 a global pandemic.

A global humanitarian plan for COVID-19

25 March 2020, OCHA launched the GHRP with an initial funding request of $2.01 billion over nine months for the additional humanitarian needs caused by the pandemic in 54 countries. The main focus was on countries with

existing humanitarian crises (OCHA, 2020a; IFRC, 2021a). This was the first time that all UN humanitarian agencies collaborated on a single global plan. The GHRP was iterative, with planned updates every six weeks.

3 April 2020, WFP laid out a plan for global common services for humanitarian agencies, for passenger and cargo transport (WFP, 2020a; WFP, 2020b).

11 May 2020, an updated GHRP was produced, with an increased funding request of $6.71 billion, for an expanded list of 63 countries. At this point, humanitarian funding for COVID-19 had reached around $1.5 billion, of which $923 million had gone through the GHRP. The plan noted that, as well as funding shortfalls, humanitarian responses were being delayed by access constraints, supply chain delays, threats to humanitarian workers perceived as carriers of the disease, and uncertainties around medical evacuation and treatment of staff (OCHA, 2020c). By this time, funding required globally for non-COVID-19-related humanitarian needs was estimated at $30.04 billion.

25 June 2020, the UN published a *United Nations Comprehensive Response to COVID-19 Report* outlining the three-pronged approach to the COVID-19 response and putting humanitarian action in the context of health and broader socioeconomic activities.

June 2020, the CERF – a pooled fund that had previously only allocated funding to UN agencies – made its first ever grant to NGOs (CERF, 2020).

30 June 2020, the Inter Agency Standing Committee (IASC), a humanitarian governance body, underlined the importance of flexible funding in the COVID-19 humanitarian response with the *IASC Proposal for a Harmonised Approach to Funding Flexibility in the Context of COVID-19* (IASC, 2020).

16 July 2020, OCHA produced an updated GHRP, with an increased funding request of $10.3 billion for 63 countries (Health Cluster, 2020; UN, 2020a:2; OCHA, 2021a; WHO, 2021a). The third GHRP provided greater emphasis on adjustments in national responses and country-level progress monitoring (Health Cluster, 2020). It sought to align itself with Grand Bargain commitments and thus added $300 million to the $8 billion country requirement as additional support to in-country NGOs. It also included funding for famine prevention. At this point, around $2.1 billion had been provided for the humanitarian response to COVID-19, of which $1.64 billion had gone through the GHRP. Progress was being made on all areas, but was constrained by supply chain disruption, high prices on international markets, and problems accessing people in need (OCHA, 2020d).

20 July 2020, the IASC, recognising that relatively little funding was going to NGOs (and particularly national NGOs) produced *Proposals to address the inconsistency in unlocking and disbursing funds to NGOs in COVID-19 response* (IASC, 2020; 2021b, 2021c).

31 August 2020, GHRP reporting showed that $4.34 billion had been provided for the humanitarian response to COVID-19, of which $2.36 billion had gone through the GHRP.

Aligning COVID-19 with other humanitarian needs

30 September 2020, the third GHRP progress report clarified that for 2021, COVID-19-related humanitarian needs would not be addressed through a separate global plan but integrated into country-level humanitarian planning. At this point, $5.12 billion had been provided for the humanitarian response to COVID-19, of which $2.87 billion had gone through the GHRP. The report showed further progress towards objectives.

16 November 2020, the fourth GHRP progress report was published. At this point, $6.27 billion had been provided for the humanitarian response to COVID-19, of which $3.63 billion had gone through the GHRP. The total funding requirement dropped to $9.5 billion as organisations adjusted figures to avoid overlaps.

22 February 2021, the final GHRP progress report was published. There had been 827,000 confirmed COVID-19 deaths in countries covered by the GHRP. The report noted that, as a result of very limited vaccination against COVID-19 in humanitarian contexts, the trajectory of the pandemic in these contexts was not likely to change in 2021. More promisingly, it noted that humanitarian planning for 2021 was, in many countries, more closely aligned with longer-term recovery planning. Overall, $6.6 billion had been provided for the humanitarian response to

COVID-19, of which $3.73 billion had gone through the GHRP. Surveys of UN agencies suggest that this funding has become less flexible over the course of the year (UN, 2021).

24 February 2021, the WHO issued the COVID-19 SPRP for 2021 (WHO, 2021a; 2021d).

What was the donor response to the pandemic?

