GLOBAL HUMANITARIAN RESPONSE PLAN

COVID-19

UNITED NATIONS COORDINATED APPEAL
APRIL − DECEMBER 2020

Contents

Foreword by the Emergency Relief Coordinator

The COVID-19 pandemic is hurting us all. But the most devastating and destabilizing effects will be felt in the world's poorest countries.

We face the biggest economic slowdown in living memory. The humanitarian system is preparing for a sharp rise in conflict, food insecurity, and poverty as economies contract, and export earnings, remittances and tourism disappear.

Lockdowns and economic recession may mean a hunger pandemic ahead for millions.

As countries with weak health systems attempt to fight the virus, we can expect an increase in measles, malaria, cholera and other diseases as vaccinations are put on hold, health systems buckle under the strain and medical supplies are disrupted.

"This pandemic is unlike anything we have dealt with in our lifetime. This is not business as usual. Extraordinary measures are needed."

If we do not support poorer countries as they battle the pandemic, we are leaving the virus to spread unchecked and circle back around the world. That is in no-one's interest. Nor is economic collapse and instability in fragile and poor countries.

It is in all our interests to come together in an urgent and coordinated response to this pandemic in the world's most fragile settings. The COVID-19 Global Humanitarian Response Plan is the international community's primary fundraising vehicle to do that. This update of the Plan is based on extensive in-country consultations and reflects real-time needs. It brings together appeals from the WHO and other UN humanitarian agencies. Non-governmental organizations and NGO consortia, often the frontline responders have been instrumental in helping shape the plan and can access funding through it.

Lockdowns, curfews and restrictions on movements of personnel and cargo – part of the strategy to slow down transmission of the virus – are affecting humanitarian operations. But despite these obstacles, resources are moving quickly to the field and having immediate impact. The Global Humanitarian Response Plan has supported the installation of handwashing facilities in vulnerable places like refugee camps; the distribution of gloves, surgical masks, N95 respirators, gowns and goggles to help vulnerable countries respond to the pandemic; and the creation of new transport hubs from which supplies can be transported by air.

The Plan prioritizes the needs of the the most vulnerable includings older people, people with disabilities, and women and girls. Given that the pandemic has already heightened existing levels of discrimination, inequality and gender-based violence, the Plan includes specific metrics to ensure that the vulnerabilities of these groups are addressed. This plan also includes programmes that respond to the projected rapid growth in food insecurity.

Everything achieved so far has only been possible because of the generous funding donors have provided. Progress will only continue if additional funding is made available.

As we come together to combat this virus, I urge wealthy governments to make their response proportionate to the scale of the problem we face.

I ask wealthy governments to take two steps. Firstly, pledge your support to this COVID-19 global humanitarian response plan. It requires $6.7 billion. Secondly, continue to support existing humanitarian response plans. If funding is diverted from these operations to tackle COVID-19, the consequences could be grave and potentially life-threatening for those already at greatest risk in humanitarian contexts. This pandemic is unlike anything we have dealt with in our lifetime. This is not business as usual. Extraordinary measures are needed.

Mark Lowcock
Emergency Relief Coordinator, United Nations

At a glance

REQUIREMENTS (US$)	FUNDING RECEIVED (US$)	COUNTRIES
$**6.71**B	$**923**M	**63**

Objectives scope, countries included

PP. 11–19

Since the publication of the Global Humanitarian Response Plan (GHRP) on 25 March 2020, the COVID-19 pandemic has taken hold in the 54 countries with ongoing humanitarian crises at varying scale, speed and severity levels. Based on their vulnerability and response capacity, an additional nine countries[1] and Djibouti, as part of the Regional Migrant Response Plan for the Horn of Africa and Yemen, were included in this update, bringing the number of countries covered by this plan to 63.

The total financial requirements have risen from US$2 billion to $6.71 billion. This significant increase is due to a rapid evolution of humanitarian needs, the inclusion of the additional countries, increased cost of essential health and other supplies, and air and sea transportation. To date (5 May), $923 million has been received, with another $608 million reported outside the GHRP, bringing the total received for the COVID-19 humanitarian response to about $1.5 billion. The GHRP requirements target the most vulnerable people and are a small part of the $90 billion required overall to support 10 per cent of the poorest populations affected by the pandemic worldwide.

The additional requirements for the COVID-19-related emergency response compound the already significant funding gap for humanitarian response plans globally. At the time of writing, only 13 per cent of the funding appealed for in the Global Humanitarian Overview (GHO) had been received. This shortfall is dramatic as humanitarian needs predating the outbreak have worsened, notably due to a deterioration of the food security situation, supply chain disruptions and ongoing conflict. In particular, the number of acutely food insecure people could almost double from 135 million in 2019 to 265 million due to COVID-19 economic impact.

In December 2019, the UN projected a requirement of $28.8 billion in the GHO for its response to humanitarian needs in 2020. Drawing a parallel to the global crisis of 2008-2009, when humanitarian requirements grew by 54 per cent, all indications are that humanitarian needs will increase significantly by the end of 2020 due to the secondary impacts of COVID-19.

Humanitarian situation and needs analysis

PP. 20–45

The GHRP begins to capture and anticipate the most immediate of those needs, based on the existing revisions or the development of new humanitarian response plans. It will be updated again mid-June. The forthcoming GHO will fully incorporate the COVID-19-related increases for 2021, together with requirements stemming from other crises, which will themselves be compounded by the consequences of the pandemic.

Data and analysis conducted since the release of the GHRP in late March confirm the anticipated humanitarian impact of the pandemic on the health and socioeconomic conditions of vulnerable groups identified. Concerns are growing around the disruption of essential health services as lockdown measures and fear of infection are leading to significant reductions in utilization and access. Due to disruption of air flights, vaccines

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[1] Benin, Djibouti (part of the Regional Migrant Response Plan), Liberia, Lebanon (now counted as 'country' on top of being part of the 3RP for Syria), Mozambique, Pakistan, the Philippines, Sierra Leone, Togo and Zimbabwe.

shipments to countries fell by approximately 80 per cent, and an increasing number of countries are reporting depleting stock, impairing essential vaccination campaigns.

Those who stand out as suffering the most are older persons, people with comorbidities, people with mental health and psychosocial needs, persons with disabilities, women, children and youth, forcibly displaced persons, refugees, asylum seekers and migrants, and people who have lost their sources of income and fall outside social protection systems. This is exacerbated when they live in dense and underserved locations, and when other shocks and stresses are occurring due to natural disasters, pest infestation or conflict.

Many population groups and individuals are negatively affected at different levels. Their health may be directly impacted along with their ability to access essential services and sustain livelihoods.

Of particular concern is the situation of women and girls due to elevated gender-based violence in lockdown situations, their important role in health care and social work and increasing exposure to the virus, and their large dependence on informal and insecure sources of income that have become inaccessible due to mobility and physical distancing measures. UN WOMEN indicates a surge in intimate partner violence of upwards of 25 per cent since the outbreak of the pandemic in countries with a reporting system in place. The realities, unique requirements and responses to the needs of women and girls, especially as relates to sexual and gender-based violence, are detailed in the GHRP.

Older people suffer from a greater health impact from COVID-19, combined with higher risks of discrimination and physical and financial barriers to access essential services. Persons with disabilities also face risks of stigmatization and loss of access to specialized-assistance services and treatment. Children are deprived not only from education but also from associated services such as school feeding and social assistance, while being at increased risk of domestic violence.

Vulnerable population groups of all ages, many of whom are also IDPs, refugees, asylum seekers and migrants, are susceptible to increased mental health issues due to stress, anxiety and an increase in violence stemming from the pandemic, at a time when mental health and psychosocial support services are either interrupted or suffering from limited resources available in countries.

Progress of the response

Humanitarian actors have stepped up their responses to additional needs caused by the pandemic. Significant efforts have been made to establish Global Humanitarian Response Hubs located close to where medical supplies are manufactured in Liège, Dubai, and China which will link to regional hubs in Ethiopia, Ghana, Malaysia, Panama, Dubai, and South Africa, maintain and increase supply chains for health and other essential items. Critical COVID-19 response interventions are enhancing the protection of the most vulnerable groups, securing the continuity and expansion of essential health services, water, sanitation and hygiene, education services, risk communication and social cohesion, and food production and consumption.

Local and international NGOs and community groups, including faith-based and women-led groups, have continued to play a vital role in the response delivery, expanding their outreach and links with development interventions that some were already implementing. While some UN agencies have taken steps to provide flexible funding and ease administrative procedures, more will be done to facilitate direct NGO access to funding, including through pooled-funding mechanisms.

Individual and collective leadership for protection against sexual exploitation and abuse remains a core commitment of the organizations participating in the GHRP.

Financial requirements and funding

Funding shortfalls, mobility and access constraints, supply chain delays, threats to humanitarian workers perceived as carriers of the disease, and uncertainties around medical evacuation and treatment of staff are constraining the response. Wherever necessary, more must be done to scale up critical COVID-19 responses together with other previously planned humanitarian responses in order to address the humanitarian needs and prevent further deterioration. Without significant and accelerated efforts to cover both the GHRP and the 2020 GHO funding requirements, a major deterioration of the humanitarian health and socioeconomic situation of the most vulnerable people must be expected. Long-term effects will ensue, significantly jeopardizing achievement of the Sustainable Development Goals.

This inter-agency appeal aims to cover the health and immediate COVID-19-related humanitarian needs. It seeks roughly $1 billion to support common humanitarian services, such as medical evacuations, field hospitals and passenger and cargo air services. From the amount requested for country-based operations, most requests will be used by the health, food security, WASH, protection and education sectors.

Of the $6.71 billion required to cover the response under this plan, $1 billion will cover global support services, while $5.7 billion will cover needs in the 63 countries covered - with $3.49 billion targeting Humanitarian Response Plans countries, nearly $1 billion intended for Regional Refugee Response Plans countries, $439 million for Regional Refugee and Migrant Response Plans countries, $157 million for countries under other plans, and $628.8 million for the countries under new plans presented in this update.

Coherent and complementary needs analysis, and planning and funding flows between humanitarian and development actors are more important than ever. Opportunities are being seized to link the GHRP, WHO's Strategic Preparedness and Response Plan, and the UN Secretary-General's Framework for the Immediate Socioeconomic Response to COVID-19 in common response areas.

Additional figures will be added in the next GHRP iteration.

Financial requirements (US$)

COVID-19 REQUIREMENTS

REQUIREMENTS

$6.71 B

OF WHICH:

HEALTH: $2.03 B
NON-HEALTH: $3.67 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS [1]

$36.75 B

OF WHICH:

COVID-19: $6.71 B
NON-COVID-19: $30.04 B

INTER-AGENCY APPEAL		COVID-19 TOTAL	OF WHICH: HEALTH	NON-HEALTH	ADJUSTED NON-COVID-19	TOTAL HUMANITARIAN COVID + NON-COVID	
Afghanistan	HRP	108.1 M	21.7 M	86.4 M	695.7 M	803.8 M	
Burkina Faso	HRP	60.0 M	15.0 M	45.0 M	311.6 M	371.6 M	
Burundi	HRP	36.7 M	-	36.7 M	131.7 M	168.4 M	
Cameroon	HRP	99.6 M	23.0 M	76.6 M	292.7 M	392.4 M	
CAR	HRP	152.8 M	7.7 M	145.2 M	400.8 M	553.6 M	
Chad	HRP	99.5 M	6.0 M	93.5 M	610.7 M	710.2 M	
Colombia	HRP	197.0 M	152.7 M	44.4 M	209.7 M	406.7 M	
DRC	HRP	287.8 M	119.4 M	168.4 M	1.82 B	2.11 B	
Ethiopia	HRP	322.6 M	100.0 M	222.6 M	1.00 B	1.32 B	
Haiti	HRP	105.0 M	105.0 M	-	319.3 M	424.3 M	
Iraq	HRP	263.3 M	65.4 M	197.9 M	397.4 M	660.7 M	
Libya	HRP	38.8 M	14.9 M	23.9 M	90.9 M	129.8 M	
Mali	HRP	42.3 M	10.1 M	32.2 M	350.7 M	393.2 M	
Myanmar	HRP	46.0 M	18.1 M	27.9 M	216.3 M	262.3 M	
Niger	HRP	76.6 M	9.9 M	66.7 M	433.3 M	509.8 M	
Nigeria	HRP	259.8 M	85.2 M	174.6 M	839.0 M	1.10 B	
oPt	HRP	42.4 M	19.1 M	23.3 M	348.0 M	390.4 M	
Somalia	HRP	176.4 M	72.1 M	104.4 M	1.08 B	1.25 B	
South Sudan	HRP	217.2 M	21.0 M	196.2 M	1.55 B	1.77 B	
Sudan	HRP	87.5 M	87.5 M	-	1.35 B	1.44 B	
Syria	HRP	384.2 M	157.5 M	226.7 M	3.42 B	3.81 B	
Ukraine	HRP	47.3 M	16.6 M	30.7 M	157.8 M	205.1 M	
Venezuela	HRP	72.1 M	44.1 M	28.0 M	677.9 M	750.0 M	
Yemen	HRP	179.1 M	101.6 M	77.6 M	3.20 B	3.38 B	
Zimbabwe	HRP	84.9 M	35.0 M	49.9 M	715.8 M	800.7 M	
Burundi *Regional*	RRP	65.4 M	36.5 M	29.0 M	209.9 M	275.4 M	
DRC *Regional*	RRP	155.7 M	94.7 M	61.0 M	483.0 M	638.7 M	
Nigeria *Regional* [2]	RRP	-	-	-	-	-	
South Sudan *Regional*	RRP	128.8 M	51.4 M	77.4 M	1.21 B	1.34 B	
Syria *Regional* [3]	3RP	643.8 M	82.6 M	561.1 M	5.56 B	6.21 B	
Venezuela *Regional*	RMRP	438.8 M	132.4 M	306.4 M	968.8 M	1.41 B	
Rohingya Crisis [4]	JRP	117.2 M	71.8 M	45.3 M	-	-	
DPR Korea	Other	39.7 M	19.7 M	20.0 M	107.0 M	146.7 M	
Benin	New	17.2 M	10.9 M	6.3 M	-	17.2 M	
Iran	New	89.5 M	64.4 M	25.1 M	-	89.5 M	
Lebanon	New	94.0 M	53.8 M	40.2 M	-	94.0 M	
Liberia	New	57.0 M	17.5 M	39.5 M	-	57.0 M	
Mozambique	New	68.2 M	16.0 M	52.2 M	-	68.2 M	
Pakistan	New	126.8 M	29.2 M	97.6 M	-	126.8 M	
Philippines	New	96.2 M	23.2 M	73.0 M	-	96.2 M	
Sierra Leone	New	60.5 M	16.8 M	43.7 M	-	60.5 M	
Togo	New	19.4 M	3.3 M	16.0 M	-	19.4 M	
Global Support Services		1.01 B	-	-	-	1.01B	
TOTAL		**6.71 B**	**2.03 B**	**3.67 B**	**30.04 B**	**36.75 B**	

[1] Funding requirement updated on 11 May 2020. The figures are expected to change as country offices continue revising their projects and ongoing activities. For the most up-to-date figures, please refer to hpc.tools or fts.unocha.org.

[1] The requirements for the Nigeria RRP are included in the Cameroon, Chad and Niger HRPs.

[2] The existing 3RP 2020 budget is 5.56 billion. A full prioritization exercise is ongoing in and an adjusted non-COVID-19 figure is pending

[3] Revised new COVID-19 related requirements, plus total 2020 JRP requirement adjusted to COVID response, will be presented in the June GHRP update

Key achievements

HEALTH

Information and prevention campaigns

Health staff training

Distribution of medical supplies

Reproductive and maternal healthcare

LOGISTICS

Air bridges for medical cargo and staff

Shipment of personal protective equipment (PPE) and laboratory supplies

WATER SANITATION AND HYGIENE

Distribution of hygiene kits

Set up of handwashing stations

Distribution of water supplies

Installation of toilets

EDUCATION

Temporary learning spaces

Educational radio programmes

FOOD AND AGRICULTURE

Food distribution respecting social distancing

Vouchers distribution

Containment of desert locust upsurge

Cash assistance

PROTECTION

Psychosocial support

Child friendly spaces

Training for caregivers

Support for survivors of gender-based violence

COVID-19 RESPONSE

SEE MORE RESPONSE ACHIEVEMENTS ON:
WWW.UNOCHA.ORG

The achievements shown above are a non-exhaustive selection of humanitarian activities from the first six weeks since the launch of the GHRP. Procurement is underway using the funds disbursed to date, and more delivery activities are to follow. Further achievements will be presented in the next GHRP iteration, the bi-monthly GHRP information updates and on www.unocha.org

> "The courage and commitment of all frontline workers during the COVID19 crisis is truly inspirational.
>
> We must give them the support they need, and ensure their health & safety at this challenging time."
>
> —
>
> **António Guterres**
> Secretary-General, United Nations

CHASIV YAR, UKRAINE
A community worker at the Arts Centre for Children and Youth in Chasiv Yar village, Ukraine, makes a face mask on a sewing machine donated by UNHCR and NGO partner Proliska. *UNHCR/Artem Hetman*

Introduction

Launched on 25 March 2020, the Global Human-itarian Response Plan (GHRP) is an Inter-Agency Standing Committee (IASC) initiative to address the risks and impact of the COVID-19 pandemic on the most vulnerable people in countries affected by humanitarian crises or at high risk of facing a hu-manitarian crisis. It aggregated relevant COVID-19 appeals from FAO, IOM, UNDP, UNFPA, UN-Habitat, UNHCR, UNICEF, UNRWA, WFP and WHO, and it complements other plans such as those developed by the International Red Cross and Red Crescent Movement. It also included inputs from NGOs and NGO consortia who have been instrumental in con-veying local actors' perspectives and play a direct role in the response.

