Objective: The side event highlighted the work of the IASC in responding collectively to the challenges posed by the COVID-19 pandemic, share best practices and lessons learned from coordinated efforts of members of the IASC and partners. The event was also an opportunity to reflect on how COVID-19 has exacerbated pre-existing vulnerabilities to shed light on the ongoing risks of COVID-19 in humanitarian settings.

Panel Members

- **Ms. Wafaa Saeed**, Director a.i., Coordination Division, Office for the Coordination of Humanitarian Affairs (OCHA)
- **Ms. Gwendolyn Pang**, Deputy Director, Asia Pacific, International Federation of Red Cross and Red Crescent Movement (IFRC)
- **Mr. Stephen Cahill**, Director of Logistics, World Food Programme (WFP)
- **Ms. Jennifer Neelsen**, COVID-19 Global Response Director, World Vision International
- **Mr. Peter Graaff**, Director, Special Initiatives, World Health Organization (WHO)

Main points:

1. COVID-19 brought out the best of the humanitarian system - humanitarian agencies strengthened their collaboration, built on existing structures and tools and came together to save lives. The role of the Inter-Agency Standing Committee, established by the General Assembly in 1992 to coordinate response to humanitarian crises and chaired by the Emergency Relief Coordinator, has been critical in the COVID-19 response. Under the leadership of the Emergency Relief Coordinator, the IASC Principals provided leadership, facilitated the coordination of the humanitarian system in collaboration with other key stakeholders and the WHO-led Crisis Management Team (CMT), and in terms of resource mobilisation for both the COVID response and the maintenance of other critical life-saving humanitarian programs. Some of the key achievements include:
   a. The IASC Principals activated the system-wide “Scale-up Protocols” adapted to the COVID-19 pandemic, the first-ever global emergency activation that eventually covered all 63 GHRP countries. This enabled IASC and humanitarian partners to collectively fast-track internal procedures and administrative processes for a more timely and flexible delivery of aid and field support where needed.
b. The IASC was able to adapt quickly and innovated to respond to the unprecedented nature of the crisis. WFP staged the largest UN-led logistics operations in support of common services, including passenger, cargo and Medivac services, and worked closely with WHO to establish field-based hospitals. I am sure my WFP colleague Stephen will provide more details about this in his intervention, and I’d like to thank WFP for their superb work including for transporting almost 28,000 humanitarian passengers from 426 organizations and undertaking 40 medical evacuations at the height of COVID-19 response.

c. A record amount of funding, $3.8 billion, was generously provided through the GHRP. This demonstrates donors’ confidence in the IASC and we are grateful to our donors for their generosity and continued confidence.

2. IASC members continue to respond to primary and secondary impacts of COVID-19. The pandemic is far from over and 2021 is very different from 2020. Our number one priority continues to be the COVID-19 response. While globally, COVID-19 cases and deaths declined since late April, the situation across Latin America, India and Nepal demonstrate the vulnerability of HRP countries to severe outbreaks of COVID-19 in the context of more transmissible variants of concern. The disparity between high-income and low-income countries is very visible. While vaccination coverage continues to increase in high-income countries, there is no sign of vaccines arriving at scale in countries with humanitarian appeals in the next six months. Countries with humanitarian response plans (HRPs) have administered 22 million doses - 1.3% of all global vaccinations. Several of these countries are yet to receive a single dose (Haiti and Chad). IASC members continue to work on the recently operationalized Humanitarian Buffer, a last-resort mechanism to ensure access to COVID-19 vaccines for high-risk and vulnerable populations in humanitarian settings. The Humanitarian Buffer is only to be used where there are unavoidable gaps in coverage in national vaccination plans and micro-plans, despite advocacy efforts. The IASC continues to focus on addressing the secondary impacts of the COVID-19 crisis in low resource and humanitarian contexts including food insecurity and access to essential services. Today, more than 34 million people worldwide face emergency levels of food insecurity—one step away from hunger and famine-like conditions. Of these people, 11.4 million live in Burkina Faso, Ethiopia, southern Madagascar, north-east Nigeria, South Sudan and Yemen. In Ethiopia, Madagascar, South Sudan and Yemen – approximately 500,000 people already live in famine-like (or IPC Phase 5, Catastrophe) conditions.

3. The IASC is working to extend some of the best practices and gains made in the COVID-19 response while also putting the spotlight on accountability to affected populations, localization, and gender-based violence. The IASC continues to engage with the donor community and UN agencies to ensure quality and flexible funding measures utilized for COVID-19 are made permanent while also working to ensure local actors have a strengthened role and leadership in humanitarian coordination structures. Likewise, significant investments were made in risk communication and community engagement during COVID-19 response which brought to the fore the importance of accountability to affected populations, a key priority that IASC is taking forward in several forums. Likewise, the significant increase in gender-based violence required collective response including through translating commitments into action.