Overview

International funding to respond to the global COVID-19 pandemic in humanitarian contexts has come from both government and private sources (such as trusts and foundations) through a variety of different mechanisms and intermediary organisations (Development Initiatives, 2021b). Most of the funding from governments has come as official development assistance (ODA): "government aid that promotes and specifically targets the economic development and welfare of developing countries" (OECD, 2021b). This ODA is spent in a variety of different ways: around 10% of it goes to humanitarian activities (OECD, 2021a).[7] Most government funding to the GHRP would have come from this humanitarian element of ODA. At the same time, countries that receive this humanitarian assistance generally receive other forms of ODA as well. In some cases they will receive more non-humanitarian funding than humanitarian funding (Development Initiatives, 2021b), which may have been spent on health and social protection systems to respond to COVID-19. In considering the donor response to the pandemic, it is therefore useful to see the humanitarian funding against a background of total ODA.

In 2020, despite initial concerns that total ODA from all governments might decrease (Dodds et al., 2021), levels increased by 3.5% overall compared to 2019 (Development Initiatives, 2021c). Total ODA directed to least developed countries grew at a lower rate of 1.8% (Development Initiatives, 2021c). In some cases, ODA was also reallocated from existing projects to the COVID-19 response, providing recipient governments with more resources to respond to the pandemic (Carson, 2021). In general, there was a movement away from funding infrastructure to funding health and social protection (Gavas and Pleek, 2021).

However, this increase in ODA was insufficient to make up for falls in domestic revenues. Given the significant falls in government revenues caused by COVID-19 in aid-recipient countries – 18% in fragile states between 2019 and 2020 (Development Initiatives, 2021c) – these increases in ODA are unlikely to have addressed government spending needs, including the increased expenditure on social protection necessitated by the pandemic.

Humanitarian funding was stable from 2019 to 2020. Looking specifically at humanitarian funding (which includes the element of government ODA that is dedicated to humanitarian response, as well as private funding from trusts and foundations), many donors – including the US, Germany and the EU – increased their levels of funding (Development Initiatives, 2021b). However, as other governments – notably the UK, but also Saudi Arabia, the United Arab Emirates and Japan – reduced humanitarian expenditure, the overall total of humanitarian aid for 2020 was very similar to that for 2019, at $30.9 billion (Development Initiatives, 2021b). At the same time, COVID-19 greatly increased humanitarian needs.

The increase in needs caused by COVID-19 and by other humanitarian crises, which was not met by an increase in overall humanitarian funding, led to the existing shortfall in humanitarian funding increasing. With no overall increase in humanitarian funding, neither COVID-19-related needs nor other humanitarian needs were fully met. UN humanitarian appeals unrelated to COVID-19 received $16.2 billion – meaning that they were 55% funded – while $3.8 billion went to the UN's GHRP for COVID-19 – which was, as a result, only 40% funded (Development Initiatives, 2021b). These global figures mask significant variations from one country to another: while seven countries received over 75% of requested funding, 17 received less than 25% (Development Initiatives, 2021b). Lack of resources to respond to the humanitarian needs caused by the pandemic is mentioned as a constraint in a number of documents (for example Grunewald et al., 2021; OCHA, 2021b).

[7] In 2020, the amount of ODA provided by the OECD-DAC group of nations that was classed as humanitarian was 11% of the total. The proportion varies from one year to the next, and from one country to another.

Specific donor responses – the US, Germany and the EU[8]

The UK was a significant donor to the global humanitarian response to COVID-19. In the period to April 2021, the UK committed $462 million to the COVID-19 emergency response (IRC and Development Initiatives, 2021a), making it the fifth-largest bilateral or multilateral donor (in terms of commitments), after the US, Germany, Japan and the EU (European Commission). This section considers the responses of these other large donors.

The US

Between March 2020 and March 2021, the US enacted four emergency supplemental funding bills with provision for overseas assistance to pandemic response[9] (Oum et al., 2021; USAID, 2021a; 2021e). Funding was channelled through several US state departments and agencies, including USAID, Centres for Disease Control and Prevention and the Department of Defence which all offered assistance towards the COVID-19 global response (USAID, 2020a; 2020b; 2020c).

Total US funding for the international response to COVID-19 was $19 billion (approximately £14.15 billion) in the period to March 2021. The largest proportion went via USAID, with the rest going through a variety of other mechanisms (Oum, Wexler and Kates, 2021; USAID, 2021f:3). USAID responses focused on facilitating access to safe and effective COVID-19 vaccinations, reducing morbidity, mitigating transmission and strengthening healthcare systems, boosting economies and other critical systems via partner support, and addressing acute needs exacerbated by COVID-19 such as combating GBV and improving WASH (USAID, 2021b; 2021c; 2021d; 2021e).