In this first update of the GHRP, contributions from field teams at country level have been instrumental to illustrate changes in the situation, needs and re-sponse since last March, on top of the inputs by UN agencies and NGOs. Resource requirements have been defined at the country level in revised humani-tarian response plans, reflecting needs, operational environments and links with other country-specific activities and plans.

The GHRP is articulated around three interrelated strategic priorities:

- Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality.
- Decrease the deterioration of human assets and rights, social cohesion and livelihoods.
- Protect, assist and advocate for refugees, inter-nally displaced people, migrants and host com-munities particularly vulnerable to the pandemic.

Several specific objectives are linked to each priority, detailing the outcomes that the plan aims to achieve. The objectives are underpinned by a series of enabling factors and conditions. Planned responses span across sectors and are guided by clear princi-ples to ensure due attention to specific vulnerable groups and cross-cutting factors.

The GHRP issued in March initially estimated that US$2.01 billion was required to address the addi-tional humanitarian needs provoked by the COV-ID-19 pandemic in the prioritized countries. It was acknowledged that this amount would be revised in subsequent updates as the situation evolved and additional countries were included. It also empha-sized the imperative to sustain funding for ongoing humanitarian response plans and preparedness to other disasters beyond COVID-19. Humanitarian response plans remain severely underfunded at the time of writing, yet they are critical to avoid further loss of life and suffering, a rise of affected people's vulnerabilities and ever-decreasing capacities to cope with the new emergency.

To enable the most appropriate and adaptive re-sponse, the IASC agreed that the GHRP should be updated on a six-week basis, offering an opportu-nity to include additional priority countries, and to report on changes in the situation and needs, and on progress and challenges of the response and funding received. This document is the first such update. It integrates the revisions being done by field teams to reflect the effects of the pandemic on humanitarian needs in ongoing Humanitarian Response Plans, Refugee Response Plans, and other plans for refugees and migrants in countries included in the GHRP.

1.0 Objectives, scope and countries included

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1.1 Objectives and scope
Objectives of the GHRP May update
Scope of the GHRP May update

1.2 Countries included
Countries included in the GHRP March
Countries added to the GHRP May update
Countries to watch

1.3 Forward-looking risk analysis at country level
INFORM COVID-19 Risk Index
COVID-19 Risk Analysis Index
WFP: Analysis of country-level economic and food security vulnerability
FAO: Risk monitoring and analysis system
COVID-19 Global Information Management, Assessment and Analysis Cell

GHASOULEH, SYRIA
Staff at the Ghasouleh warehouse package food assistance commodities.
They are now wearing masks and taking regular temperature checks to
reduce the risk of COVID-19 infections. *WFP/Hussam Al Saleh*

1.1
Objectives and scope

Objectives of the GHRP May update

The overall objective of this first update is to take stock of:

- The evolution of the pandemic in priority countries and resulting health and socioeconomic impact on the most vulnerable groups
- The progress of the response.
- Funding received and still required.

Specifically, the update of the GHRP aims to:

- Highlight countries prioritized and added since the first iteration of the GHRP in March, and provide a forward-looking country-level risk analysis.
- Reflect changes in the humanitarian situation and needs due to the COVID-19 pandemic.
- Report on progress towards achieving the strategic priorities and specific objectives agreed upon in the GHRP, and operational challenges faced at country and global levels.
- Revise resource requirements, and assess the funding received as well as funding gaps, funding flows to UN agencies and NGOs, and related issues.
- Reassert principles of response implementation, adaptation of humanitarian programmes and partnership.

Scope of the GHRP May update

This first update of the GHRP does not repeat the GHRP released on 25 March, which remains a valid reference framework that guides the strategic approach and adheres to clear principles of humanitarian response implementation to the pandemic. Instead, this update reflects the evolution of the situation, needs, responses and challenges on the ground as of end April/early May, based on inputs from field teams in the prioritized countries and the revision of ongoing humanitarian plans to address the effects of the pandemic, and the perspectives of IASC members and global clusters.

The GHRP update remains focused specifically on the short-term, immediate additional needs, responses and funding requirements for the COVID-19 pandemic while recognizing that these needs often compound pre-existing humanitarian needs, and that the response to the pandemic can be combined with already planned interventions addressing other shocks and stresses. It does not describe the whole humanitarian situation and needs and responses in the prioritized countries or repeat the general description of the expected impact of the pandemic and vulnerable groups. Instead, it seeks to illustrate needs and responses based on what is happening on the ground. Ongoing revisions, addendums and newly developed country and regional humanitarian plans capture the broader humanitarian needs, including those pre-existing and those resulting from the pandemic.

1.2
Countries included in the GHRP May update

The pandemic knows no borders, and all countries worldwide have been, are or will be affected. The scale, speed of expansion, severity/mortality, and duration of the outbreak depend on the timeliness, effectiveness of prevention-and-response measures, and capacities of the health system. These factors are difficult to capture, particularly in fragile and conflict or natural disaster-prone country settings.

In its first iteration launched on 25 March 2020, the GHRP prioritized all countries with ongoing Humanitarian Response Plans (HRPs), countries part of a regional Refugee Response Plans (RRPs), the Regional Refugee and Resilience Plan (3RP) for the Syria crisis, the Regional Refugee and Migrant Response Plan (RMRP) for the Venezuela crisis, and the Joint Response Plan for the Rohingya Humanitarian Crisis (JRP). These countries were considered a priority due to prevailing humanitarian needs and pre-existing low national response capacity. Iran was added in view of the scale and severity of the outbreak and a Government request for international assistance.

The IASC decided to include a second set of priority countries in a subsequent update of the GHRP, based on the impact of the outbreak on affected people's ability to meet their essential needs, considering other shocks and stresses (e.g. food insecurity, insecurity, population displacement, other public health emergencies), the capacity of the Government to respond, and the possibility to benefit from other sources of assistance from development plans and funding.

Countries included in the GHRP March

The following countries were included in the first iteration of the GHRP:

- **Countries with HRPs:** Afghanistan, Burkina Faso, Burundi, Cameroon, Central African Republic (CAR), Chad, Colombia, Democratic Republic of the Congo (DRC), Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, occupied Palestinian territory (oPt),Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela and Yemen.

- **Countries with RRPs:** Angola, Burundi, Cameroon, Chad, DRC, Egypt, Iraq, Jordan, Kenya, Niger, Nigeria, Lebanon, Republic of Congo, Rwanda, South Sudan, Uganda, Tanzania, Turkey and Zambia.

- **Venezuela RMRP:** Argentina, Aruba,* Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao,* Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay.

- **Others:** Bangladesh, Democratic People's Republic of Korea (DPR Korea), and Iran.

These 54 countries remain a priority in this update of the GHRP in view of the risks and, in a number of cases, observation of the first COVID-19 cases, significant increases in caseloads, and unabated pre-COVID-19 humanitarian crises and needs. Existing country humanitarian response plans and refugee response plans are being adjusted to address additional humanitarian consequences of the COVID-19 pandemic. While the GHRP is highlighting emergency and short-term requirements until the end of 2020, those will be progressively integrated into country plans and programmes.

The low funding of HRPs (less than 14 per cent at the time of writing) is highly worrying, as it means pre-COVID-19 humanitarian needs remain mostly unaddressed and risk being aggravated by the outbreak.

* Aruba (Netherlands), Curaçao (Netherlands)

Countries added to the GHRP May update

In addition to the above priority countries, the IASC undertook a review based on the below criteria to screen and select additional priority countries:

- COVID-19 risk analysis based on vulnerability (transmission and epidemic risk factors) and response capacity (institutional capacities; access to water, sanitation and hygiene services; and access to health care) to the pandemic.

- Existing humanitarian concerns[2] despite the absence of an ongoing humanitarian plan.

- Countries part of the Regional Migrant Response Plan (RMRP) for the Horn of Africa and Yemen.

- Existing shocks or stresses, such as food insecurity, displacement, a high number of migrants in-country or in transit.

- Low-income country status.

The countries identified on this basis were further discussed at the IASC level to confirm the selection.

Based on this process, the following nine countries plus one included in the RMRP are considered as a priority in the GHRP: Benin, Djibouti (part of the RMRP)[3], Liberia, Lebanon (now counted on top of being part of the 3RP for Syria), Mozambique, Pakistan, the Philippines, Sierra Leone, Togo and Zimbabwe.

Countries to watch

In addition, the following countries are considered at risk and "to watch": Côte d'Ivoire, Guinea, Kenya, Malawi, Northern Triangle of Central America (El Salvador, Guatemala and Honduras), Papua New Guinea, Timor-Leste, Small Island Developing States in the Caribbean and the Pacific, and Uganda.[4]

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[2] Existing humanitarian concerns were proxied by the designation and presence of a Humanitarian Coordinator in-country.
[3] Ethiopia, Somalia and Yemen are also part of the RMRP for the Horn of Africa and Yemen but already prioritized as they have ongoing HRPs.
[4] The UNHCR budget of $745 million covers UNHCR´s additional COVID-19-related needs for refugees, IDPs and Stateless people for operations worldwide, regardless of geographic location.

GHRP countries: May update

Countries included in GHRP March
Countries added to GHRP May
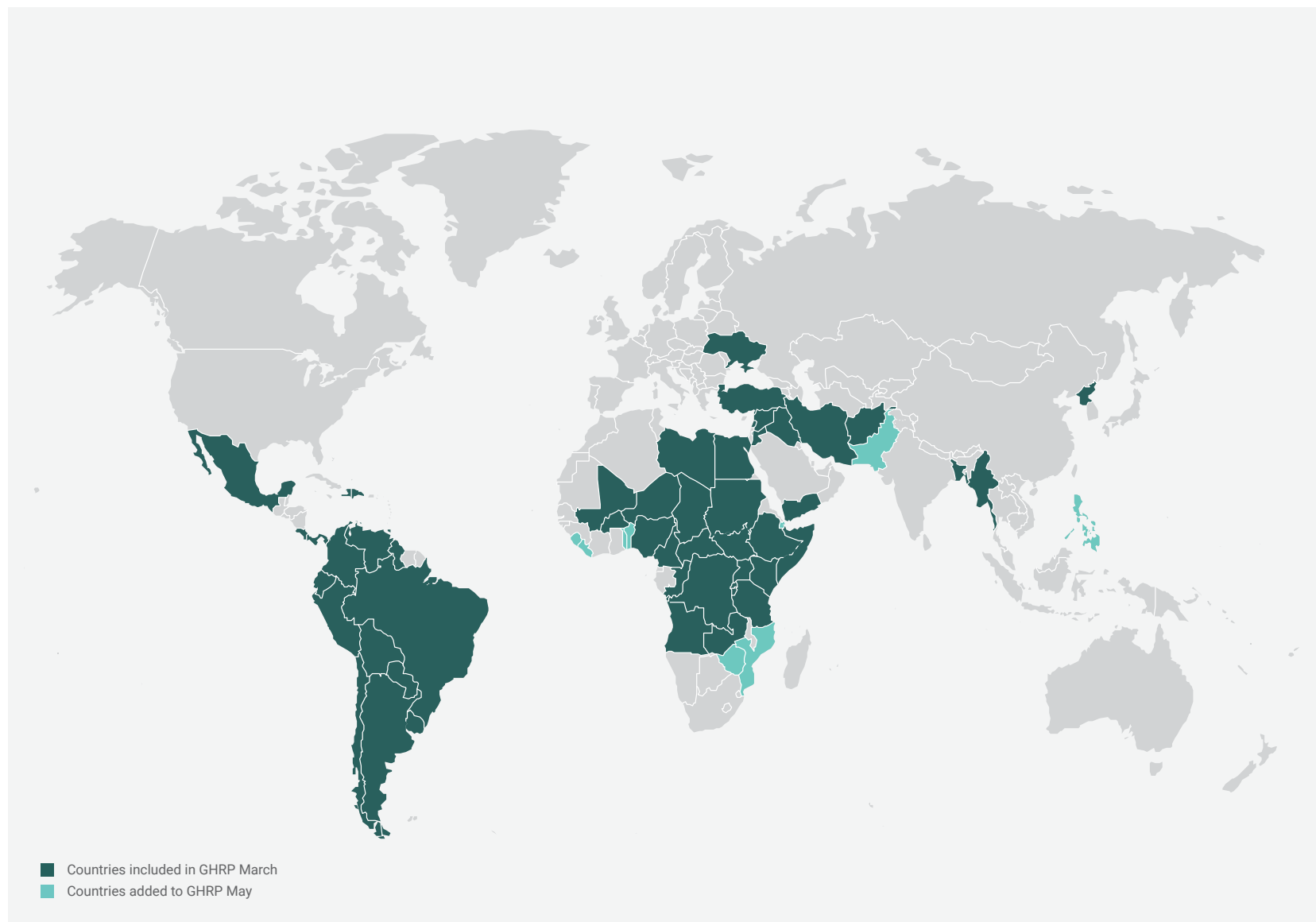
NUMBER COUNTRIES
GHRP MAY

63

OF WHICH:
NUMBER COUNTRIES
GHRP MARCH

54

Afghanistan, Angola, Argentina, Aruba*, Bangladesh, Bolivia, Brazil, Burundi, Burkina Faso, Cameroon, CAR, Chad, Chile, Colombia, Costa Rica, Curaçao*, Dominican Republic, DPR Korea, DRC, Ecuador, Egypt, Ethiopia, Guyana, Haiti, Iran, Iraq, Jordan, Kenya, Lebanon, Libya, Mali, Mexico, Myanmar, Niger, Nigeria, oPt, Panama, Paraguay, Peru, Rep. of Congo, Rwanda, Somalia, South Sudan, Sudan, Syria, Tanzania, Trinidad and Tobago, Turkey, Uganda, Ukraine, Uruguay, Venezuela, Yemen, Zambia.

NUMBER COUNTRIES
ADDED TO GHRP MAY

9

Benin, Djibouti, Liberia, Mozambique, Pakistan, Philippines, Sierra Leone, Togo, Zimbabwe

Source: OCHA. **Disclaimer:** The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

* Aruba (Netherlands), Curaçao (Netherlands)

GHRP countries: per type of humanitarian appeal
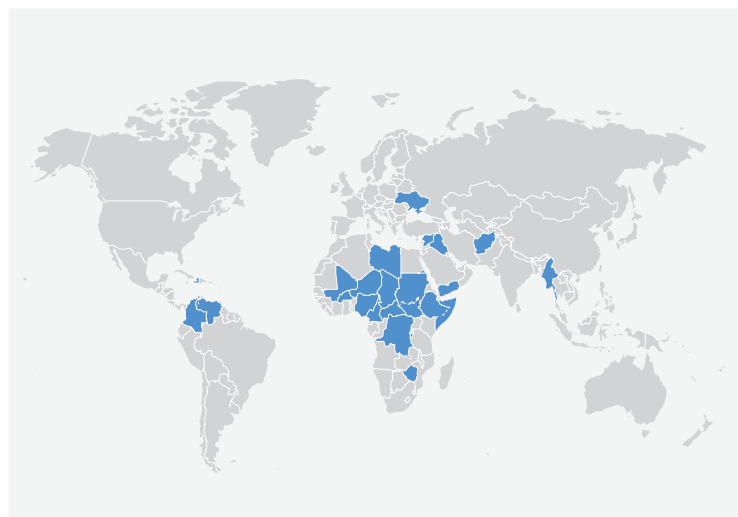
HUMANITARIAN RESPONSE PLANS (HRP)

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Afghanistan, Burkina Faso, Burundi, Cameroon, CAR, Chad, Colombia NEW DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, oPt, Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela, Yemen, Zimbabwe NEW
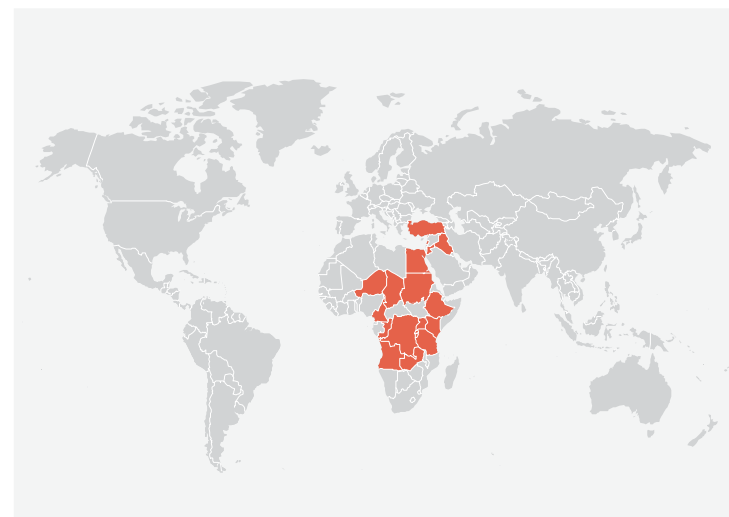
REGIONAL REFUGEE RESPONSE PLANS (RRP)