4. Epidemics and pandemics start and end at community level. Developing and reinforcing the capacity of community-based local actors and volunteers to do so is the key in curbing the epidemic and pandemic. Our investment must work on building trust and empowering people so they can protect themselves correctly, including making informed decisions for vaccination. Another issue that requires local support is mental health. We have observed the fear of contracting the virus has brought the stigma to people who have contracted the virus and their families. It has serious impact to people who are already marginalized. The uncertainty about the diseases, how long it will last, how contagious and severe it can be is another aggravating factor for mental health.
5. Prevention must be complemented by vaccines in order to stop the spread of COVID-19. Internationally, we must also address the inequity of countries in their access to vaccines. As long as this inequity is there, no one can be safe from COVID-19. States with full access to vaccines, and the companies producing the major COVID vaccines, must do more to bridge the geographical gap in access. Delivery of vaccine doses at the airport tarmac is the half job done, we need to work with local community-based organizations and local leaders to ensure they reach the arms of the most vulnerable. We need to listen to people’s concerns and address them while making sure there is accurate information available.

6. COVID-19 has manifested a number of gaps and the international community must adopt a systemic approach to shared objectives on a global level as infectious diseases know no borders. These gaps include gaps in information sharing including on border closures, medical and protective equipment; challenges in the protection of marginalized, isolated and socio-economically disadvantage persons, including refugees and migrants; and a lack of sustainable investment in local and community-level preparedness.

Key messages of the side event:

1. **The pandemic is far from over and its public health and socio-economic effects continue to be felt in humanitarian settings.** Globally, COVID-19 infection rates and death counts continue to rise with approximately four million people reported to have died as of 2 June. In countries covered by the Global Humanitarian Overview, more people have been infected and/or died of COVID-19 in the first four months of 2021 compared with the whole of 2020. Likewise, COVID-19 variants demand further capacities for testing and medical interventions, which may not necessarily available in most emergency affected settings. As such, the risk of new waves of infections in low capacity and humanitarian settings is real. This calls for continued IASC investment in COVID-19 preparedness and response particularly at the community level, and support to governments in the roll-out of COVID-19 vaccines, and where necessary, use of the humanitarian buffer to vaccinate vulnerable populations not included in national plans. The humanitarian community will also need to reinforce delivery systems and engage communities to tackle vaccine hesitancy. The public health and socio-economic impacts of the pandemic are here to stay for some time; mortality rates from other diseases outstripped COVID-19 rates. Simultaneously, acute food insecurity and risk of famine have affected more than 34 million people across the world including half a million people who are already at the brink of starvation.

2. **The pandemic has demonstrated and brought out the best of the humanitarian system.** The adaptability and resilience of the system are worth noting as humanitarian agencies strengthened their collaboration and built upon existing structures and tools to save lives. The role of the Inter-Agency Standing Committee, established by the General Assembly in 1992 to coordinate response to humanitarian crises and chaired by the Emergency Relief Coordinator, has been critical in the COVID-19 response. Under the leadership of the Emergency Relief Coordinator, the IASC Principals provided leadership, facilitated the coordination of the humanitarian system in collaboration with other key stakeholders and the WHO-led Crisis Management Team (CMT). This was evident in the activation of the system-wide “Scale-up Protocols” adapted to the COVID-19 pandemic on 17 April 2020, the first-ever global emergency activation that eventually covered all 63 GHRP countries. Likewise, the World Food Programme staged the largest UN-led logistics operations in support of common services, including passenger, cargo, and Medevac services, and worked closely with WHO to establish field-based hospitals. This enabled humanitarian partners to stay and deliver. The collaborative efforts at the Global and field level facilitated the development of the Global Humanitarian Response Plan (GHRP) which supported a coordinated and prioritized response to needs in 63 countries. The agility and
leadership by field humanitarian leaders were crucial to this effort. Improved donor confidence in the system, led to the mobilization of US$ 3.8 billion, facilitated by the IASC’s stepped up advocacy efforts as well as adjustments within IASC partner organizations to provide funding fast and at scale to frontline responders.

3. **Flexible and quality funding to frontline actors is key to scale up and respond swiftly.** Flexible and unearmarked funding was central to ensuring that humanitarian organizations could respond swiftly and nimbly to the COVID-19 pandemic, particularly in the first months of the crisis. IASC advocacy under the leadership of the Emergency Relief Coordinator and IASC Principals was critical for donor and UN agency flexibility measures. For instance, UNHCR introduced simplified reporting requirements while IOM scaled up its medical response in remote areas thanks to flexible donor funding. Likewise, the COVID-19 response demonstrated what local actors can achieve when they have access to flexible and quality funding, which should be extended beyond the COVID-19 response.