Within USAID, the main source of humanitarian funding is the Bureau for Humanitarian Assistance (BHA), which was created during the pandemic through a merger of Food for Peace and the Office of Foreign Disaster Assistance (USAID, 2021f). BHA collaborated with the USAID COVID-19 Task Force and other USAID entities to activate a COVID-19 Response Management Team to support readiness and response activities related to COVID-19 in existing humanitarian crises. In 2020, the US committed $1.1 billion (approximately £820 million) to the humanitarian response to COVID-19 (Development Initiatives, 2021b:49), a figure that had risen to over $2.4 billion (approximately £1.79 million) by the end of 2021 (USAID, 2022),[10] largely through BHA. Early expenditure focused particularly on mitigating transmission and responding to immediate humanitarian impacts, while expenditure in 2021 addressed famine and food insecurity, GBV, protection and public health in humanitarian settings.

The US was the largest single donor to the GHRP, providing 24% of funds received (OCHA, 2021d).

Germany

German ODA is primarily the responsibility of the Federal Ministry for Economic Cooperation and Development (BMZ), although humanitarian aid falls under the Federal Foreign Office. In August 2021, the BMZ reported that it expected to provide about €4.7 billion (approximately £4.08 billion) to developing countries and emerging economies under its Emergency COVID-19 Support Programme over 2020-21 (BMZ, 2021:9).

In 2020, the German Federal Foreign Office 'frontloaded' their humanitarian aid, disbursing the budget early in the year. Over the year, they committed $947 million (approximately £705 million) specifically for COVID-19-related humanitarian support (German Federal Office (AA), 2020a; 2020b; 2020c).

Germany was the second-largest donor to the GHRP, providing 11% of funds received (OCHA, 2021d).

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8 This section is largely based on reports and press releases issued by the governments of the US and the Federal Republic of Germany and by the EU and the European Commission. As each of these entities records and categorises expenditure in different ways, the figures cited – while indicative – may not be directly comparable.

9 The Coronavirus Preparedness and Response Supplemental Appropriations Act (March 2020), the Coronavirus Aid, Relief, and Economic Security (CARES) Act (March 2020), the Coronavirus Response and Relief Supplemental Appropriations Act, 2021 (December 2020) and the American Rescue Plan Act of 2021 (March 2021).

10 Consisting of $1.9 billion in American Rescue Plan funds and $558 million from the Supplemental Appropriations Acts and the CARES Act.

The EU

On 8 April 2020, EU development ministers agreed to launch 'Team Europe', a global response package made up of contributions from the EU, member states and financial institutions like the European Investment Bank and the European Bank for Reconstruction and Development (European Commission, 2021a; EU Council, 2020). The package sought to help high-risk countries, particularly in Africa, areas close to the EU, Asia and the Pacific, and Latin America and the Caribbean (EU Council, 2020). By the end of 2021, Team Europe had mobilised around €38 billion (around £32 billion) for tests, treatments and vaccines, to strengthen partner countries' healthcare, water and sanitation systems and to mitigate the immediate social and economic consequences of the crisis (European Commission, 2021d).

In 2020, the EU, through the European Commission, committed $599 million (approximately £446 million) for the humanitarian response to COVID-19 (IRC and Development Initiatives, 2021b). EU funds prioritised healthcare, WASH and logistics (Development Initiatives, 2021b). The European Commission provided 7% of funds committed to the GHRP (OCHA FTS, n.d.). The European Commission also contributed to the international response to COVID-19 through the EU Humanitarian Air Bridge and deployment of the EU Civil Protection Mechanism (European Commission, 2021b; 2021c).

4. Humanitarian performance over the period from January 2020 to August 2021

Did humanitarian assistance reach the people most in need?

Over the last decade, humanitarian organisations have found it increasingly difficult to reach people in need (Egeland, 2011; Jackson and Zyck, 2016; Knox Clarke, 2018). Difficult operating environments, insecurity and bureaucratic obstructions hamper access to people in need in many humanitarian crises (Kurtzer, 2019). The COVID-19 pandemic made access even more challenging, as governments' actions to mitigate the pandemic led to further restrictions on the movements of people and goods (Brucker et al., 2021; Danish Refugee Council, 2021). It also, as outlined above (see the 'donor response' section, p. 16), forced existing humanitarian budgets to be spread across a greatly expanded caseload.

The degree to which people in need were reached differed from one type of activity to another. Global targets for coverage laid out in the GHRP[11] were met or exceeded for provision of essential health services (57 million people in 60 countries), support to distance learning for children (129 million children in 60 countries), provision of WASH supplies (72 million people), and activities to directly support vulnerable livelihoods (23 million people)[12] (OCHA, 2021a). For other types of activity, however, the UN agencies and large international NGOs working on the response plan did less well. Only 50-60% of the people expected to benefit from increased or expanded social protection as a result of UNICEF/UNDP activities actually received support[13] and only 41% of the targeted number of children were treated for severe acute malnutrition (SAM) (OCHA, 2021a).