19

Angola, Burundi, Cameroon, Chad, DRC, Egypt, Ethiopia, Iraq, Jordan, Kenya, Lebanon, Niger, Rep. of Congo, Rwanda, Sudan, Tanzania, Turkey, Uganda, Zambia.
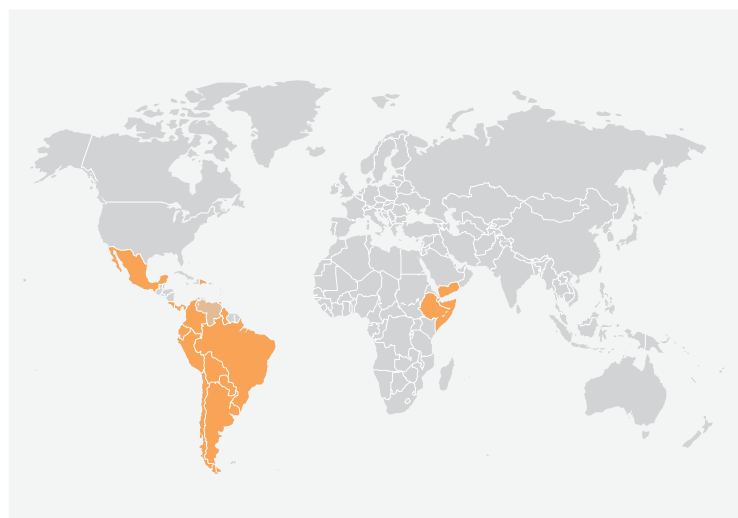
REGIONAL REFUGEE AND MIGRANT RESPONSE PLANS (RMRP)

21

Argentina, Aruba*, Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao*, Djibouti NEW Dominican Republic, Ecuador, Ethiopia NEW Guyana, Mexico, Panama, Paraguay, Peru, Somalia NEW, Trinidad and Tobago, Uruguay, Yemen NEW
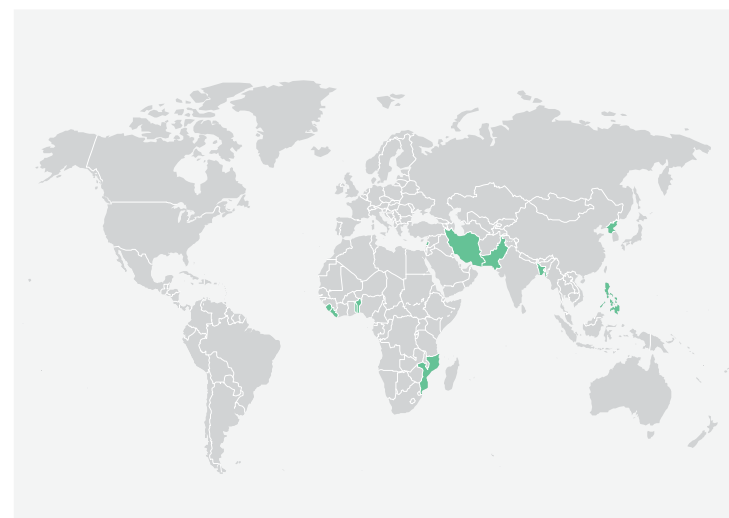
OTHER APPEALS AND COUNTRIES WITHOUTH PRE-EXISTING HUMANITARIAN APPEALS

11

Bangladesh, Benin NEW DPR Korea, Iran, Lebanon NEW Liberia NEW Mozambique NEW Pakistan NEW Philippines NEW Sierra Leone NEW Togo NEW

Source: OCHA. **Disclaimer:** The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

* Aruba (Netherlands), Curaçao (Netherlands)

1.3
Forward-looking risk analysis at country level

Several organizations and academic institutions are developing risk analysis models to predict the evolution of the pandemic at the country level and support decision-making on prevention, preparedness and response measures. These models use several variables and apply different hypotheses, and all recognize the uncertainties of the results obtained.

Most models focus on predicting the health impacts of the pandemic (scale, speed, severity), with some introducing variables to reflect pre-existing vulnerability conditions of the population that will lead to socioeconomic impacts. Some models take a more sectoral angle, such as food security. WFP, for example, is projecting the number of people who will be food insecure due to loss of access to food as a result of the loss of jobs and remittance income.

Protection of rights, gender-based violence, child protection, displacement and the capacity of local responders are generally not measured by existing models. While these are essential to capture, they remain very difficult to modelize.

Below is a brief description of two multisectoral models that have been developed in partnership with different organizations, academia and experts, and a food insecurity country vulnerability model and data facility developed by WFP and by FAO. While neither of the models claims to provide accurate predictions, they usefully contribute to scenario-building and prioritization processes.

COVID-19 Risk Analysis Index

The OCHA-led COVID-19 Risk Analysis Index combines indicators on vulnerability and response capacity to the pandemic.[5]

Vulnerability indicators include:

- Transmission indicators: population density and mobility.
- Epidemic risk factors: population demography (proportion of older people), food insecurity, and comorbidities.

Response capacity indicators include:

- Institutional capacity indicators: lack of coping capacities for epidemic and Government effectiveness.
- Adult literacy rate, access to sanitation, access to drinking water, access to hygiene.
- Access to health-care services: physician density and per capita health care.

As a matter of illustration, on the basis of this risk model the top 10 countries with the highest risk index (above 6 on a scale of 10) are (by decreasing order) South Sudan, CAR, Somalia, Haiti, Burundi, Afghanistan, DRC, Chad, Sudan and Malawi.

INFORM COVID-19 Risk Index

The INFORM COVID-19 Risk Index[6] is a composite index that identifies countries at risk by examining health and humanitarian impacts of the pandemic that could overwhelm current national response capacities and lead to a need for international assistance. The index is primarily based on structural risk factors (hazard and exposure, vulnerability, capacity) that existed before the outbreak.

The INFORM Index on Hazard and Exposure uses a person-to-person component. Vulnerability is based on:

- Population movement (particularly relevant when restrictions are partial or lifted) and behaviours (based on risk awareness).
- Demographic and comorbidities specific to COVID-19.
- Pre-existing socioeconomic vulnerabilities
- Most relevant vulnerable groups.

Lack of Coping Capacity considers:

- Health system capacity specific to COVID-19.
- Health system governance.
- Access to health care.

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[5] Contact: OCHA Humanitarian Financing Strategy and Analysis Unit ocha-hfrmd-hfsa@un.org. Sources of information for the indicators include DESA, INFORM, Journal of American College of Cardiology, Open Street Map, UNDP, UNESCO, UNHCR, UNICEF, UN-STATS, WHO, WFP/IPC, and the World Bank.

[6] INFORM is a multi-stakeholder forum for developing shared, quantitative analysis relevant to humanitarian crises and disasters. INFORM includes organizations from the humanitarian and development sectors, donors and technical partners. The Joint Research Center of European Commission is the INFORM scientific and technical lead.

In mid-April 2020, the INFORM COVID-19 Risk Index identified the following 10 countries at the highest risk (above 6 on a scale of 10, in decreasing order): CAR, Somalia, South Sudan, Chad, Afghanistan, DRC, Haiti, Burundi, Yemen and Burkina Faso.

Analysis of country-level economic and food security vulnerability

WFP's analysis of country-level economic and food security vulnerability[7] considers the prevalence of pre-COVID-19 chronic and acute food insecurity (Integrated Phase Classification 3 or above), pre-existing shocks (climate, economic, politico-security) and anticipated macro-economic impacts: dependence on exports of primary commodities (e.g. fuel, ores and metal), dependence on imports of food and other essential needs, share of remittances in total GDP, share of tourism, levels of public debt and levels of foreign currency reserves. Countries presenting multiple risks across these dimensions and macro-economic impact channels are considered the most vulnerable to impacts of the COVID-19 crisis. At a household level, the people likely to face the most severe impacts are those who were already acutely poor and food insecure prior to COVID-19, and who rely on humanitarian assistance, remittances and seasonal migration, or daily informal labour markets. This economic projection analysis suggests that the number of acutely food insecure people could almost double from 135 million in 2019 (Global Report on Food Crises) to 265 million due to COVID-19-induced economic impacts. As country-level monitoring is scaled up, including expanding real-time and remote monitoring in 32 countries, projections will be refined alongside food security partners.

Risk monitoring and analysis system

FAO is establishing a data facility to set up a risk monitoring and analysis system to capture the current and potential impacts of COVID-19 on agricultural production, food security and livelihoods, with a focus on 22 priority countries already in or at risk of food crisis contexts. In these countries, FAO is setting up a remote data collection system that consists of periodic phone surveys in high-priority areas (e.g. Integrated Phase Classification of food security level 3 or above), and rapid or in-depth assessments. This will be complemented by the collection of the Food Insecurity Experience Scale indicator on a periodic basis with national coverage. Remotely collected data will feed into a global knowledge exchange and analytical platform.

COVID-19 Global Information Management, Assessment and Analysis Cell

OCHA is establishing a multi-partner COVID-19 Global Information Management, Assessment and Analysis Cell,[8] co-led by OCHA, WHO and UNHCR, to complement the country-level identification of risk, scenarios and projections, with a more granular analysis of the impact of the pandemic on the most vulnerable groups within countries. The outcomes of the analysis will help identify and adjust COVID-19 responses at the population level, complementing decisions and interventions at institutional and structural levels.

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[7] WFP Economic and Food Insecurity Implications of the COVID-19 Outbreak. An update with insights from different regions, 14 April 2020.
[8] Contact: OCHA Needs and Response Analysis Section ocha-cd-apmb-naras@un.org. Partners include UN agencies and NGOs.
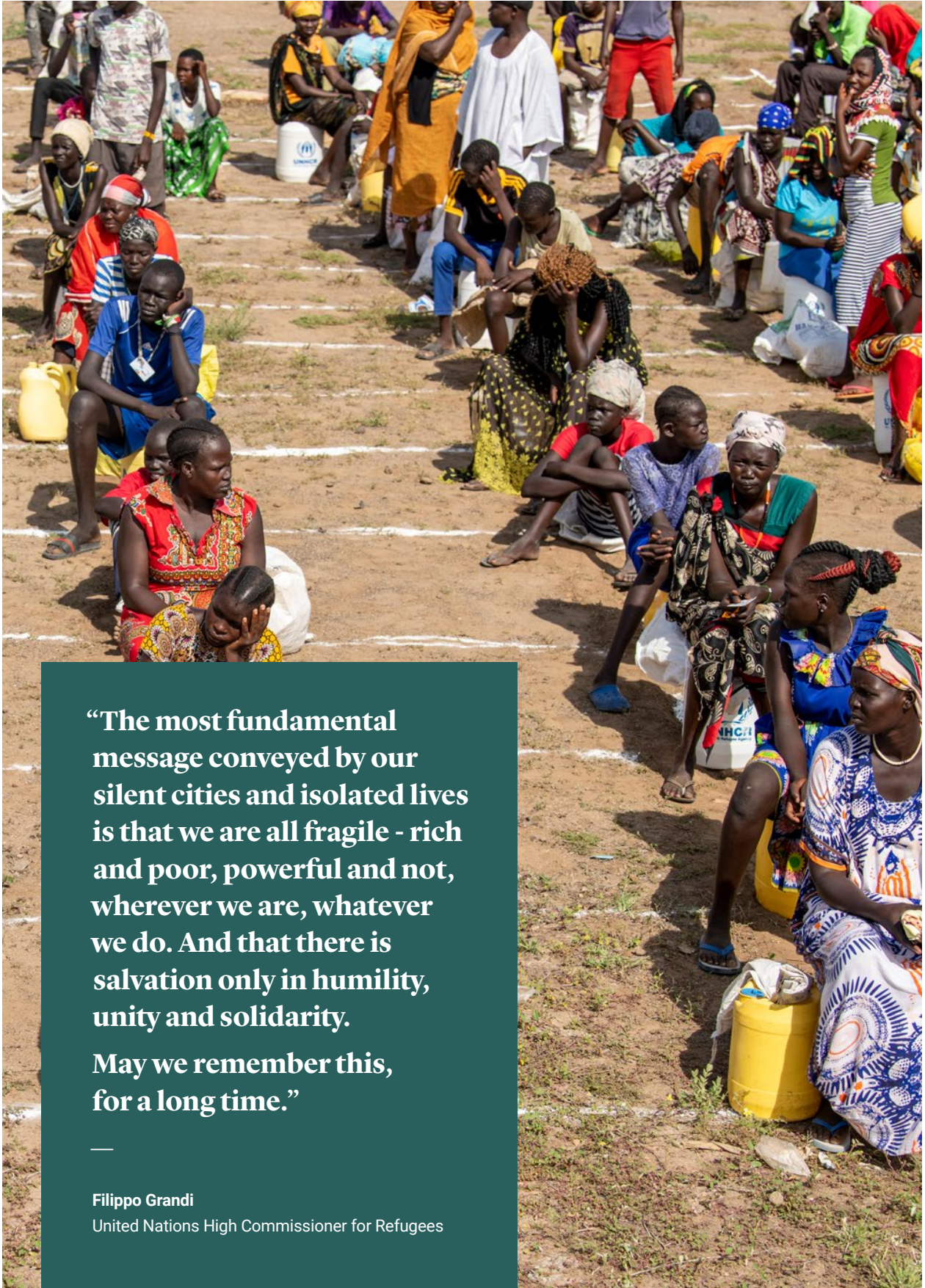
"The most fundamental message conveyed by our silent cities and isolated lives is that we are all fragile - rich and poor, powerful and not, wherever we are, whatever we do. And that there is salvation only in humility, unity and solidarity.

May we remember this, for a long time."

—

Filippo Grandi
United Nations High Commissioner for Refugees

KAKUMA CAMP, KENYA
South Sudanese refugees practice social distancing as they wait to access food distribution at the Kakuma camp in Kenya. *UNHCR/Samuel Otieno*

2.0 Humanitarian situation and needs analysis

2.1 **Update on the public health impact of COVID-19**
Health effects on people
Effects on public health services
Projected effects on health and health services

2.2 **Update on the socioeconomic impact of COVID-19**
Main macroeconomic and country-level effects
Collateral effects on people

2.3 **Most affected population groups**
Older persons
Persons with disabilities
Children and youth
Internally displaced persons, refugees, asylum seekers, stateless persons and migrants
Unprotected workers and workers in the informal economy and food-insecure people

NIAMEY, NIGER
UNICEF Niger's Immunization Manager supervises the tent installations to treat COVID-19 patients next to Niamey's National Reference Hospital. *UNICEF/Juan Haro*

2.1
Update on the public health impact of COVID-19

Since the GHRP was launched on 25 March, there has been a dramatic increase in COVID-19 cases in fragile settings, especially those in conflict or hosting refugees, IDPs or returning migrants, and already facing an economic and social crisis before the pandemic. Underreporting is also likely due to the lack of widespread testing.

By early May, cases in Africa had risen to more than 42,000, including in countries where people already struggle to cope with conflict and displacement, such as Burkina Faso, Niger, Cameroon and DRC, which is still fighting Ebola. The epidemic is still in its early stages in many of those countries (with a few exceptions such as Iran), but significant underreporting is also possible due to a lack of widespread testing. For example, DRC had 674 cases, while Yemen and Syria combined had reported 65 confirmed cases as of 6 May.

Health effects on people

By the end of April 2020, there were more than 3 million confirmed COVID-19 cases globally and 220,000 deaths. While the majority of reported cases at the time were in Europe and North America, incidence and associated mortality in Africa, the Eastern Mediterranean, South-East Asia and South America continue to rise.

In GHRP countries where community and individual health are already severely challenged by the impact of conflict, displacement, concurrent disease outbreaks and frequent natural disasters, the added burden of COVID-19 is expected to be profound. Reported COVID-19 cases and deaths, and self-reported transmission classifications[9] vary widely within GHRP countries. Most now recognize ongoing local transmission, reporting either community transmission (16 countries), clusters of cases (24 countries) or sporadic cases (11 countries).

With few exceptions, GHRP countries are at relatively early stages of the pandemic, with upward trajectories in COVID-19 case and death incidence.[10] It is important to acknowledge that while countries expand their surveillance, testing and response capacities, current case counts and transmission levels may be significantly underestimated. Moreover, while many countries have or will experience a period of rapid and exponential growth, very gradual declines (slow halving times) should be expected after reaching peak incidence, with high risks of rapid escalation as public health and social measures are relaxed.

Effects on public health services

In addition to the direct impacts on individual and community health, COVID-19 has caused major disruptions to essential health and humanitarian services worldwide. For example, in many GHRP countries, essential immunization services have been interrupted or are suboptimal, increasing the risk of vaccine-preventable disease outbreaks. Reduced accessibility to health services and disruptions in wider health and food supply chains are likely to result in greater excess mortality than COVID-19 infections alone.