4. **The humanitarian community should translate commitments into action on localization.** COVID-19 reinforced the critical role that local actors and communities play in sustaining humanitarian operations. Since the World Humanitarian Summit in 2016, the IASC has advocated for bringing the voices of local communities and NGOs to the center of discussions that shape the humanitarian response. Localization is a strategy; it requires enhanced and quality partnerships with local actors as well as strengthened leadership of local actors in humanitarian coordination settings recognizing their voice and capacity to respond best to the needs of their communities. Likewise, investments in community-level pandemic and epidemic preparedness are key to preventing, detecting, and controlling diseases. Investments in local action including partnerships with national and local authorities and communities will save lives, build resilience, and speed early recovery.

5. **The COVID-19 pandemic put the spotlight on protection, accountability to affected populations, gender-based violence, and PSEA.** These are areas of work that the humanitarian system has grappled with and struggled to make the required step-change in for years – including around changing the power dynamics in the response to put people at the centre (accountability to affected populations); meaningful engagement with, resourcing and capacitating local actors (localization); addressing the persistent and rising protection crises on the ground (including GBV); preventing and better handling of PSEA incidents. Humanitarian organizations have made several investments to make a step change on some of these issues, which require sustained efforts moving forward. For instance, IASC members have made several investments in risk communication and community engagement during the pandemic. Thousands of IFRC volunteers -- among many other organizations-- have disseminated key messages on COVID-19 and vaccination in their communities in the Philippines, Bangladesh and Nepal helping to address misinformation about COVID-19 and reduce vaccine hesitancy. The significant rise of protection risks and gender-based violence incidents have also led IASC members to take concrete action by generating robust protection analysis in needs and response analysis and finding ways to engage with and allocate funding to women and women’s organizations. This progress must be retained by the COVID-19 response.

**Additional points raised during the discussion:**

1. The humanitarian system and IASC members moved swiftly and adapted the humanitarian response to COVID-19. Partners scaled-up operations and mobilized to support the global humanitarian system’s efforts to provide timely action on the ground in support of Governments. A record amount of funding,
$3.8 billion, was generously provided through the GHRP. This demonstrates donors’ confidence in the IASC and we are grateful to our donors for their generosity and continued confidence.

2. The importance of coordinated action and the provision of critical common services to support the system’s ability to stay and deliver lifesaving assistance and protection has been paramount including during the response to this unprecedented crisis. WFP, in coordination with partners, established one of the largest logistics and medical evacuation systems to support the UN, NGOs and other partners to be on the ground to prepare and respond to this crisis. WFP dispatched 150,000 m3 of critical COVID-19 cargo to 173 countries for more than 70 organizations, transported nearly 30,000 health and humanitarian workers to and from 68 destinations, on behalf of over 400 organizations, and completed 147 medevacs out of the 258 conducted by the UN Medevac Cell.

3. A critical, enabling factor in this regard was systems integration and data analytics that allowed WFP to plan, coordinate, track and monitor a network of critical transport movements, including in countries where it has no presence. Other key factors included the support of host governments, keeping supply chain corridors open especially for humanitarian cargo and workers; and the close collaboration with WHO to plan deliveries of essential items to affected countries across the globe.

4. Another essential takeaway of the session was the importance of the partnership between UN and the private sector. When COVID-19 brought commercial airlines to a halt, WFP had to step up to ensure humanitarian staff and cargo could still reach their destinations. International travel/commercial sector is vital - 60 percent of cargo is carried in the underbelly of passenger aircraft. When this stopped, humanitarian responses were compromised and humanitarian sector had to step as the private sector retracted, at a huge cost to everyone. Looking forward, one of the ways to be better prepared logistically for future emergencies, including pandemics, is to invest in a stable and durable relationship with the private sector by sharing knowledge and expertise so that both UN and private sector can learn from each other, by mutually supporting each other during crises, and by engaging in joint preparedness activities and initiatives.

5. As a final point of reflection, the scale, breadth and complexity of the impacts caused by the pandemic should lead the humanitarian community to reflect on the cluster system and its efficiency when it comes to fulfilling its coordination role in global emergencies, and whether changes and innovations should be brought into the cluster system to ensure global coordination in future large-scale emergencies.

6. The pandemic reinforced once again that more needs to be done to work with and through local actors who are best placed to respond within their communities. Given the unparalleled network of grassroots volunteers of Red Cross Red Crescent Societies across the world, IFRC worked with volunteers at the national level to disseminate information and listen to populations on their needs. Thanks to these networks, IFRC maintained its trust-based relationships with communities and provided assistance at the community level through national Red Cross and Red Crescent societies and volunteers. This experience demonstrates that localization should be taken as a strategy with sufficient resources invested to deliver expected results.