Differences in meeting these targets were partially a result of the approaches that humanitarian organisations took to scaling up activities. Education services, for example, could be easily scaled up to reach large numbers of children by using digital technologies, TV and radio (UNICEF, 2021a). Responding to SAM, on the other hand, required surveillance, staff and medical facilities, which were all placed under strain by the response to the pandemic itself.

The degree to which people in need were reached also varied from one country to another. There were large differences between countries in the amount of funding available (OCHA, 2021a). There were also important differences in country context: the degree to which conflict prevented access to certain areas and the degree to

11 Not all humanitarian funding went through the GHRP, but as the largest coordinated element of the international humanitarian response, success against GHRP objectives is used here as a proxy for success in humanitarian activities overall.

12 The figure is for UNDP. UNHCR, UNICEF and IOM also reported against (lower) targets, with UNHCR and UNICEF exceeding the targets.

13 It is possible, however, that some of these people may instead have received social assistance through expanded national programmes supported by international donors through the World Bank. In the period from March 2020 to March 2022, $12.5 billion (around £10 billion) was spent by the World Bank on social protection programmes).

which government movement controls constrained humanitarian response varied widely across countries receiving humanitarian assistance (Brucker et al., 2021).

There is limited information on whether or not particular population groups were overlooked by humanitarian responses: **refugees, IDPs and migrants, and elderly and disabled people are likely to have been overlooked in some cases.** Global figures suggest that women and men were assisted equally (OCHA, 2021a:10). The situation of refugees and IDPs is more concerning: only 58% of the refugees, IDPs and migrants targeted in the GHRP to receive COVID-19 assistance were reached (OCHA, 2021a). There is also evidence that refugees, IDPs and migrants were excluded from government healthcare and livelihood support initiatives in a number of countries (ACAPS, 2020a; Vishwanath et al., 2020; Danish Refugee Council, 2021).

The situation with regard to elderly people and people with disabilities is less clear. These population groups can find it more difficult to access humanitarian assistance and are therefore at risk of being 'missed' by humanitarian programmes (Knox Clarke, 2018; Swithern, 2020). These groups were badly affected by the pandemic (ACAPS, 2020c; Handicap International, 2020) and as such were recognised as a specific group in need of assistance in the GHRP. However, there are no specific targets for elderly people or people with disabilities, and the figures provided in GHRP monitoring are not disaggregated to show the degree to which these people received assistance.

Shortcomings with monitoring systems meant that 'newly vulnerable' groups may have been overlooked. There is some evidence that assessment and monitoring looked overwhelmingly at provision of planned assistance to predetermined vulnerable groups, and may have prevented humanitarian organisations from becoming aware of population groups which, while not traditionally seen as 'vulnerable' in humanitarian operations, were becoming more vulnerable and more in need of assistance over the course of the pandemic (UNICEF, 2021a).

While humanitarian assistance may have reached (many of) those in the very worst need, many more people are likely to have missed out. While the scale of the response is impressive, it should also be remembered that, because humanitarian funding did not increase to match the increased needs caused by COVID-19 (see the 'donor response' section, p. 16), the number of people receiving assistance and protection for other reasons (such as conflict) will have declined: humanitarian agencies typically cut back on the number of people served when resources are insufficient (Swithern, 2018).

It is also important to recognise that the UN's targets only cover those assessed to be in the most critical need and those which agencies could reasonably expect to be able to reach. It is likely that many of those in need were not included in the targets. A similar situation has occurred with the expansion of government social protection systems (many supported by ODA) in response to the pandemic. While the numbers of people now in receipt of humanitarian cash-based assistance in low-income countries has greatly increased over the course of the pandemic, these transfers still only reach, on average, 4.5% of the population of these countries, and in a number of cases are restricted to urban areas (Gentilini et al., 2021).

Many people in need may have been missed because assistance was channelled through mechanisms to which they did not have access: government health and social protection services also require that participants are registered on electoral rolls or with government agencies, and that they have access to bank accounts. This has had the effect of excluding many of the poorest people, particularly those working in the informal economy (a group which often includes refugees and displaced people, women and the urban poor) (Beazley et al., 2021; Gentilini et al., 2021; Lowe et al., 2021).

Did humanitarian assistance address the most important needs?

The picture with regard to the relevance of humanitarian aid is mixed. Evaluations of the work of the Disasters Emergency Committee group of NGOs suggest that their humanitarian interventions did address the most important needs created by the COVID-19 pandemic (Grunewald et al., 2021). Given the limited humanitarian funding available, however, **humanitarian organisations had to make trade-offs between the new needs caused by COVID-19, and existing, life-saving needs** (COVID-19 Global Evaluation Coalition (GEC), 2021). While

some organisations – and regional/country offices within organisations – made conscious and explicit prioritisation decisions between existing and new needs, this was not the case everywhere (UNICEF, 2021a). Vital services such as immunisation were undoubtedly disrupted (Chard et al., 2020; Gaythorpe et al., 2021; Wilder-Smith, 2021), although this was often a result of inability to conduct planned activities under COVID-19 conditions, rather than the activities themselves being deprioritised (Wilder-Smith, 2021).