Disease surveillance capacities have also been stretched. In the absence of a comprehensive surveillance approach for COVID-19, the current reliance on universal tracking of confirmed cases and deaths presents only a minimum estimate of the true burden of disease. To understand if the spread of the disease is under control, and to manage risk appropriately and guide decision makers in the adjustment of public health and social measures, surveillance systems need to detect cases and clusters rapidly, and track the overall evolution of disease across geographic locations and groups.

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[9] WHO, 2020. Coronavirus disease (COVID-19) technical guidance: Surveillance and case definitions, available online:
www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions
[10] Country-level case and death trends may be followed here: https://covid19.who.int

COVID-19: Transmission classification

- Community transmission
- Clusters of cases
- Sporadic cases
- Pending / No data
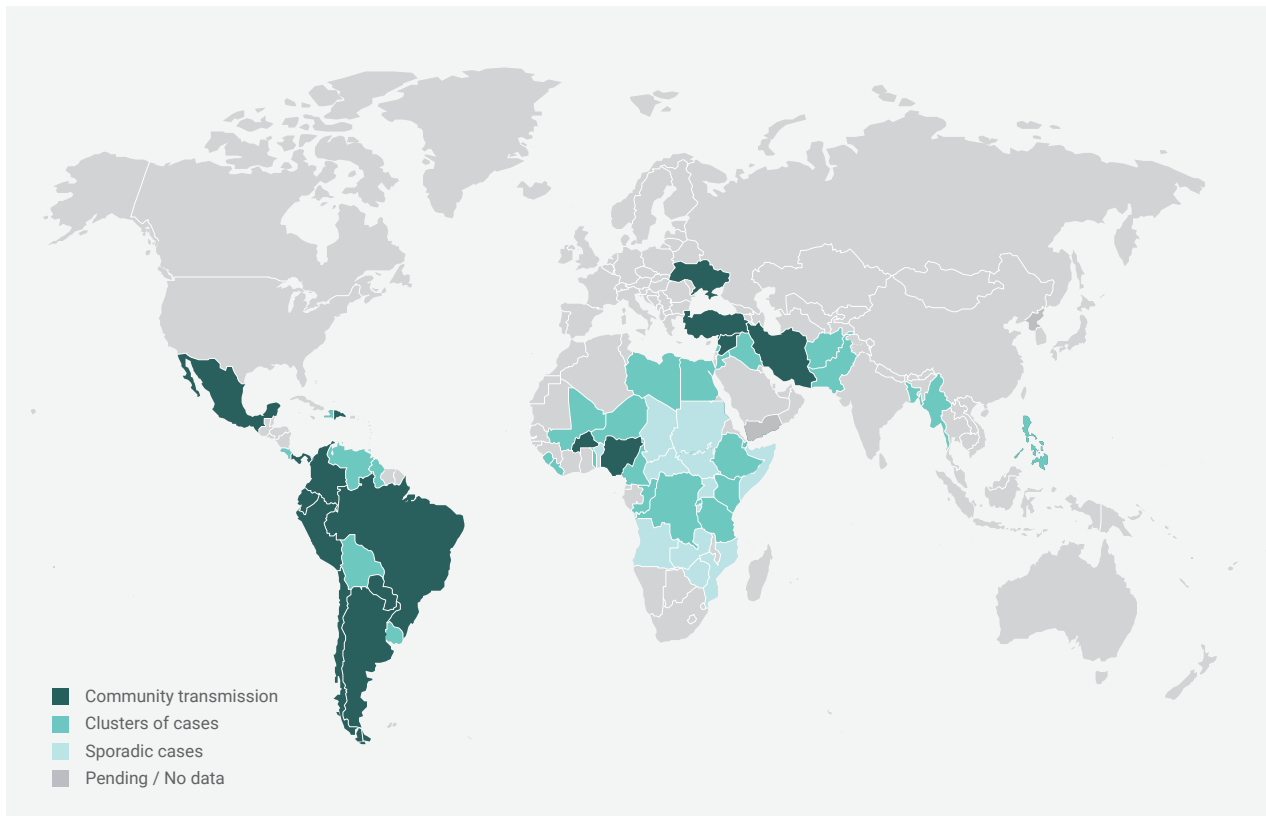
Source: World Health Organization, as of 6 May

Number of cases and deaths

NUMBER OF CASES
GHRP COUNTRIES

565 k

NUMBER OF DEATHS
GHRP COUNTRIES

26 k

GHRP COUNTRY	NUMBER CASES	NUMBER DEATHS		TRANSMISSION CLASSIFICATION
Afghanistan	3,224	95		Clusters of cases
Angola	35	2		Sporadic cases
Argentina	4,799	250		Community transmission
Aruba	100	2		Clusters of cases
Bangladesh	10,929	183		Clusters of cases
Benin	96	2		Sporadic cases
Bolivia	1,594	76		Clusters of cases
Brazil	101,147	7,025		Community transmission
Burkina Faso	672	46		Community transmission
Burundi	19	1		Sporadic cases
Cameroon	2,077	64		Clusters of cases
CAR	94	0		Sporadic cases
Chad	117	10		Sporadic cases
Chile	20,643	270		Community transmission
Colombia	7,668	340		Community transmission

Source: World Health Organization https://covid19.who.int, as of 6 May

GHRP COUNTRY	NUMBER CASES	NUMBER DEATHS		TRANSMISSION CLASSIFICATION
Costa Rica	739	6		Clusters of cases
Curaçao	16	1		Sporadic cases
Djibouti	1,120	2		Clusters of cases
Dominican Rep.	8,235	346		Community transmission
DPR Korea	-	-		No cases
DRC	682	34		Clusters of cases
Ecuador	31,881	1,569		Community transmission
Egypt	7,201	452		Clusters of cases
Ethiopia	140	3		Clusters of cases
Guyana	82	9		Clusters of cases
Haiti	88	9		Clusters of cases
Iran	99,970	6,340		Community transmission
Iraq	2,346	98		Clusters of cases
Jordan	471	9		Clusters of cases
Kenya	490	24		Clusters of cases
Lebanon	741	25		Clusters of cases
Liberia	166	18		Clusters of cases
Libya	63	3		Clusters of cases
Mali	580	29		Clusters of cases
Mexico	23,471	2,154		Community transmission
Mozambique	80	0		Sporadic cases
Myanmar	161	6		Clusters of cases
Niger	755	37		Clusters of cases
Nigeria	2,802	93		Community transmission
oPt	538	4		Clusters of cases
Pakistan	21,501	486		Clusters of cases
Panama	7,197	200		Community transmission
Paraguay	396	10		Community transmission
Peru	45,928	1,286		Community transmission
Rep. of Congo	236	10		Clusters of cases
Rwanda	261	0		Clusters of cases
Sierra Leone	178	9		Clusters of cases
Somalia	835	38		Sporadic cases
South Sudan	49	0		Sporadic cases
Sudan	778	45		Sporadic cases
Syria	44	3		Community transmission
Tanzania	480	18		Clusters of cases
The Philippines	9,485	623		Clusters of cases
Togo	126	9		Clusters of cases
Trinidad and Tobago	116	8		Sporadic cases
Turkey	127,659	3,461		Community transmission
Uganda	89	0		Sporadic cases
Ukraine	12,697	316		Community transmission
Uruguay	655	17		Clusters of cases
Venezuela	357	10		Clusters of cases
Yemen	21	3		Pending
Zambia	137	3		Sporadic cases
Zimbabwe	34	4		Sporadic cases

Source: World Health Organization https://covid19.who.int, as of 6 May

For extremely low-resource humanitarian settings, including for displaced populations, specifically camps and camp-like settings warranting additional considerations,[11] Early Warning, Alert, and Response Systems (EWARS) should be strengthened to detect cases early to curb dangerous community transmission. At present, EWARS are operational in a range of countries covering both emergency- and non-emergency-affected populations.[12] In complement, UNHCR's Health Information System is in use in refugee settings in 18 countries with an early warning component facilitating alerts to enable early case investigation and response measures.

In many countries, it is clear that the secondary impacts of stay-at-home orders and other similar policy responses include significantly increased risk of gender-based violence at the same time that the very services women and girls require are significantly reduced. The pandemic is disrupting the access of women and girls, including survivors of gender-based violence, to essential services such as sexual and reproductive health services, and clinical management of rape. Other essential health-care services, such as mental health and psychosocial support, are also disrupted, while stress induced by the COVID-19 pandemic is impacting mental health with increasing reports of alcohol-related incidents in communities. These include domestic violence and worsening or exacerbation of pre-existing severe mental health, neurological and substance abuse conditions.

In some countries, teams providing rehabilitation services essential to the functioning and well-being of persons with disabilities, older persons and others with specific health conditions have been forced to discharge patients before completing their treatment. Without referrals to other programmes, such patients will face ongoing complications and risk long-term impairments.

The COVID-19 pandemic is also having adverse effects on the supply chain for contraceptive commodities and threatening women's access to family planning. Beyond preventing the increase of unintended pregnancies, this is also a time-sensitive and life-saving service. Exacerbation of already existing health disparities and a decline of health coverage for women and girls in humanitarian situations will result in much higher maternal and newborn mortality.

There are reports that national and international health-care workers are being targeted (including female health workers[13] who make up 70 per cent of front-line health-care and social workers globally[14]) and stigmatized due to perceptions that they are bringing COVID-19 into communities. Reports from South Sudan, Mexico, Colombia, India, the Philippines, Australia, Bangladesh, Nigeria, Sudan and other countries indicate that attacks on health-care workers have increased across the world in the form of physical and verbal attacks, as well as psychological and non-physical "attacks", such as eviction from homes. At the same time, attacks on health services in conflict situations (e.g. Syria, Libya) have not abated despite the increased need for health care for COVID-19. These attacks have affected the functioning of health-care facilities and health workers in countries where the health system is already stretched thin, and diminished access to health-care services for patients and health-care resources.

Projected effects on health and health services

Looking ahead, while there is a lack of documented experience in dealing with COVID-19 in low-capacity and humanitarian settings, the assumption is that COVID-19 will spread rapidly once present. The high prevalence of comorbidities in humanitarian crises, including malnutrition, communicable diseases, common childhood diseases, vaccine-preventable diseases, tuberculosis and other respiratory diseases, cholera and other infectious waterborne diseases, HIV and a range of other sociodemographic factors, could result in a different epidemiological distribution, yet with a significant proportion of serious and critical COVID-19 cases, despite the relatively younger demographics. Younger populations may mitigate the overall mortality rate, but the speed of transmission, limited options for preventative measures and limited response capacity mean that older people and people with underlying conditions face

[11] WHO, 2020. Coronavirus disease (COVID-19) technical guidance: Humanitarian operations, camps, and other fragile settings as well as refugees and migrants in non-humanitarian and non-camp settings. Available online: www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/humanitarian-operations-camps-and-other-fragile-settings

[12] Conflict-affected South Sudan, North East Nigeria, Republic of Congo, Democratic Republic of Congo, Cyclone-affected Mozambique, North-West & South-West of Cameroon, Guyana, Rohingya crisis in Bangladesh, Fiji, Yemen, Afar and Oromia regions of Ethiopia, and Northern Syria

[13] Fraser E. Impact of COVID-19 Pandemic on Violence against Women and Girls (UK Aid, March 2020). Accessed at: www.sddirect.org.uk/media/1881/vawg-helpdesk-284-covid-19-and-vawg.pdf

[14] WHO, 2019. Gender equity in the health workforce: Analysis of 104 Countries

serious and imminent risks in humanitarian settings. The situation of the COVID-19 pandemic may exacerbate existing mental health conditions, induce new conditions and limit access to the already scarce mental health services available in many countries, especially in humanitarian settings.

Critical measures for COVID-19 prevention and containment are also much more difficult to implement without the required capacities for testing, tracing, isolation and treatment, and adequate infection prevention and control.

A study conducted by the London School of Hygiene and Tropical Medicine (LSHTM) during mid-April 2020 attempted to provide global, regional and national estimates of the numbers of individuals at increased risk of severe COVID-19 disease for this year by virtue of their underlying medical conditions.[15] Overall, it was estimated that 1.7 (1.0 - 2.4) billion individuals (22 per cent [15-28 per cent] of the global population) are at increased risk of severe COVID-19 disease. The share of the population at increased risk ranges from 16 per cent in Africa to 31 per cent in Europe, including with chronic kidney diseases, cardiovascular diseases, diabetes and chronic respiratory diseases being the most prevalent conditions. African countries with a high prevalence of HIV/AIDS and Island countries with a high prevalence of diabetes also have a high share of the population at increased risk.

Measures to control the spread of COVID-19 run the risk of pausing routine immunization, leaving millions of unvaccinated children vulnerable to deadly yet preventable diseases. It is estimated that more than 117 million children could miss out on measles vaccinations as immunization campaigns are delayed or cancelled. At least 24 countries have postponed Measles Supplementary Immunisation Activities to date[16] including Chad, DRC, Ethiopia, Nigeria, Somalia and South Sudan. The LSHTM weighed the benefits of continued routine infant immunization vaccination programmes against the risk of infections in Africa and found in its modelling[17] that for each COVID-19 death, at least 34 and as many as 1,247 future deaths would occur from a range of diseases including measles, yellow fever and polio.

There are indications that in many GHRP priority countries, demand for or utilization of health services has dropped significantly, even when essential services are still maintained. Rapid surveys done by the Health clusters in Libya[18] and Syria,[19] for example, indicate that many partners' service delivery has been affected by prevention measures and movement restrictions leading to reduced access to affected populations and services. Loss of income due to the economic impact may further increase existing financing barriers to access health care.

The impact of COVID-19 is also affecting the capacity of authorities to maintain essential water, sanitation and hygiene service provision while these are essential to the prevention and control of the pandemic in communities and health facilities. The most vulnerable populations with no access to adequate water, sanitation and hygiene facilities will be the most at-risk.

Countries will need to make difficult decisions to balance the demands of responding directly to COVID-19, while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of system collapse. Many routine and elective services might have to be postponed or suspended. When routine practice comes under pressure due to competing demands, simplified purpose-designed governance mechanisms and protocols can mitigate outright system failure. The priority should be to reduce the loss of life, avoiding a trade-off between those at risk of most serious outcomes and death, and broader health concerns for the wider population. Delayed care-seeking, disrupted services, and increased needs such as for mental health or health services related to domestic, sexual and gender-based violence, will lead to an increased demand for health services once COVID-19 is controlled.

Indicators to monitor the evolution of the pandemic were identified in the first iteration of the GHRP last March. It has not been possible to provide results for this update. Data will be included in the next update in July.

[15] London School of Hygiene and Tropical Medicine, How many are at increased risk of severe COVID-19 disease? Rapid global, regional and national estimates for 2020, accessed at:
www.lshtm.ac.uk/newsevents/news/2020/one-five-people-globally-could-be-increased-risk-severe-covid-19-disease

[16] www.unicef.org/press-releases/more-117-million-children-risk-missing-out-measles-vaccines-covid-19-surges

[17] London School of Hygiene and Tropical Medicine, Response Strategies for COVID-19 epidemics in African settings: a mathematical modelling study, accessed at: https://cmmid.github.io/topics/covid19/control-measures/report/LSHTM-CMMID-20200419-Covid19-Africa-strategies.pdf

[18] Impact of COVID-19 prevention measures on humanitarian operations for Health Sector in Libya – Health Cluster Report April 2020.

[19] Impact of COVID-19 prevention measures on humanitarian operations for Health Sector – Syria Health Sector report – April 2020.

Situation and needs
Spread and severity of the pandemic.
The incidence informs on the trajectory of the epidemic

#	INDICATOR [20]	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
1.1	**Number of COVID-19 cases nationwide**	Weekly	WHO	-
1.2	**Total number of deaths among confirmed cases nationwide**	Weekly	WHO	-
1.3	**Number and proportion of new confirmed cases in health care workers**	Weekly	WHO	-
1.4	**Case fatality among confirmed COVID cases[21]**	Weekly	WHO	-

Situation and needs
Sexual and reproductive health
COVID-19 containment measures and high COVID-19 incidence rates affect pregnancy and safe delivery

#	INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	SITUATION AS OF 28 APRIL 2020
5.1	**Number of deliveries in health facilities in COVID-19-affected areas**	Monthly	UNFPA	Reporting not yet available

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[20] Insofar as possible, indicator data should be collected disaggregated by sex, age and disability.

[21] Case fatality is calculated as the number of deaths reported to date divided by the number of cases reported to date. This figure may not reflect the true risk of dying from COVID-19 infection, as it does not account for individual case progression; country variations in case and death reporting, including differences in testing strategies; differences in country population age and risk factor profiles; and time lags between being reported as a case and having a fatal outcome, amongst other factors.

2.2

Update on the socioeconomic impact of COVID-19

Measures taken to contain the spread of the virus and economic disruption are having a devastating impact on the lives and livelihoods of the most vulnerable people in humanitarian crises. These range from global macro and local economic dynamics to the consequences of confinement measures and physical distancing. In refugee-hosting countries, there are growing concerns that socioeconomic pressures on host communities due to COVID-19 will have consequences for refugee protection.