'No regrets' approaches and the use of cash helped humanitarian organisations to address the most important needs. Given the many uncertainties around how the pandemic would unfold, many organisations took a 'no regrets' approach: adapting existing activities and planning for new activities (which ideally would provide benefits under most scenarios) before infections increased (Grunewald et al., 2021). These approaches were effective in ensuring that, when the pandemic did arrive, activities were relevant to needs – although in some cases they had the side effect of spreading available resources thinly between different activities (Grunewald and Omar, 2020). The widespread use of humanitarian cash-based assistance (at around 19% of total humanitarian assistance, the highest proportion to date) (Development Initiatives, 2021a) is also likely to have made it easier for recipients to address their priority needs.

More communication with affected people, and particularly more effective feedback mechanisms, could have helped aid to be more relevant. Humanitarian organisations do not consistently establish feedback mechanisms – and when they do, this feedback is often not used (Knox Clarke, 2018; CHS Alliance, 2020). Operating conditions in the pandemic made face-to-face communication with affected people difficult (Grunewald et al., 2021; UNICEF, 2021a) and so it was even less likely that organisations would collect and use feedback. Where population surveys have been conducted, some have been fairly positive on the degree to which people feel they were able to comment on programmes (Ground Truth Solutions, 2021), while others do not feel that decisions on aid provided were informed by their needs (Ramizova, 2021).

Many organisations did not change COVID-19-related programmes to ensure that they remained relevant as the situation evolved. While some organisations made conscious attempts to change programmes as the pandemic evolved and new information came to light (UNICEF, 2021a), many did not (GEC, 2021). As the pandemic still has some way to run in many humanitarian contexts, it is important that humanitarian organisations improve their ability to adapt programmes over time.

Did humanitarian assistance address the specific needs of women and girls, the elderly, people with disabilities and other marginalised groups?

Humanitarian organisations that had experience in meeting the specific needs of women and girls continued to perform well in this area, although this was not the case across the response as a whole. Those humanitarian organisations which had experience in addressing gendered needs attempted to fill gaps left in national responses. From early in the pandemic, it was evident that women and girls would face additional risks and vulnerabilities across a range of areas and would also face gender-specific needs in areas such as healthcare, protection and income-generation activities (Bandiera et al., 2018; ACAPS, 2020b; 2020c; Fuhrman et al., 2020; Laouan, 2020; Wenham et al., 2020). In many cases, government action in response to the pandemic has not sufficiently prioritised these needs (CARE, 2020). Indicators for areas such as sexual and reproductive health show declines in the numbers of users accessing services (OCHA, 2021a). Overall, evaluations so far suggest that humanitarian organisations have done their best to plug these gaps and made "a good level of effort overall to address the disproportionate impacts of the pandemic on women and girls... including a concerted effort to address risks of sexual exploitation and abuse" (GEC, 2021:8). However, the focus on the needs of women and girls has not been consistent across, or even within, organisations: those which already had expertise and strong strategies in place before the pandemic have done better in addressing these specific needs than those which did not (GEC, 2021; UNICEF, 2021a).

Only a limited number of the documents considered in this review contain specific information on the degree to which the particular needs of elderly and disabled people have been met. Despite the recommendation that operational agencies integrate a focus on older people in the overall humanitarian response to COVID-19 (United Nations, 2020b:12). The GHRP did not include specific objectives related to the

particular needs of elderly and disabled people, and information on the degree to which their needs are met are not included in the final report of the GHRP (OCHA, 2021a). The majority of global evaluations published to date also fail to provide any information on the degree to which elderly and disabled people's needs were met, although two evaluations (Danish Refugee Council, 2010; Pelham et al., 2021) suggest that elderly people and people with disabilities were prioritised for support by the Danish Refugee Council and Oxfam International (but do not say how successful this prioritisation was). It is possible that as more evaluations are completed – particularly at a country level, where data are more likely to be more finely disaggregated – a more comprehensive picture of the ways in which the response supported elderly and disabled people will emerge. But for now, the impression given of the humanitarian response is similar to that for the UN's Multi-Partner Trust Fund: "women, adolescents/children/youth, and migrants/refugees/IDPs garnered heavy focus while… potentially vulnerable groups including the elderly, indigenous, food insecure, people living with HIV/AIDS and people in extreme poverty received much less focus" (Varghese et al., 2021).

Humanitarian organisations have contributed to preserving the health of refugees but have been less successful in meeting their economic and protection needs. Fears in the early stages of the pandemic that refugees and IDPs would be particularly vulnerable to catching COVID-19 (ACAPS, 2020a; Khouzam and Verma, 2020) have not become a reality (at least for refugee populations living in camps), in part because of efforts taken by humanitarian organisations to ensure effective infection prevention and control (Egeland, 2020). The situation for people living outside camps is much less clear, as there is very limited information available for these groups (Vishwanath et al., 2020). However, refugees, IDPs and migrants have also faced a number of specific vulnerabilities in areas of livelihoods and protection. They have been particularly affected by reduced access to employment (UNHCR, 2021a:1; 2021b, 2021c:2; BMZ, 2021:7). In addition, people fleeing conflict, as well as other migrants, have been affected by controls over movement. In 2020, at least 160 countries fully or partially closed their borders to stem the spread of the COVID-19 virus, with at least 55 states making no exceptions for asylum seekers (UNHCR, 2020c), which led to people using more dangerous routes or becoming stranded (ACAPS, 2020a). In many places, asylum claims have been processed more slowly (ACAPS, 2020a; Danish Refugee Council, 2021), forced returns have become more frequent (Amnesty International, 2021; Danish Refugee Council, 2021) and, for the first time in history, UNHCR and the International Organisation for Migration (IOM) had to largely pause their global resettlement schemes (OCHA, 2020c:16-24). There has been a significant increase in the number of countries reporting incidents of stigmatisation and xenophobia directed at refugees, IDPs and stateless people (OCHA, 2021a). The ability of humanitarian organisations to address these protection issues is limited. However, UNHCR has worked with government authorities to adapt and speed up refugee registration (OCHA, 2021a).

Did humanitarian organisations coordinate well with each other?

The pandemic posed coordination challenges at all levels. A number of commentators have outlined the ways in which the pandemic demonstrated weaknesses in the global multilateral architecture, in areas such as the limited initial provision of financial support through the International Monetary Fund by G7 and G20 states (Patrick, 2020) and failures in ensuring equitable supplies of vaccines for low-income states (Saksena, 2021). The international medical architecture, centred on the WHO, has been particularly criticised, with some commentators suggesting that the WHO was slow to take action in the initial months of the crisis (Sharma and De Vriese, 2020). The challenge, however, goes well beyond the WHO. Literature considered in ICAI's rapid review (2020) suggested that poor coordination of global health is a structural issue, resulting from the very large number of actors, some of which compete with the WHO for leadership (Spicer, 2020), distortions caused by the influence of pharmaceutical companies (Sharma and De Vriese, 2020), and the desire of some powerful governments to retain sovereignty by preventing the effective working of multilateral systems (Patrick 2020; Sharma and De Vries, 2020; Saskena, 2021).

Overall, country-level coordination was less effective than in previous emergencies, but there were important developments at a global level. Humanitarian organisations – those which habitually receive public or private funding for humanitarian response work – often experience coordination difficulties and have put significant funding into the development of country-level coordination mechanisms since at least 2005 (Knox Clarke and Campbell, 2018). The pandemic put these coordination systems under pressure: it became even

harder to gather and update information in a constantly changing situation, and interactions were decreased and became virtual (Grunewald et al., 2021). As a result, in many countries, humanitarian coordination seems to have been less effective than in past crises (Danish Refugee Council, 2020; GEC, 2021; Grunewald et al., 2021), although there were still examples of effective and productive working relationships (FAO, 2021; UNICEF, 2021a). In the review's case study countries, coordination was noted as being a challenge in Yemen and Bangladesh (Heward and Rahman, 2020; De Geoffroy and Al Kaff, 2020).

At the global level, the pandemic saw significant attempts to improve humanitarian coordination. For the first time, the UN produced a Global Humanitarian Response Plan, with a common reporting structure and a common services system for the movement of personnel and cargo (OCHA, 2021a). The effectiveness of this approach has yet to be evaluated.

Did humanitarian assistance contribute to resilience in the face of future pandemics?

The COVID-19 pandemic demonstrated the need – and provided opportunities – for humanitarian action to articulate more closely with resilience and development processes (Danish Refugee Council, 2020). The global humanitarian system has been addressing this challenge – with only limited success – for many years (Knox Clarke, 2018), most recently under the banner of the triple nexus (see p.7). Overall, the pandemic may have seen the pace of change increase. In many countries, humanitarian and development actors collaborated with governments in joint analysis and joint programming (OCHA, 2021a). This combined approach was supported by the UN Framework for the Immediate Socioeconomic Response to COVID-19 which provided a "valuable platform for information sharing and coordination in many countries" (GEC, 2021:9).