Main macroeconomic and country-level effects

The IMF's April World Economic Outlook forecasts a negative 3 per cent growth in global GDP in 2020 and a reduction in global trade by 11 per cent. Developing market economies are expected to shrink less (-1 per cent) than advanced economies (-6 per cent).[22] Although uncertain, the main underlying assumption is that the pandemic fades in the second half of 2020 and containment measures can gradually be unwound, resulting in a strong recovery in 2021 with global growth reaching 5.8 per cent and trade 8.4 per cent. The IMF points out that several countries are at particular risk as they face a multi-layered crisis including health shock, economic disruption, drop in external demand, capital outflows and a collapse in commodity prices.[23]

Economic stability may be compromised if fragile contexts – often already at risk of debt distress – take on further debt to refinance broken health systems and lose important tax revenue. Progress towards stability and the Sustainable Development Goals could be compromised if Official Development Assistance is diverted to the COVID-19 response, if the private sector (particularly small and medium enterprises and the informal economy) does not receive any economic relief, and if access to markets is restricted by containment measures and closed borders.

The extent to which the global economic downturn is affecting low-income economies is becoming increasingly visible. Prices of primary commodities, whose export is vital for large parts of the developing world, have plunged. Economies relying on oil exports are being particularly affected as the price of crude oil has plummeted to US$25/barrel. Tourism, which contributes significantly to foreign exchange earnings in several vulnerable countries, has come to a complete halt. Remittances flows are expected to decrease by 20 per cent compared to 2019, while in some low-income countries they represent up to 30 per cent of GDP. The flow of foreign direct investments is expected to shrink by 30 - 40 per cent in 2020/21.

Early IFPRI simulations of the impact of COVID-19 on global extreme poverty show that reduced growth in the world economy by 1 per cent would push more than 14 – 22 million additional people into extreme poverty.[24] The World Bank estimates are even higher, expecting 40 - 60 million additional people.

Economic analysis[25] suggests that low-income and lower-middle-income countries presenting the following characteristics are likely to be among the hardest hit:

- Large dependence on imports of food and other essential needs
- Large reliance on exports of primary commodities
- Significant levels of public debt and/or low foreign currency reserves
- Large reliance on the export of labour and remittances.

Countries that combine these characteristics, countries with already fragile economies that are also affected by conflict, and countries coping with large-scale economic shocks as well as natural hazards, diseases and pests prior to COVID-19, will face a double or triple burden. According to the 2020 Global Report on Food Crises, 10 countries (all part of the

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[22] www.imf.org/en/Publications/WEO/Issues/2020/04/14/weo-april-2020

[23] www.imf.org/en/Topics/imf-and-covid19/COVID-Lending-Tracker

[24] WFP *Economic and food security implications of the COVID-19 outbreak,* 14 April 2020

[25] WFP *Economic and food security implications of the COVID-19 outbreak,* 14 April 2020; WFP acute food insecurity projection analysis, 21 April 2020

GHRP) constituted the worst food crises in 2019: Afghanistan, DRC, Ethiopia, Haiti, Nigeria, South Sudan, Sudan, Syria, Venezuela and Yemen. Eight countries had at least 35 per cent of their populations in a state of food crisis: Afghanistan, CAR, Haiti, South Sudan, Sudan, Syria, Yemen and Zimbabwe.

In terms of food security, FAO forecasts for the 2020 world wheat production predicted record levels compared to last year, close to the near-record levels of 2019. Until now, the pandemic's first effect on food prices was mainly deflationary, a 4.3 per cent decline from February to March, due to contraction in global demand.[26] However, logistical issues and concerns over food availability are sparking localized market disruptions and export restrictions, resulting in price spikes and increased price volatility.

Countries most at risk are those heavily dependent on food imports, including small and/or insular countries well integrated into the global economy and specialized in other economic sectors. In Yemen, for example, basic food commodity prices rose sharply across the country. In South Sudan, where the latest Integrated Food Security Phase Classification analysis indicates that 6.48 million people (55 per cent of the population) will experience acute food insecurity between May and July, prices of imported wheat flour have already increased as screening measures to contain the spread of the COVID-19 pandemic, implemented by the Government of Uganda, affected trade activities and reduced food imports.

The past month saw a rise in tariffs, food export bans, and quotas on key commodities. Export bans are in place for rice in Malaysia, wheat in Romania, and pulses in Egypt. Rice export bans in Vietnam were lifted while still following a monthly quota. The main wheat exporters (Russia, Ukraine and Kazakhstan) have almost reached their fixed quota for the May-June period, which may lead to potential bans until harvest in July. WFP global food price monitoring during the week of 22 April observed high increase in prices of rice due to the export bans, and wheat prices by more than 15 per cent linked to domestic stockpiling by some governments. In East Africa, high levels of volatility in the price of maize are observed linked to uncertainty on global markets coupled with the locust spread.[27] Monitoring in Libya shows a 26 per cent average retail price increase compared to March.

Food security is impacted in all regions where GHRP countries are located. In East Africa, the pandemic strikes at a time when the region is fighting an ongoing desert locust outbreak and is recovering from drought and floods in 2019. Food insecurity is alarmingly high, with more than 15 million people in IPC phase 3 or above in Ethiopia, South Sudan, Somalia and Kenya.

The Southern Africa region has been affected in the recent past by growing climate-related shocks, resulting in a record number of people being pushed into food insecurity. According to an April 2020 OCHA Humanitarian Snapshot report, the region is now home to 15.6 million severely food-insecure people, most of them in Malawi, Mozambique, Tanzania, Zambia and Zimbabwe. Vulnerable and commodity export-dependent economies, such as Angola, Mozambique, Zambia and Zimbabwe, are expected to be significantly affected by the economic fallout of COVID-19.

While many West and Central African countries continue to be affected by conflict (e.g. Burkina Faso, Cameroon, CAR, Mali, Niger, Nigeria) and climate-related shocks, the major fallout from COVID-19 is likely to be commodity market volatility and supply chain disruption impacting food imports. Decreased Government revenue in major oil-exporting countries, such as Cameroon, Chad, Nigeria and Senegal, could increase the cost of imports of critical goods, such as food. The Central Sahel pre-lean season and pre-COVID accounts for some 3.9 million food-insecure people. This is a staggering increase of 167 per cent% compared to the same time last year (Mar-May 2019). As the peak of lean season approaches, 5.5 million people are projected to be food insecure, with the steepest increase seen in Burkina Faso (2.1 million, +213 per cent).

COVID-19-induced vulnerabilities will be pronounced in Middle East and North Africa countries that are heavily dependent on commodity export revenue, particularly oil, and/or those with fragile macroeconomic conditions (high public debt and/or low foreign currency reserves). Iran, Iraq, Libya, Lebanon and Sudan are particularly vulnerable because of their dependence on oil exports. These effects will compound those of conflicts in Iraq, Libya, Syria and Yemen.

[26] FAO Food Price Index
[27] WFP food price tracking, Headquarters, week 22 April

The shock to private consumption following measures to prevent the spread of COVID-19 across large parts of Asia will have a heavy economic toll, particularly in South Asia, where this has been an important driver of growth. Afghanistan imports food worth more than twice the value of its total exports – and long blockages at borders have already affected supply and movement, including humanitarian food assistance.

While primary commodity exports are arguably the most important channel through which COVID-19 affects Latin America's economies, the region's reliance on remittances and tourism adds to its vulnerability. Amid a struggling global economy, a decline in remittances by 7 per cent compared to the previous year (implying a drop by US$6 billion in remittances from the US) is seen as a conservative estimate. The region is also affected by the exodus of about 5 million people from Venezuela. April saw a marked rise in social unrest and violence in parts of the region as lockdown measures and economic disruptions impact access to food and essential needs.

Collateral effects on people

Update on the effects on livelihoods and food security

The lives and livelihoods of millions of people living in countries experiencing humanitarian crises are being affected by:

- Loss of jobs due toas a result of health shocks and gGovernment containment measures (e.g. stay- at- home orders) and closure (temporary and permanent) of businesses of all sizes, resulting in loss of income for highly vulnerable workers such as daily workers, the urban poor, migrant workers, remittance-s recipient households, and all informal sector workers especially where safety nets are not available.

- Disruption in the local, national and global supply chains, and in the agricultural input supply chains, reducing informal labourers' access to farmland and impacting day labourers' wages, area of land cultivated, etc.

- Disruption and distortion ofin consumption patterns, and, as a result of a combination of all of the above aspects, increased risk of undernourishment, especially for low- income households in countries with high commodity-import dependence.

Before the pandemic, an estimated 135 million people experienced acute food insecurity in 2019 (Phase 3 and above of the Integrated Phase Classification), and a further 183 million people were on the verge of crisis, some 60 per cent in African countries alone.[28] WFP projects that the economic impacts of COVID-19 stand to push these figures to 265 million in 2020, an increase of up to 130 million people.[30] COVID-19 will exacerbate parallel crises including the locust crisis in East Africa and anticipated localized poor rainfall (including the northern triangle and Haiti). A recent FAO policy brief predicts that if the anticipated global recession were to trigger a reduction in the growth rate of gross domestic product (GDP) of between two and ten percentage points, the number of undernourished people in net food-importing countries would increase by 14.4 million to 80.3 million, with the majority of the increase coming from low-income countries.

The COVID-19 pandemic is directly affecting food systems by impacting food supply and demand. It is decreasing purchasing power while affecting the capacity to produce and distribute food. Millions of African smallholder farmers who grow fruits and vegetables for export have lost access to global markets as flights are cancelled and borders restricted. The disruption of supply chains is also affecting the import of agricultural inputs such as seeds, fertilizers and insecticides. As movement restrictions are imposed, agricultural input supply chains are impacted at critical times in the season, reducing informal labourers' access to farmlands, wages, area of land cultivated and harvesting capacity, and constraining transport of goods to processing facilities and/or markets. Immediate impacts tend to be more severe for fresh food leading to food losses, reduction of income and deterioration in nutrition, especially among the already vulnerable population.

Livestock supply chains could also be hit by the pandemic, with significant implications for pastoralist households, especially in Africa's drylands. Transhumance routes are already affected by movement restrictions and border closings, limiting the access to pasture and market and increasing intercommunity tensions, dramatically impacting transhumant pastoral livelihoods. For example, in East Africa, transhumant pastoralists rely heavily on the Middle Eastern markets during Ramadan and Eid as a main source of income, and movement restrictions thus threaten their entire year's income and food

28 2020 edition of the Global Report on Food Crises
29 WFP projection analysis, 21 April 2020
30 www.fao.org/3/ca8800en/ca8800en.pdf

access. These will translate into significant income and purchasing power losses, with negative impact on nutrition and overall resilience to the COVID-19 health emergency.

These impacts on livelihoods and food security are already manifesting in countries of particular concern. In Yemen, as of mid-April, small and micro enterprises have been affected by imposed COVID-19 curfews, with reduced working hours affecting small businesses and open-air markets. Availability of perishable food commodities such as fruits, vegetables and fresh milk (critical to nutrition in a country experiencing desperately high levels of acute malnutrition) is also in short supply in many markets. In Cox's Bazar in Bangladesh, where a large number of Rohingya refugees are located, a rapid assessment highlighted negative effects of the COVID-19 pandemic for the agriculture sector, including disruption of harvesting due to a lack of seasonal labour, of planting due to a lack of seed or fertilizer, of transport due to reduced transport facilities, and of market exchange due to lockdowns or physical distancing. In CAR, major disruptions in the supply chain leading to shortages of certain food products in markets have been reported.

The risk of rural-urban migration/displacement is increased by the loss of purchasing power of vulnerable rural smallholders, in turn compounding the likelihood of disease outbreak and destitution. For example, in Burundi, the closure of border points with DRC, Rwanda and Tanzania due to COVID-19 has negatively impacted IDPs and the agriculture sector. Many daily workers are no longer able to undertake their daily activities (cross-border farming or other businesses). Many IDPs have also reported being unable to afford food due to inflation in market prices, and tensions are increasing in displacement sites placed under movement restrictions.

With over 80 per cent of the world's refugees and nearly all of the IDPs living in low- to middle-income countries with already weak economic and health systems, socioeconomic impacts are disproportionately high for the forcibly displaced and Stateless whose access to formal labour markets, education and public health services is often not on par with citizens of a country. With movement restrictions and lockdowns, forcibly displaced populations such as refugees and asylum seekers, returnees, IDPs, Stateless persons, as well as host communities,

are increasingly unable to make a living. Border closures and movement restrictions will also lead to extended periods of family separation. This will have an immediate impact on children's mental health and well-being and put them at risk of exploitation and abuse.

Reports from surveys, call centres or helplines indicate serious problems in meeting basic needs, such as difficulties in purchasing food and paying rent; evictions and threats of such; abrupt falls in access to livelihoods; generalized and widespread falls in abilities to access food and health care; and the resorting to negative coping mechanisms, such as reducing food consumption and going into debt, child labour and child marriage. Measures taken in response to the pandemic have increased the risk of disruption to global food supply chains, including for the 1 million Palestine refugees who receive quarterly food assistance from UNRWA in Gaza, a territory with the world's highest levels of unemployment. Food security for refugees and other recipients of food assistance may also be compromised if rations are reduced. For example, in Uganda, food rations for 1.3 million refugees were cut by 30 per cent as of 1 April 2020.[31]

In the past, forcibly displaced people were one of the last groups of vulnerable people to be considered by Government economic stimulus packages. Based on previous experience (2008 financial crisis, 2014 Ebola outbreak in West Africa), as host communities feel the economic impact of COVID-19, they limit the access of refugees and IDPs to land and other natural resources that have supported basic needs such as food and energy. This is beginning to have harmful effects on, for instance, income or access to social services, and it is leading to a rise in harmful coping mechanisms and discrimination.

Women in particular face the economic consequences of the pandemic, as they are overrepresented in the sectors and jobs that are hardest hit, particularly in the most vulnerable types of employment with the least protection, such as self-employed, domestic workers, daily wage workers and contributing family workers. UN WOMEN reports that many lost their livelihoods within a day, but without any safety nets, financial security or social protection to rely on.[32]

[31] https://reliefweb.int/sites/reliefweb.int/files/resources/Uganda_FSOU%2004_2020_Final.pdf
[32] The first 100 days of COVID-19 in Asia and the Pacific: a gender lens. Accessed at:
www2.unwomen.org/-/media/field%20office%20eseasia/docs/publications/2020/04/ap_first_100-days_covid-19-r02.pdf?la=en&vs=3400

Update on the effects on protection and rights, including gender

Threats to and abuses of older people's rights are occurring in both the public health emergency response and in the wider impact of the pandemic. Public discourses around COVID-19 that portray it as a disease of older people can lead to social stigma and exacerbate negative stereotypes about older people.[33] Ageist stereotypes, prejudices and hate speech on social media, in the press and in statements made by politicians isolate and stigmatise older people.[34] Discriminatory policies based on age, including triage protocols that use arbitrary age criteria as the basis for allocating scarce medical resources, are already a feature in some countries dealing with the pandemic. There are also reports of 'do-not-resuscitate' orders being placed on older people without their consent, and curfews and self-isolation policies imposed on older people on the basis of their age, disproportionately restricting their freedoms.

The current outbreak of COVID-19 is also fast becoming a protection crisis, especially for women and girls. Confinement, loss of income, isolation and increased psychosocial needs have led to a spike in gender-based violence predominately perpetrated against women and girls. Since the outbreak of the pandemic, UN WOMEN is reporting increased violence against women around the world, with surges of upwards of 25-30 per cent in countries with reporting systems in place.[35] As the virus spreads in countries affected by humanitarian crises with institutional weaknesses on protection, police and justice, it is expected that the vulnerability and risk exposure for women and girls will rapidly increase.

At the same time, gender-based violence services have reduced their capacities or been repurposed to create additional capacity for COVID-19 testing/ treatment. In an effort to enhance physical distancing and minimize gatherings, key structures such as women safe spaces have also had to drastically reduce the number of clients or disband, creating a huge challenge for women in abusive relationships to seek a safer place to share their problems and receive protection as well as mental health and psychosocial support and information.

With families' loss of livelihoods and potential prolonged family separation due to mobility restrictions, negative coping mechanisms may be adopted, leaving children without care and facing increased exposure to abuse, violence and exploitation, including violence at home, child marriage and child labour. The virus itself and the response measures may also create new unaccompanied and separated children. A drastic increase in calls to hotlines indicates that domestic violence against children is increasing. At the same time, movement restrictions are curtailing the ability of social services to respond to threats of abuse and provide protection.

Youth, people with disabilities, members of minority groups as well as people deprived of liberty and/ or of the right and access to information are also experiencing a higher degree of protection risks. Younger children and adolescents, especially girls and adolescent mothers, are particularly at risk, as high levels of stress and isolation can impact brain development, sometimes with irreparable long-term consequences. Child and women survivors of serious protection violations may suffer the physical and emotional consequences of traumatic experiences. Mental health is affected by pandemic-induced stress, with concerns with alcohol-related incidents in communities, including domestic violence, and worsening or exacerbation of pre-existing severe mental health, neurological and substance-abuse conditions.

There are concerns that some governments may use the pandemic to expand executive power, restrict individual rights, disrupt electoral processes, oppressively limit civic mobilization and impose strict restrictions on media. Such measures have led to public demonstrations in several countries including Lebanon, Algeria and Venezuela.[36] Economic and governance crises and increasing authoritarian tendencies were already taking place across the globe prior to COVID-19. These tensions and tendencies will only be compounded by the global pandemic and ensuing economic crisis, and they need to be carefully monitored.

Reports are emerging of Government authorities and criminal gangs using lockdown measures as justification to advance their own political interests or to further marginalize vulnerable groups. Armed groups may also use the outbreak to take advantage of the vacuums that may be created as governments re-task their military capacity to support public health response and travel restrictions delay deployments of international troops.

[33] www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/04/Policy-Brief-on-COVID19-and-Older-Persons.pdf

[34] www.helpage.org/newsroom/press-room/press-releases/coronavirus-older-people-in-low-and-middleincome-countries-must-be-protected-to-prevent-global-humanitarian-catastrophe/

[35] www.unwomen.org/en/digital-library/multimedia/2020/4/infographic-covid19-violence-against-women-and-girls

[36] COVID-19 Disorder Tracker, ACLED, https://acleddata.com/#/dashboard

There are already signs that these effects have many protection implications, including the marginalization of vulnerable groups and violations of fundamental principles of refugee and human rights, and disrupting community and individual protection capacities. Use of emergency measures in some contexts are limiting freedom of expression, including on dissemination of information on COVID-19, and there are increasing reports of excessive, disproportionate and discriminatory use of force, arrests and detention in the enforcement of prevention and containment measures, such as lockdowns and curfews.

Large population movements have been observed, with waves of vulnerable people fleeing pandemic-affected areas, or due to loss of sources of income. For example, over 260,000 Afghan nationals have returned home from Iran and Pakistan37 since January,[37] and similar movements have taken place in several regions in the Americas, Asia and Africa. Conversely, in some contexts IDPs, migrants and refugees living in overcrowded conditions with limited access to sanitation facilities and health care are prevented from moving or forcibly returned by authorities. Negative consequences can occur, including on public health, should premature or induced returns take place to countries that are in conflict situations or countries with fragile health-care systems.

The COVID-19 emergency exacerbates pre-existing vulnerabilities and risks of violence and discrimination faced by migrants, asylum seekers and IDPs, which intersect with other factors, such as gender, age, disability, mental health and psychosocial needs, or pertaining to a minority. With more people falling below the poverty line, tensions with host communities are likely to increase, especially in communities depending on humanitarian assistance. The inability to interact with the local population will largely affect the social cohesion in communities with a large migrant population, thereby reducing their resilience and capacity to recover.

The main protection impacts noted to date include:

- Border closures and restrictions on access to asylum and asylum procedures, and humanitarian resettlement. As of 20 April 2020, UNHCR estimated that 167 States have partially or fully closed their borders to contain the spread of the virus, of which 57 are making no exception for people seeking asylum.

- Incidents of large-scale deportations, including of children, with countries of origin being unprepared for their arrival. Where deportations have been stopped, incidents of extended immigration detention, including of children.

- Increased spontaneous and induced returns in the Americas and in Asia and the Pacific in particular.

- Limitations on or discriminatory freedom of movement for people living in internal displacement camps and sites.

- Intensification of conflict in some regions (CAR, Colombia, DRC, Lake Chad Basin, Libya, the Sahel and Yemen).

- Limited access to life-saving assistance and services for refugees, IDPs and other people of concern, and restricted UNHCR and partners' access to them.

- Xenophobia (for example, refugees and migrants from Venezuela facing stigmatization and negative perceptions from host communities associated with a fear of spreading the virus).

- Increased risk of violence against children, with limited access to help due to predominantly remote modes of case management, and vulnerability to separation due to restrictions or forced movement and suspension of family tracing and reunification, with heightened risk of negative coping mechanisms and exploitation.

- Increased risk of gender-based violence for households in lockdown situations.

- Increased risk of exploitation and trafficking of vulnerable groups due to the socioeconomic impacts of the pandemic.

- Stigmatization and discrimination of population groups thought to carry the virus, such as older people, people with disabilities, and IDPs, refugees and returnees in particular. This leads to targeted attacks on collective sites, as well as heightened tensions within communities, and isolation of vulnerable groups, and discouraging or reducing access to services, including for health treatment.

- Forced evictions, with many refugees or IDPs unable to pay rent and left homeless.

- Increased forced displacement due to some non-State actors taking advantage of lockdowns to gain and solidify territory, causing further displacements.

37 https://reliefweb.int/report/afghanistan/return-undocumented-afghans-weekly-situation-report-19-25-april-2020

The stigmatization faced by vulnerable people perceived to be infected is mirrored by mounting intolerance observed towards foreigners, including humanitarians, seen by locals to be carriers of the disease. Incidents of hostile attitudes against internationals have been reported, and worse, attacks against health and humanitarian workers, assets and facilities, including while conducting COVID-19 testing and treatment. By the end of April, the Surveillance System for Attacks on Health Care recorded 64 incidents of attacks on health care in nine countries experiencing complex humanitarian emergencies and COVID-19. This resulted in the deaths of more than 30 and injury of more than 70 health workers and patients. This figure does not capture all the additional attacks witnessed against health workers due to stigmatization, which means the real magnitude of attacks on health care is much higher. Attacks on health care in times of crises deprive the community of much-needed essential health services, and its gravity compounds in a pandemic situation.

The pandemic may eventually also affect political stability if trusted elderly leaders succumb if misinformation and rumours circulate and information about the pandemic is used as a weapon against particular groups. Security may be at risk if social unrest looms over an economic recession, security forces violently crackdown protests and/or try to enforce lockdown policies, peacekeepers are confined to barracks, or if peace and dialogue processes are hampered by the inability to physically meet. Where security forces are mono-ethnic or have a history of abuses, societal tensions and violence may be exacerbated when enforcing security and order.

In some cases, the pandemic may create opportunities for positive and sustainable peace and development in fragile contexts. The UN Secretary-General has called for an immediate global ceasefire to create corridors for life-saving aid, open windows for diplomacy and bring hope to places most vulnerable to COVID-19. There are already promising signs, including partial or full ceasefire announcements in Cameroon, CAR, Colombia, Libya, Myanmar, the Philippines, South Sudan, Sudan, Syria, Ukraine and Yemen,[38] even though it is too early to say whether these ceasefire announcements will actually be followed.

Update on the effects on education and society

Over 480 million children and adolescents enrolled in pre-primary, primary, secondary or tertiary education, among them approximately 8 million refugee children, are seeing their right to education disrupted, as education facilities in countries covered by the GHRP are being closed to contain the spread of the virus. In the 29 countries covered by the GHRP, more than 250 million children are now unable to physically attend school.

Empirical evidence[39] indicates that households with little access to credit markets are more likely to reduce children's full-time school attendance and send them back to work when hit by economic shocks, using child labour as a form of risk-coping mechanism. The picture turns bleaker once children enter the workforce, as it becomes difficult to incentivize them to return when schools open. This was seen in the aftermath of the Ebola crisis in Sierra Leone, Liberia and Guinea, where a surge in early pregnancies created additional barriers in returning to education in adolescents. The social costs of ignoring girls' education are even higher as young girls not continuing education are more likely to be married early and more prone to early pregnancies.

Schools serve as safe spaces for many vulnerable children. Incidents of child abuse increase in economic recessions and disruption of routines. Vulnerable children living in particularly violent or dysfunctional family settings rely on their school network as safe spaces. Teachers, counsellors and school friends serve as critical support systems who may raise concerns about the child's well-being. In the absence of schools, these support systems have disappeared, having huge implications for many vulnerable children.

While closing schools is intended to contain the spread of the pandemic, it disrupts access to school-feeding programmes, mental health and psychosocial support, and personal assistance or medical care, which are often available through schools. Without the protective and social environment of schools and the services associated with them, children are more exposed to violence and vulnerability. Children with disabilities face increased risks, as they are likely to be more affected by reduced access to prevention and support measures, and excluded from alternative education solutions.

[38] www.un.org/press/en/2020/sgsm20032.doc.htm

[39] www.unicef.org/protection/files/UCW_Summary_Financialcrisis_TCfinal.pdf

It is estimated that about a third of primary-school and lower-year secondary-school students worldwide received food or meals at school. School closures in 197 countries means 369 million children (48 per cent girls) are missing out on school meals.[40] School-meal programmes serve an important safety net function as they reduce household food needs, freeing up disposable income, thus reducing volatility in household finances. School-feeding programmes can also ensure children's intake of micronutrients to build a robust immune system.

Closing schools to control the transmission of COVID-19 may have a different impact on women and adolescent girls as they provide most informal care within families, which in turn limits their economic and educational opportunities. Experience from previous crises shows that in many contexts girls were less likely to benefit from home-based learning opportunities, while experience from post-crisis situations shows them less likely to return to school.

Migrant, refugee and IDP children are disproportionately affected, as they tend to have no or only limited opportunities for remote learning due to limited access to online resources. In addition, there are substantial disparities between migrant and non-migrant families in their ability to support their children given a range of linguistic, cultural and educational barriers they are likely to encounter in that process.

Due to the pandemic and host government directives, all of UNRWA's 709 schools and eight Technical Vocational Education and Training (TVET) centres in Gaza, Lebanon, Syria, Jordan and West Bank, including East Jerusalem, have been closed since mid-March, impacting over 533,340 UNRWA pupils (half of whom are girls) and 8,000 youth at TVET centres. Efforts are made to compensate for the educational impact of the pandemic through the distribution of and online access to self-learning materials for school and TVET students, remote access to mental health and psycho-social support, messaging on health and hygiene, and monitoring.

School closures

33% OF ALL CHILDREN AFFECTED BY SCHOOL CLOSURES LIVE IN COUNTRIES WITH A HRP

57% OF THE STUDENTS IN COUNTRIES WITH A HRP ARE IN PRIMARY AND PRE-PRIMARY SCHOOLS

481M NUMBER OF STUDENTS IN COUNTRIES WITH A HRP AFFECTED BY LOCAL OR NATIONAL SCHOOL CLOSURES

88% NUMBER OF STUDENTS IN COUNTRIES WITH A HRP AFFECTED BY LOCAL OR NATIONAL SCHOOL CLOSURES

PUPILS IN SCHOOL IN HRP COUNTRIES
BY EDUCATION STAGE AND GENDER IN MILLIONS

■ MALE   ■ FEMALE

PRE-PRIMARY	PRIMARY	SECONDARY	TERTIARY
49.1% / 40.5 / 50.9%	48.3% / 235.8 / 51.7%	48.6% / 154.2 / 51.4%	49.9% / 50.1 / 50.1%

Source: UNESCO https://en.unesco.org/covid19/educationresponse
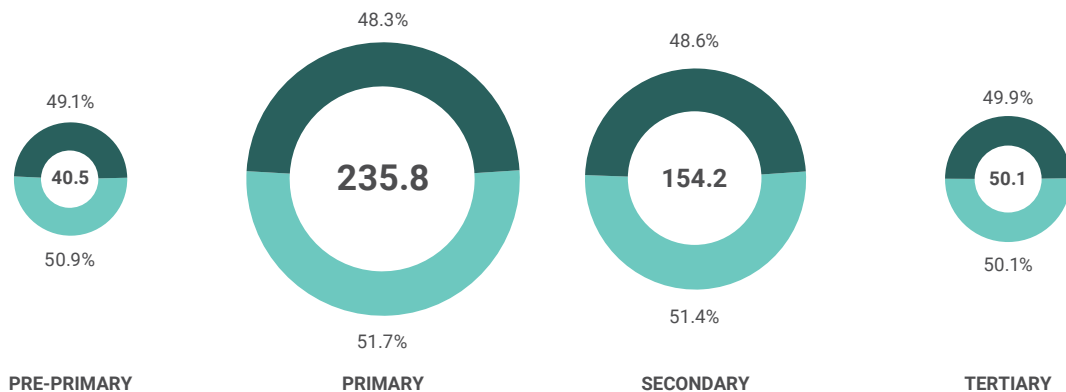
40 WFP Global Monitoring of School Meals During COVID-19 School Closures https://cdn.wfp.org/2020/school-feeding-map

Update on the effects on supply chains and logistics

Lockdowns, curfews and reduced manpower due to physical distancing are impacting all stages of the supply chain: from production and manufacturing (with reduced manpower and curfews slowing) to sea, road and air transport.

Real-time tracking of restrictions by the Logistics Cluster and partners in more than 50 countries covered by the GHRP shows that more than half have put in place transport restrictions ranging from border closures or one or more land borders, limiting cargo movement (air/sea/overland) to a few entry points, restricting movement to only prioritized cargo, requiring trans-shipment at border, and/or requiring quarantine of incoming vessels/trucks.[42] All countries – even those without restrictions in place – report that land, air and sea points of entry are operating at reduced capacity linked to curfews, physical distancing, etc. Overland crossing time at the Uganda/Sudan border has increased from two to three days to two weeks; at the port of Mombasa, throughput has reduced from some 5,000-6,000 mt/day to 2,000 mt/day.

Global health product supply chains are disrupted, affecting the availability of key materials and ingredients, finished health products, logistics, shipping, water treatment, disinfection products and more. Following disruption on the air flight market, vaccines shipments delivered to countries fell by approximately 80 per cent, and an increasing number of countries are reporting depleting stock. Pharmaceutical-related production in China is recovering, and production in India is expected to continue through the lockdown period. However, capacity will be reduced due to manpower and increasing logistics constraints.

The International Civil Aviation Organization found that in the first half of April, international passenger capacity had reduced to an unprecedented 89 per cent. The withdrawal of aircraft belly capacity reduced air cargo in March by 31 per cent (compared to the same time the previous year); an increase in cargo freighters offset some of the loss, though cargo remained at nearly 20 per cent reduction. The shipping industry projects that idle and unused containership capacity will reach a record high of three million TEU[43] within weeks - twice the level seen during the 2009 global financial crisis. Similar to the grounding of aircraft seen across many air carriers, container lines will need to anchor many ships.

Combined, these challenges are directly impacting humanitarian and health partners' ability to deliver assistance. Delays of two to three weeks or more are observed for the movement of food supplies. The cost to deliver planned programmes is significantly impacted as the cost of goods and services (including logistics costs) increases and partners have difficulty accessing countries (see Part III for response challenges related to humanitarian and health supply chains).

Situation and needs monitoring

Indicators to monitor the evolution of socio-economic impacts of the COVID-19 pandemic were identified in the first iteration of the GHRP in March. Indicators are still being refined and data is available for a limited number of them in this update. Additional results will be shown in subsequent GHRP updates.

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[42] Logistics Cluster Cargo Entry Points Update 23 April 2020 https://logcluster.org/sites/default/files/logistics_cluster_covid-19_cargo_entry_points_update_200423.pdf
[43] Twenty foot Equivalent Unit.

Situation and needs
Mobility, travel and import/export restrictions in priority countries

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
1.1	**Number and proportion of priority countries with partial or full border closures in place**	IOM[45] WHO	58
1.2	**Number of priority countries with international travel restrictions in place**	IOM[46] WHO WFP	60. The majority of GHRP countries have travel restrictions in place, 75% have total restrictions
1.3	**Number and proportion of priority countries with cargo movement restrictions in place**	WFP	> 50%

Situation and needs
Food security [47]

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
2.1	**Market functionality**	WFP	Available data cannot be aggregated at global level
2.2	**Food consumption score**	WFP	Available data cannot be aggregated at global level
2.3	**Reduced Coping Strategy Index (RCSI)**	WFP	Available data cannot be aggregated at global level
2.4	**Food and crop production estimates**	FAO	Will be available after the 2nd round of data in September
2.5	**Food Insecurity Experience Scale (FIES)**	FAO	1st round of collection in May
2.6	**Number of priority countries with degraded availability of / access to agricultural inputs**	FAO	1st round of collection in May

[44] Insofar as possible, indicator data should be collected disaggregated by sex, age and disability.

[45] As of 21 April, no border closure has been recorded in Iran. The oPt is not included.

[46] As of 21 April, IOM data for 60 countries out of 63 GHRP prioritised countries with international travel restrictions in place (oPt not included when looking at international travel restrictions). Benin, Mozambique and Tanzania have medical restrictions (quarantine upon entry) in place only. Twenty countries have recorded exceptions to the travel restrictions for entry pertaining to the UN, international and humanitarian organizations, or diplomatic officials, health-care professionals, special approvals from governments, medical cases and others including evacuation and humanitarian emergency flights. to the UN, international and humanitarian organizations, or diplomatic officials, healthcare professionals, special approvals from governments, medical cases and others including evacuation and humanitarian emergency flights.

[47] No funding has been secured yet under the GHRP to scale-up real-time remote monitoring in DGHRP countries.