Humanitarian organisations, however, often prioritised immediate or shorter-term assistance over building system capacities, and "systems strengthening, including health systems strengthening [was]...the most challenging aspect of the response" (GEC, 2021:8). Strategies for resilience were sometimes lacking (FAO, 2021). There are a number of reasons why humanitarian organisations focused on shorter-term activities. They needed to act quickly, had limited funding and, in many contexts, lacked state systems with which to work (Al Kaff and De Geoffroy, 2020). In some cases, governments themselves preferred to establish 'one-off' systems to respond to the pandemic rather than to commit to longer-term investments (Smith, 2021). Before the pandemic, there were only weak links between humanitarian and government systems in many areas – notably in the area of social protection, where there are major structural differences to overcome (Sabates-Wheeler and Longhurst, 2020). While the pandemic accelerated coordination between humanitarian cash programming and social protection in some contexts (Jodar Vidal et al., 2020; Smith, 2021), the overall picture was still one of weak links in many places. The literature suggests that this was a result of, among other things: a lack of joint analysis and planning, limited knowledge and skills on the part of both humanitarian and social protection actors, failures to demarcate roles and responsibilities, the lack of a 'space' for social protection in the humanitarian coordination architecture, and inflexible social protection systems which could not be easily adapted to address increased need (Jodar Vidal et al., 2020; Smith, 2021).

Working within government systems and processes helps build resilience to future emergencies, and humanitarian organisations seem to have performed well in this area. Relationships between humanitarian organisations (which prize independence and neutrality) and governments have historically been difficult, with many organisations being seen as 'government-avoiding', particularly in countries in conflict. Over the past five or so years, there has been a trend for these relationships to improve (Knox Clarke, 2018). Evaluations suggest that humanitarian organisations worked effectively in government mechanisms, particularly where these mechanisms had been in place before the pandemic (GEC, 2021). In the review's case study countries, effective working relationships between governments and humanitarian organisations were noted particularly in Yemen and Jordan (Chazaly and Goldman, 2021).

The global humanitarian response was less effective in supporting civil society organisations. A second important way to enhance resilience to future crises is to support and develop local civil society organisations. Humanitarian organisations have committed to 'localisation' as part of the Grand Bargain (see p. 9). Over the

course of the pandemic, the amount of humanitarian programming delivered by national and local organisations has increased (Petersen, 2020; DA Global, 2021; UNICEF, 2021a), but this has not necessarily translated into these organisations having more leadership over the response or influence in coordination mechanisms (Petersen, 2020; AIDMI, 2021). It has also not, importantly, led to increased funding going directly to these organisations – in 2020, 3.1% of total humanitarian assistance went directly to local civil society, compared to 3.6% in 2018 (Development Initiatives, 2021a). Local and national organisations have better access to CBPFs than to direct funding– in 2020 they received 28% of CBPF funding. But the great majority of funding to civil society organisations in humanitarian contexts is still being 'passed through' international organisations, and these pass-through mechanisms have been, in some cases, slow and inflexible (UNICEF, 2021a).

Was the humanitarian system able to respond effectively to an unprecedented global emergency?

The COVID-19 pandemic was unprecedented in modern history. Humanitarian agencies had to work at greater scale, while redesigning planning and delivery processes to deal with a very different situation from the ones in which they have worked in the past.

Humanitarian organisations demonstrated adaptability in the face of the crisis. The humanitarian system has often been inflexible and bad at adapting to new or unexpected circumstances (Knox Clarke, 2018; Obrecht, 2018; 2019). Early evaluations suggest that humanitarian organisations were flexible and adaptive in the face of COVID-19, although it took some time to establish new ways of working (Danish Refugee Council, 2020; FAO, 2021; GEC, 2021; OCHA, 2021a). Examples of flexibility and adaptiveness were noted in all six of the review's case study countries (Heward and Rahman, 2020; Chazaly and Goldman, 2021; Kaggwa et al., 2021).

Flexible, non-earmarked funding was central to this ability to adapt. Many donors made successful attempts to make funding less fixed and bureaucratic, allowing agencies to extend funding beyond anticipated deadlines, using common reporting formats and allowing for reprogramming of existing funds (GEC, 2021; OCHA, 2021a; Metcalfe-Hough et al., 2021). The importance of flexible funding to respond to the COVID-19 pandemic was demonstrated by the fact that humanitarian organisations used the great majority of the flexible funding that they had to respond to COVID-19 rather than to other emergencies (OCHA, 2021a). Given this, it is unfortunate that the flexibility of donor funding decreased over the course of 2020 (OCHA, 2021a).