Situation and needs
Education

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
3.1	**Number of children and youth out of school due to mandatory school closures**	UNICEF UNESCO UNHCR	1,578,657,884 affected learners 90% of total enrolled learners 190 country-wide closures

Situation and needs
Gender-based violence

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
4.1	**Number and proportion of gender-based violence response services continuing or newly established to provide specializsed gender-based violence response to the COVID-19 crisis**	UNFPA	-

Situation and needs
Child protection

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
5.1	**Number and proportion of child protection services continuing to provide specialized response during the COVID-19 crisis**	UNICEF	-

Situation and needs
Nutrition

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
6.1	**Number of children under age 5 with COVID-19**	UNICEF	-

Situation and needs
Protection

#	INDICATOR [44]	RESPONSIBLE ENTITY	CURRENT SITUATION
7.1	**Number of countries reporting incidents of xenophobia, stigmatization or discrimination against refugees, IDPs or Stateless persons**	UNHCR	32

2.3
Most affected population groups

People affected by humanitarian crises and those living in low-capacity settings are affected differently by the COVID-19 outbreak (regardless of the social, humanitarian, citizenship, migration and asylum status of its residents and where these settings are located) due to overcrowding and inadequate dwellings or shelter; lack of availability of clean water and sanitation; high dependence on the informal economy and daily wages; poor access to health care; prevalent food insecurity and malnutrition.

Population groups and individuals are negatively impacted at different levels and for a combination of reasons. Their health may be directly affected, as well as their ability to access essential services and sustain their livelihoods. Below is a description of the most vulnerable groups, with a highlight on women and girls given the intersecting inequalities and challenges they face.

Older persons

Older persons face a disproportionate risk on many levels. They are at risk of complications and death by COVID-19, especially when they present comorbidities such as diabetes and hypertension. Many older persons are also presenting higher rates of disability, including cognitive disabilities such as dementia (see below, persons with disabilities). Initial research in China based on over 44,000 cases of COVID-19 showed a mortality rate of 2.3 per cent for the general population, rising to 8 per cent in those aged 70-79 years and nearly 15 per cent in those 80 years and over. About 95 per cent of those who have died from COVID-19 in Europe were over 60 years, and more than half of those were over 80 years.

Older persons are at higher risk of being discriminated against, including when seeking health care. Public discourse around COVID-19 that identifies it as a disease of older people risks stigmatizing them as vulnerable, dependent and disposable. Social stigma and a perceived link with the disease may result in older people being isolated, stereotyped, discriminated against and treated differently. It risks exposing and intensifying deep-rooted ageism across societies that will not abate when the pandemic ends.

They report high levels of stress and anxiety about the immediate effects of the virus and the longer-term impact on their lives, as well as increased distress due to physical distancing and isolation measures and the death of life-long friends and partners from the disease, Many are reporting concerns about their ability to get the medicine they need to manage ongoing conditions, including cognitive disabilities.

In humanitarian situations, older persons face well-documented barriers accessing information and humanitarian assistance. In combination, their high risk of complications or death, and their poor access to vital health services and humanitarian assistance, expose them to extremely high risk from the direct health impacts of the crisis.

Older persons also face a significant risk of indirect consequences from the crisis. They are at risk of increased levels of violence, abuse and neglect due to heightened household tensions. Older women in particular face additional consequences due to gender and age discrimination.

Most older persons in lower- and middle-income countries rely on irregular, unreliable multiple income sources including pensions, employment, small businesses, assets, savings, and financial support from family and friends. Only 20 per cent of older people in low- and middle-income countries have at least basic income security through a pension, and women are considerably less likely to have a pension. Older persons, particularly older women, are often excluded from humanitarian interventions to protect their well-being and restore livelihoods. This happens intentionally due to misconceptions about their age and ability, or unintentionally due to a lack of targeting.

Persons with disabilities

Because of their situation of marginalization in society in many countries, persons with disabilities may have greater difficulties implementing and accessing health information on preventive measures, for example, access to clean water/sinks and regular disinfection of assistive technologies and devices, and equal access to information. Applying physical

distancing is hard or impossible for people who rely on physical contact. Evidence collected by organizations of persons with disabilities reflects incidents of discrimination and violence based on stigma and lack of accessible information.[49] Those living with specific health conditions are at higher risk of contracting and developing severe cases of COVID-19, as this infection exacerbates existing health conditions (i.e. decreased immune response, respiratory dysfunctions and other impairments or conditions).

Persons with disabilities (as well as older persons and other marginalized groups) are at higher risk of being discriminated against, adding further barriers when seeking care. COVID-19 physical distancing and self-isolation measures also put them at further risk of isolation and exclusion, and create difficulties to eat, dress and bathe, as social support services and networks are cut or interrupted, including personal assistance, on which some people rely for their daily living. For example, in Manila and Jakarta, 68 per cent of youths with disabilities indicated that they do not know where or who to ask for support, and 37 per cent faced difficulties obtaining relief goods, quarantine passes and other forms of aid.[50] In Jordan, a survey reported that 88 per cent of respondents could not go to the hospital for their regular checks or additional medical needs.[51]

Where usual in-home support services are no longer being provided, persons with disabilities may be forced to rely on family and other household members for assistance with daily tasks, further increasing their risk of violence, exploitation and abuse, as well as neglect or abandonment. Children and adults with disabilities who usually rely on family members or others for personal assistance and support for daily tasks face increased risk of abandonment, neglect, abuse and violence when separated from community support networks due to physical distancing measures. Women and girls with disabilities face even higher risks of gender-based violence, experiencing twice the rate of domestic violence as other women. This puts them at further risk of violence during quarantine.

Similarly, persons with disabilities living in residential settings, such as institutions and detention facilities, will be even further isolated from family and support networks where visits to these facilities are restricted. They face a heightened risk of neglect, restraint, isolation or abandonment due to understaffing or staff desertion from facilities impacted by COVID-19.

Many children, adults and older persons with disabilities depend on assistance with daily-living tasks, or require regular access to services, medicines, specialized foods and products to maintain functioning and good health. However, they may lose this support due to the measures taken to prevent the spread of the pandemic. Children and adults with intellectual disabilities and those on the autism spectrum may become particularly distressed at a change in routine

Persons with disabilities and their families are more likely to live in poverty and therefore are particularly vulnerable to financial impacts of the pandemic, as well as less likely to have the means to stock up on food, medications and other essential items. A survey in the Philippines showed that 95 per cent of youths with disabilities in Manila needed urgent financial aid, and 74 per cent were worried about insufficient food supply, 69 per cent about the loss of employment or income, and 64 per cent about the lack of availability of transportation.[52]

Children and youth

The broader impacts on children risk being catastrophic and long lasting. To date, children have been largely spared from the severe symptomatic reactions more common among older people. However, as health services become overwhelmed in caring for large numbers of infected patients requiring treatment, children are less able to access standard care, including immunizations. While the relative risk of COVID-19 complications may be lower for children from high-income countries, we do not yet know how it will affect children in regions where the prevalence of child wasting is high, as is the case in sub-Saharan Africa (6 per cent) and South Asia (14 per cent). It is reasonable to assume that wasted children are at a higher risk of COVID-19-related pneumonia.[53]

Migrant, refugee and IDP children are less likely to be able to prevent infection and spreading. According to a UNICEF study[54] in the Horn of Africa (Ethiopia, Somalia and Sudan), almost 4 in 10 (37 per cent) of children and young people on the move (those living in camps, in urban or other areas) do

49 www.internationaldisabilityalliance.org/blog

50 Survey on the Impact of Enhanced Community Quarantine on persons with disabilities in Manila, Philippines and Jakarta, Indonesia, April 2020 (Humanity and Inclusion).

51 Needs Assessment Impact of COVID-19 on People with Disabilities and their Families in Jordan, April 2020, Humanity and Inclusion

52 Survey on the Impact of Enhanced Community Quarantine on Persons with Disabilities in Manila, Philippines and Jakarta, Indonesia (ICVA, April 2020).

53 www.nutritioncluster.net/Joint_statement_on_COVID_19_and_Wasting

54 https://blogs.unicef.org/evidence-for-action/children-on-the-move-in-east-africa-research-insights-to-mitigate-covid-19/

Particular challenges of women and girls in the context of COVID-19

Photo: UNICEF

As highlighted by UN WOMEN, the impacts of COVID-19 are exacerbated for women and girls.[55] **Women's health care generally is adversely impacted through the reallocation of resources and priorities, including sexual and reproductive health services. As health systems become overburdened, many people infected by COVID-19 need to be cared for at home. This adds to women's overall burden and puts them at greater risk of becoming infected. Older women are at particular risk due to the age-related risk from the virus.**

Other health risks are heightened for women and girls, particularly in camps, and in formal and informal settlements where housing is overcrowded and hygiene conditions are generally very poor. In these and other impoverished settings, women of all ages lack access to clean water, soap, cleaning supplies and towels, let alone masks and other crucial sanitation products to avoid COVID-19 infection. Women and girls may also not have access to menstrual hygiene supplies due to disruptions of services.

While empirical evidence of the impact of COVID-19 on those living with HIV is limited, they will face additional vulnerabilities and challenges. Worldwide, 1.4 million pregnant women and 2.8 million children and adolescents are living with HIV. Among them, about 20 per cent of pregnant women and close to 50 per cent of children and adolescents are not on HIV treatment. In the circumstances, they are more likely to be immune-compromised and may be at risk of more serious illness if they contract COVID-19.

As the pandemic deepens, gender-based violence is increasing as COVID-19 movement restrictions, educational and food insecurity and economic stressors combine to exacerbate existing gender inequality. Risks may also increase for people who experience multiple and intersecting forms of discrimination such as indigenous women and girls, older women, and women and girls with disabilities, or for other factors such as race, sexual orientation, socioeconomic status, religion, ethnicity, and migrant or refugee status. Adolescent girls are also facing heightened risks, including child marriage. Gender-based violence risks are exacerbated in the context of the pandemic, as households face added economic stress and are forced into prolonged periods of isolation in confined spaces due to physical distancing and quarantine procedures.

Countries with reporting systems in place indicate a surge in intimate partner violence upwards of 25 per cent. This increase is happening at the same time that access to services is compromised. Rule of law, health, mental health and psychosocial support services, which are the front line for violence response, are overwhelmed, have shifted priorities, or are unable or unwilling to respond. Civil society is unable to operate. Domestic violence shelters are full, scared to take in new victims because of the virus, or are being repurposed to health centres. Women and girls with disabilitie, in particular are disproportionately vulnerable to gender-based violence, sexual exploitation and abuse.

Unpaid care work has augmented with children out of school, heightened the care needs of older people and overwhelmed health services. According to the International Labor Organization, globally, women perform 76 per cent of total hours of unpaid care work, more than three times as much as men. Increased childcare could further limit work and economic opportunities. This would have compounding impacts on low-income families, and especially on women-led households.

Severe economic impacts are felt especially by women and girls who are generally earning less, saving less, and holding insecure jobs or living close to poverty. Older women are less likely than men to receive a pension, and if they do they have considerably lower benefit levels. An overall economic downturn will cause a significant spike in sexual exploitation and abuse. The breakdown of job opportunities for women in the informal sector in particular will result in increased levels of poverty (with virtually no savings left), causing women to face a whole range of unsafe coping practices, such as transactional sex, sex work, and marrying girls at a very young age.

[55] UN Secretary-General Policy Brief on impact of COVID on women (April 2020).

not have access to facilities to wash themselves. In addition, even before the pandemic, these children were less likely to have access to health care, and their access will likely further diminish. Children at heightened risks, such as separated and unaccompanied children, children deprived of liberty, and survivors of violence, can be the most affected and the hardest to reach due to the disruption of core child-protection services, including case management, family reunification and ability to provide alternative care. Robust data is still limited, but based on experiences from previous emergencies and outbreaks, children, adolescents and young people are likely to face increased difficulties accessing essential health-care services, mental health and psychosocial services, social work and child-violence response services, and supplies and information for prevention and treatment. This increases risks of direct health effects.

The pandemic is having profound effects on children's mental health and well-being, and their social development, safety, privacy, economic security and beyond. Just as the combined effect of school closures and economic distress is likely to force some children to drop out of school, the same combination can be expected to compel children into child labour and into child marriage in high-risk countries, and to become child soldiers. Children without parental care are especially vulnerable to exploitation and other negative coping measures.

Families with children out of school and struggling for income may risk adopting harmful coping mechanisms, such as child labour or child marriage. Children out of school may be a heightened risk of association with and recruitment into armed forces or groups, or at risk from traffickers and criminal gangs. It will also put adolescents' mental health at risk due to isolation, anxiety and stress (10-20% of adolescents already experience mental health conditions).[55]

Children with disabilities who are out of care or school may have higher support needs compared with other children. Children and adults with intellectual disabilities and those on the autism spectrum may become particularly distressed at a change in routine.

Girls, especially those of secondary school age, are likely to be severely affected by the socioeconomic impact of COVID-19. For example, globally, refugee girls at the secondary level are half as likely to enroll as male peers, and evidence from the Ebola

crisis in West Africa suggests that school closures could significantly worsen this outcome. The Malala Fund's report[56] estimates that if dropouts follow the same rates as post-Ebola, around 10 million more secondary-school-age girls could be out of school because of COVID-19. Applied to refugee girls globally, up to 3 million more are projected to drop out, with ensuing consequences on early and forced child marriage. UN WOMEN indicates that digital gender gaps mean that girls may benefit less from online learning[57] where that is utilized.

Young people have also been heavily affected by the pandemic. Lockdowns and school and university closures are disrupting education, while economic collapse is likely to disproportionately impact them, as with past economic crises.

Internally displaced persons, refugees, asylum seekers, Stateless persons and migrants

Barriers to accessing national health services due to exclusion from public health care, high costs, administrative hurdles, lack of documentation, as well as overburdened health services in camps and similar settings, may hamper the early detection, testing, diagnosis and care of refugees, other forcibly displaced populations and migrants. In countries where the health situation is already fragile, additional threats will be posed by diseases such as tuberculosis, malaria, measles and diarrhoeal disease, along with the overcrowded and poorly ventilated conditions in which many people of concern are obliged to live. Displacement also exacerbates gender inequality, including compounding the risk of gender-based violence for women and girls.

Restriction of movement and reduction of services also mean that preparation work in camps and camp-like settings for the coming monsoon/rainy and hurricane season in some countries have been placed on hold, increasing the risk of malaria, clogged-up infrastructure, landslides and flooding. As COVID-19 is triggering a protection and human rights crisis, with refugees, Stateless persons, other forcibly displaced populations and migrants at particular risk, measures implemented to contain the propagation of COVID-19 have limited access to asylum, and access to public health assistance, protection services (including for survivors of gender-based violence), education, livelihoods

[55] Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007; 6: 168–76

[56] www.malala.org/newsroom/archive/malala-fund-releases-report-girls-education-covid-19?source=modal

[57] www2.unwomen.org/-/media/field%20office%20eseasia/docs/publications/2020/04/ap_first_100_days_covid-19-r02.pdf?la=en&vs=3400

and markets. As a result, displaced families are suffering, particularly those in camps and camp-like settings. Many are engaged in daily-wage labour activities that require travel, exacerbating pre-existing vulnerabilities among the 3.6 million refugees and estimated 17 million IDPs in camp or camp-like situations, as well as among refugees and IDPs dispersed in urban areas.

Refugees and migrants with regularized status have lost their jobs and are often unable to return home. As they are losing access to income and support services, they increasingly become victims of xenophobia and discrimination. For populations living in protracted displacement situations, increased commodity prices and scarcity, as well as a decline in demand for informal labour, will continue to exacerbate localized tensions and could result in violence and further marginalization. Referral pathways are also facing disruptions, resulting in immediate protection gaps for vulnerable refugees and migrants who go unidentified and/or unassisted.

Displacement sites that are not on full lockdown are often under measures to restrict movements, including scale down or complete stop of protection and other services considered 'non-essential' by authorities. Movement restrictions have also resulted in increased tension and violence in some camps. Others are facing the pressure to leave the protection of displacement sites ahead of possible mass transmissions.

The 5.6 million Palestinians registered with UNRWA are highly vulnerable due to high rates of poverty and unemployment. They are dependent on jobs in the informal sector and lack the financial means to absorb the financial shocks created by the COVID-19 pandemic. In Syria, two thirds of the more than 430,000 Palestine refugees estimated to remain in the country have been internally displaced. Currently, 418,000 rely on UNRWA cash assistance to meet basic needs. A quarter of families are female-headed and 20 per cent are headed by an older person, with around three quarters living on less than US$2 per day. Among those employed, 49 per cent do not have a fixed income and work as daily paid or casual labour in the informal economy. Around 50,000 Palestinian refugees who have fled Syria for Lebanon and Jordan are living in extremely precarious conditions and facing greater hardship as a result of COVID-19. This is due to increased costs of basic commodities and lost earnings due to eco-

nomic shutdowns. A majority of Palestine refugees in Gaza and Lebanon are living below the poverty line. For those who are confined in overcrowded camps, a lockdown is extremely difficult to observe.

The COVID-19 pandemic and the related measures to curb transmission are also causing widespread anxiety and stress among refugees, asylum seekers and IDPs. These populations already have higher baseline levels of mental health problems. One in five people in conflict settings has a mental health condition, which is three times higher than among other populations. Government measures to curb the pandemic increase vulnerability to mental health conditions. For example, in camps or settlements it is often difficult or impossible to adhere to measures such as physical distancing. This increases risk for COVID-19 but also generates high levels of stress.