Preparedness was fundamental to the ability to adapt and respond effectively. In almost all of the areas considered by the evaluations, preparedness activities had laid the foundations for adaptive responses to the pandemic by giving humanitarian agencies more programmatic options, and a 'head start' on activities. Organisations which had invested in relationships with governments and local NGO partners were able to shift to locally led programme approaches (Grunewald et al., 2021), organisations that had invested in information collection and management had a better overview of the situation, and were able to plan more effectively (FAO, 2021), and governments that had established the basis for social protection were quicker and more effective at making emergency payments (Beazley et al., 2021; Gentilini et al., 2021; Lowe et al., 2021). In the review's case study countries, the importance of preparedness was mentioned particularly in Jordan and Yemen (Chazaly and Goldman, 2021). Building relationships and structures appears to have been more effective in preparing for the pandemic than formal contingency planning activities. Many organisations found that their contingency plans were not relevant, as they had not anticipated an event of this type, or of this scale (GEC, 2021; UNICEF, 2021a).

Poor information management hampered flexibility and effectiveness. Evaluations suggest that humanitarian information management was poor during the pandemic. Large amounts of information were collected – to the degree that some agencies encountered an 'infodemic' – but the information was not always useful and was often not used in programming (GEC, 2021; UNICEF, 2021a). This was partially a response to "extractive and relentless" reporting demands from headquarter offices and donors (UNICEF, 2021b :30), and partly a result of inflexible monitoring systems and a lack of clarity around which types of information were actually needed by decision-makers (GEC, 2021).

5. Conclusion

The COVID-19 pandemic was a significant challenge to the international humanitarian system for a number of reasons. In 2020, when the pandemic was declared, the number of people assessed to be in need of humanitarian assistance was at the highest level for decades. The factors that had led to these extremely high numbers – a combination of conflict, displacement, climate change and food insecurity, among other factors – were all getting worse (and have generally continued to do so over the last two years). Donor funding for humanitarian action was insufficient to meet assessed needs. The pandemic occurred at a time when the system was already significantly overstretched, and further increased existing humanitarian needs while creating new needs and new classes of vulnerability. As needs increased, the pandemic – and government actions taken in response to the pandemic, such as closing borders and instituting 'lockdowns' – made humanitarian programming significantly more difficult.

The limited number of evaluations that have been produced to date suggest that, in the face of these challenges, the international humanitarian system responded rapidly. It did so in a way which suggested that lessons had been learned from previous regional epidemics, such as SARS and Ebola. Humanitarian organisations focused from the outset both on health issues and on socioeconomic issues such as economic support, prevention of gender-based violence and maintenance of essential health services – areas that had initially been 'missed' in the Ebola response.

Humanitarian organisations were also successful, in many cases, in adapting their existing delivery processes to work in new and constrained situations: increasing the amount of work done by local organisations, making use of new media for activities such as health promotion, education and 'e-shops, and changing the physical layouts of camps housing displaced people and refugees. This ability to work in a more flexible manner was particularly notable given poor performance in this area in the past. It was supported to a great degree by previous investments and innovations: in data collection, in developing partnerships with government agencies and civil society, and in delivery approaches such as cash payments and online technology. In a situation which was hard to predict, and where forecasts could be inaccurate, the system also appears to have made some movement beyond the logic of advance planning and command and control approaches to a more flexible and responsive approach with higher levels of flexible funding and delegated decision-making.

The changes made in response to the pandemic tended to be operational in nature, and focused on doing the same things in different ways. It is to be hoped that research and evaluations published over the next year will shed light on the degree to which the pandemic drove more transformational, systemic change. Early indications suggest that there has not been a great deal of progress in areas such as localisation, accountability to affected people, linking humanitarian action to activities aimed at the underlying, developmental causes of humanitarian need, or the architecture of information management in the humanitarian system.

With respect to coordination – an area in which there has been significant investment over a long period of time – the picture is mixed. The humanitarian system took some steps towards increased system-wide coordination, in the shape of the GHRP and the common services approach. While the literature does not provide evidence on the success or otherwise of these initiatives, they were particularly notable because they took place at a time when the broader international, multilateral architecture was struggling to provide a coordinated or coherent response to the pandemic. At the same time, country-level humanitarian coordination appears, in many cases, to have been less effective than in previous responses

The initial forecasts of the pandemic made by humanitarians suggested that it would last for 18 months, and the humanitarian system, led by OCHA, ended discrete COVID-19 operations in February 2021. Since then, COVID-19 has been 'mainstreamed' into ongoing, country-level humanitarian responses. It is important to remember that the pandemic is not over, and that it may continue to add to, and disrupt, humanitarian activities for some time to come. The inclusion of COVID-19 into broader humanitarian programmes also points to a further question: how damaging, compared to the other drivers of humanitarian need, was the pandemic? Pandemic response drew on humanitarian funding that would in all probability have been used to meet other needs: was this, in hindsight, the

best use of resources? It is not possible to answer this question with the evidence available to this review, but it is a question worth answering.

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