Unprotected workers and workers in the informal economy and food-insecure people

The impact on income-generating activities is especially harsh for unprotected workers and the most vulnerable groups in the informal economy who are at risk of losing their livelihoods, particularly women, youth, small-scale farmers, daily-waged, care workers, persons with disabilities, refugees and IDPs. Low-skilled migrants and their families work in sectors with high exposure to health risks and in living conditions that can contribute to the spread of the virus. They often do not receive adequate information, as illustrated by the high proportion of migrants with confirmed COVID-19 cases relative to local populations in several countries. This is compounded by conditional access to health care in many countries across South Asia, the Middle East and North Africa regions.

The majority of people experiencing acute food insecurity are rural and peri-urban communities. Those in the most remote rural areas may be at less risk of COVID-19 themselves, as they have less physical interaction with people beyond their own family and community. However, they will undeniably experience severe impacts from the restrictions associated with efforts to prevent the spread of the pandemic.

In addition, the pandemic exposes particular groups to increased vulnerability to food insecurity, including persons in isolation, treatment or quarantine whose access to food is constrained for a particular time period, pregnant and lactating women, and per-

sons with pre-existing health conditions or older persons whose movement is reduced due to increased risk of infection, thus limiting access to food.

UNU-WIDER[58] estimates the adverse impact on poverty to over 500 million people, and the International Labour Organisation expects a devastating 200 million jobs losses in the second quarter of 2020, including 125 million in Asia-Pacific. According to early estimates from ESCWA, the Arab region is set to lose at least 1.7 million jobs in 2020.

People depending on daily mobility for livelihoods and survival do not have access to their sources of income and are exposed to risks of violence, exploitation, abuse and trafficking, and of recurring to negative coping mechanisms. The poorest households, often female headed and with a high dependency ratio, as well as casual labourers and petty traders, will suffer disproportionately, as they tend to spend the largest share of their income on food while typically lacking savings or access to credit.

Learning from the 2008/9 triple food, fuel and financial crisis, the following groups are expected to be among the hardest hit:

- Households already acutely food insecure prior to the pandemic.
- Female-headed households and households with high dependency ratios.
- Households dependent on income from the informal sector (e.g. daily labour, petty trade).
- Households relying on support from others (formal and informal safety nets).
- Households with migrant workers largely depending on remittances and/or seasonal migration.
- Households depending on the mining sector and processing industry.
- Urban households relying on markets to access food.
- Migrants and refugees, likely to be left out of national social-protection systems.
- Small-scale producers of cash crops who are dependent on income to purchase food and particularly vulnerable to global supply chain disruptions.
- Nomadic pastoralists who can be highly affected by movement restrictions to access grazing lands.

[58] United Nations University World Institute for Development Economics Research
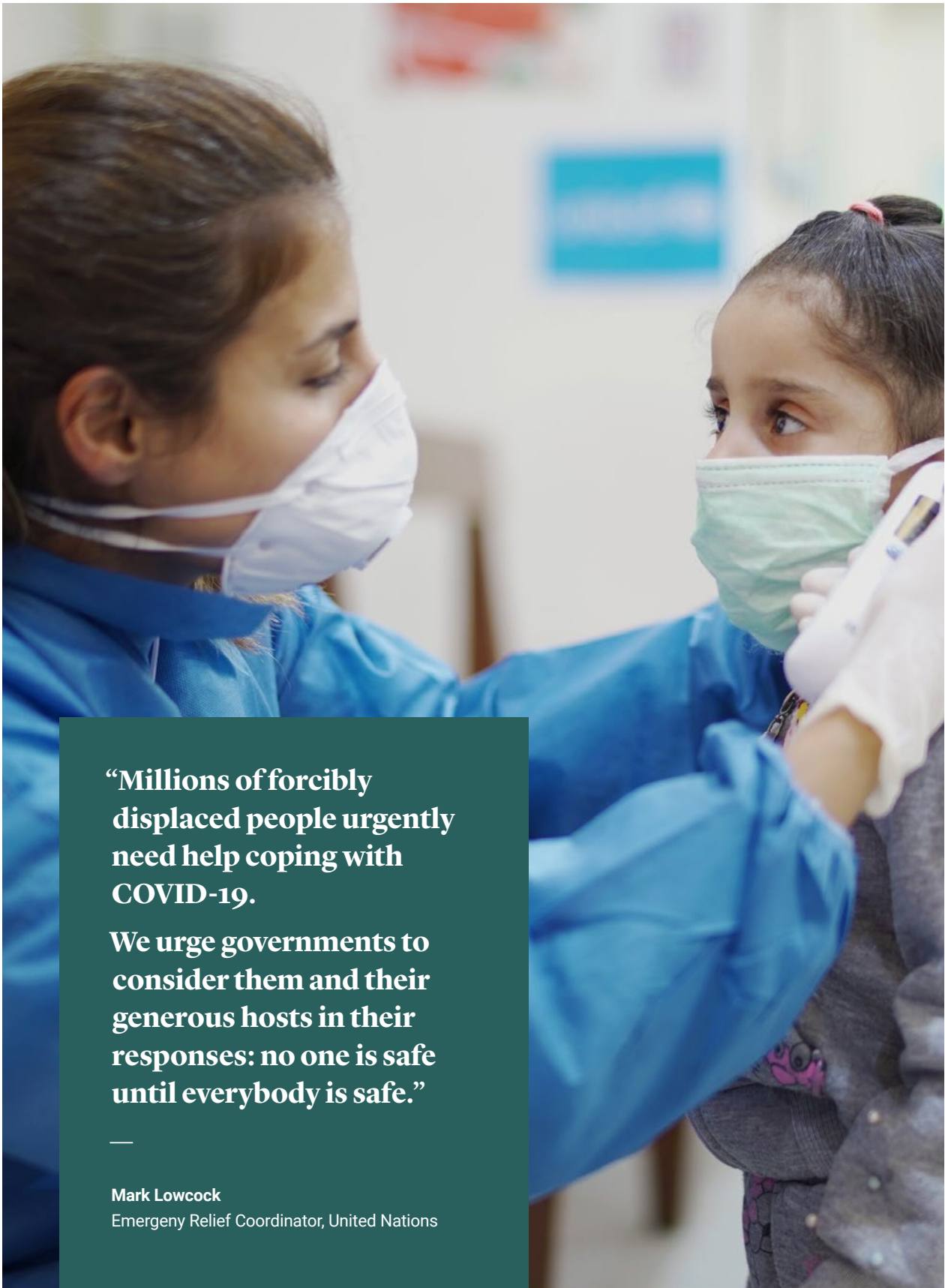
"**Millions of forcibly displaced people urgently need help coping with COVID-19.**

We urge governments to consider them and their generous hosts in their responses: no one is safe until everybody is safe."

—

Mark Lowcock
Emergeny Relief Coordinator, United Nations

BEIRUT, LEBANON
A nurse takes a girl's temperature at a Primary Health Care Centre in Beirut, Lebanon. *UNICEF/Fouad Choufany*

3.0 | Progress of the response

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QATABAH DISTRICT, YEMEN
People stand in line during a round of food distribution for
1000 displaced or host community families in the district of
Qatabah, Yemen. *MFD/Elyas Alwazir*

3.1
Progress of the response against the strategic priorities and specific objectives

Humanitarian and development actors continue to respond to the health and socioeconomic impact of the pandemic on the most vulnerable groups. Operational modalities have been adapted to the public health measures (mobile money, no-contact biometrics measures, use of personal protective equipment, etc.), and most countries have implemented measures to ensure and facilitate the continuity of humanitarian operations. The facilitation of humanitarian movements has taken various forms, including official letters, distribution of official badges for humanitarian actors and vehicles, and exemption of humanitarian staff in national COVID-19 decrees or laws. The operationalization of these special arrangements remains a priority.

Pre-existing access constraints (volatile security environment, open conflict, bureaucratic impediments, sanctions and counterterrorism measures) are also undermining COVID-19 preparedness-and-response efforts.

In addition, new/emerging constraints include:

- Restrictions of movements of aid personnel (with a positive, stronger reliance on local actors) and of goods into countries.

- Restriction of movements of aid personnel within countries (requiring special authorization required for critical movements).

- People's lack of access to humanitarian assistance.

- Violence and threats against humanitarian personnel and assets perceived to be vectors of COVID-19.

Progress on responses is summarized below under each GHRP strategic priority and specific objectives. Additional details by agency are provided in annexes 1 and 2. Based on ongoing revisions of HRPs, RRPs and other refugee and migrant response plans, the responses include adjustments to previously planned operations in order to address the additional needs caused by the pandemic, using already available resources, as well as new operations made possible by the additional funding received by agencies under the GHRP.

Strategic priority 1

Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality

Progress by specific objective

A summary of the main responses (not exhaustive) undertaken by agencies and their partners is illustrated under each specific objective. Additional details by agency can be found in annexes 1 and 2.

Specific objective 1.1 - *Prepare and be ready: prepare populations for measures to decrease risks, and protect vulnerable groups, including older people and those with underlying health conditions, as well as health services and systems.*

National authorities are being supported to strengthen their preparedness-and-response capacity to handle the treatment of sick patients and prevent the spread of the pandemic, and to protect other essential health services, including for survivors of gender-based violence and sexual and reproductive health services, as well as mental health and psychosocial support. Alternative approaches are applied to comply with the physical distancing measures, including remote management of these services, and remote data collection and surveillance. Personal protective equipment and other supplies have been provided to health structures, and health personnel have been trained in COVID-19 signs and symptom detection.

Risk Communication and Community Engagement measures at the community level are taken to raise awareness and decrease misinformation. Networks of community-based volunteers and workers and civil-society organizations are leveraged to disseminate these messages, promote hygiene practices and distribute soap. Public health measures have been enhanced at border points of entry to support case identification, case management and surveillance, benefiting migrants in particular.

Logistics assistance is provided to increase governments' and humanitarian health actors' capacity to store and dispatch essential health inputs and equipment. Emergency telecommunications support is also given to establish COVID-19 hotlines for two-way communication in conflict-affected countries.

Specific objective 1.2 - *Detect and test all suspect cases: detect through surveillance and laboratory testing and improve the understanding of COVID-19 epidemiology.*

Personal protective equipment and technical support are provided to health and other front-line workers to assist with COVID-19 case detection and testing. COVID-19 surveillance is built in Early Warning, Alert and Response Systems (EWARS) are applied to enhance COVID-19 detection and surveillance including in remote and high-security risk locations.

Specific objective 1.3 - *Prevent, suppress and interrupt transmission: slow, suppress and stop virus transmission to reduce the burden on health-care facilities, including isolation of cases, close contacts quarantine and self-monitoring, community-level physical distancing, and the suspension of mass gatherings and international travel.*

Infection prevention and control activities are conducted at community and health facility levels. Emphasis is put on strengthening and expanding water, sanitation and hygiene services and delivering equipment, including in densely populated urban areas and in camp and camp-like settings and other displacement sites. Isolation and treatment facilities have been set up in displacement sites. Modalities of distribution of assistance are adapted to avoid large gatherings.

Preparedness and response procedures and guidance have been formulated for IDPs in camps and developed to enable efficient identification of cases, treatment and quarantine. Technical support is provided to national and local health personnel to strengthen epidemiological surveillance and laboratory testing.

Specific objective 1.4 - *Provide safe and effective clinical care: treat and care for individuals who are at the highest risk for poor outcomes, and ensure that older patients, patients with comorbid conditions and other vulnerable people are prioritized, where possible.*

Health facilities are strengthened or newly created to care for patients with or at risk of severe illness from COVID-19, including with the provision of equipment and health personnel. In parallel, support is given to ensure routine health services remain available, including in camp and camp-like settings. Procedures to treat other diseases and to provide essential services, such as for sexual and reproductive health, are adapted to minimize the potential exposure of patients and other service users. This includes distribution of personal protective equipment, and increased water supply, sanitation and waste management.

Specific objective 1.5 - *Learn, innovate and improve: gain and share new knowledge about COVID-19, and develop and distribute new diagnostics, drugs and vaccines. Learn from other countries, integrate new global knowledge to increase response effectiveness, and develop new diagnostics, drugs and vaccines to improve patient outcomes and survival.*

Learning from the Ebola response, approaches using social sciences analysis and research are being applied. A Migration Health Evidence Portal for COVID-19 has been set up to provide access to research and evidence on the intersection between COVID-19 and migration health.

Specific objective 1.6 - *Ensure essential health services and systems: secure the continuity of the essential health services and related supply chain for the direct public health response to the pandemic as well as other essential health services.[59]*

Health supplies have been pre-positioned at decentralized facilities to limit the disruption of availability of essential health and nutrition items and related programmes and services. Digital health platforms are used to disseminate information on available routine health services and engage with health workers. Guidance has been developed to limit the decrease or suspension of services, such as for maternal, newborn, child and adolescent health.

Under the leadership of a High-Level Supply Chain Task Force and coordination by the Supply Chain Interagency Coordination Cell, actions are taken with manufacturers and freight carriers to procure health items and equipment, and to safeguard supply and logistic chains. Seven international consolidation hubs and regional staging areas are now active, with an additional one expected shortly, providing the supply chain backbone of the response. As of end April, a network of dedicated free-to-user air (and sea) cargo and passenger transport is connecting these international hubs, regional staging areas and GHRP countries. Procedures and logistics to enable medical evacuations of humanitarian workers are being set up.

Response gaps and challenges

The main areas that require further improvement and scale-up, and some of the challenges, include:

Inclusivity, older age, gender and disability

- More consultations must take place with older persons, adolescents, children, women, persons with disabilities and people with mental health and psychosocial needs, to better understand their specific needs and risks. Consultations are also required for a meaningful participation in the response.

- Communication about COVID-19 prevention and response (including protective measures) needs to be made accessible and tailoredequally effective to all audiences. This includes ensuring that websites, telephone, radio, videos and, leaflets are accessible,; using local languages, plain language (and age-appropriate when targeting children), subtitles and sign language.

- Health triage policies and protocols must be implementedput in place to ensure that decisions about access to medical treatment are based on medical grounds, scientific evidence and ethical principles, rather than age or disability status.

- More generally, all responses should be more disability, age and gender -inclusive, including in the design of targeting methodology and selection of delivery mechanisms.

- Given the predominant role of women as frontline health-care and social workers and as such in prime positions to identify trends at the local

50 Specific objective 1.6 and specific objective 2.3 overlap. Each is spelled out under their respective Strategic Priority due to the importance of maintaining the supply chain for both the direct health response and the response to urgent indirect humanitarian needs. The reporting is done against both objectives as one narrative.

level, they should be better included in the health and other sectors should be better included in all decision-making and policy spaces to improve health security surveillance, detection, information and prevention mechanisms.

- Gender-based violence prevention- and- response services must be more accessible to, and prioritized for children and adults with disabilities, including using remote gender-based violence case management support, inclusion of gender- based violence response services in other essential services, accessible hotlines and age-adapted interventions. Health workers and community workers should be trained to detect signs of abuse of children and adults with disabilities. Free and informed consent regarding gender-based violence services should remain a priority in the COVID-19 response.

- Without appropriate care and support to gender-based violence survivors resulting fromdue to services disruption, the long-term impact will be an increase in unwanted and/or teenage pregnancies, child and maternal mortality, sexually transmitted infections, psychological trauma and an intergenerational cycle of violence.

- Existing mental health and psychosocial support services should be maintained and scaled up, and those developed or adapted as part of the COVID-19 response should be accessible to and inclusive of persons with disabilities, migrants, displaced population, people with pre-existing physical and health conditions and all age groups.

- Mechanisms for the protection of children and adults living in institutions, such as relocation to family-based/community- based settings, should be established. If staff have deserted the facilities or if these are understaffed, human resources may be mobilizsed from civil- society organizations and/or other trained protection stakeholders. Accessible remote means for family members and other support persons to remain in contact may also be supported.

- For persons with disabilities requiring special assistance, interventions should involve service providers, including local partners to ensure the continuation of essential services and stocking of WHO list of essential medicine and develop innovative accessible delivery mechanisms.

- Social services should be accessible for children and adolescents affected by the pandemic. Health workers and community workers should be trained to detect signs of abuse of children and use a clear referral system for response.

- Remote/ distance- learning options should be accessible to all children including those with disabilities, such as through modification of learning materials. More generally, there is scope to increase the role that learning infrastructure and the education system can play in reaching communities with critical messages to contain the spread and reduce morbidity and mortality, and to prevent new infections when schools reopen.

- With high proportions of intergenerational households in many contexts, as well as active community engagement, young people should be engaged in the humanitarian response, for example, to help in spreading information through social media and acting as culture brokers through behaviour- change communication.

Mobility, access and delivery capacities

- Movement restrictions are limiting humanitarian agencies' access to some affected people. In the immediate and medium term, an overall reduction in global, regional and local mobility is expected to last due to fear, lack of confidence in public health measures, and general protectionism and xenophobia. Current travel restrictions could well outlast the immediate crisis. Confidence of national governments and communities in the efficiency of control-and-prevention measures will be urgently needed to reopen borders and allow travel and trade to resume and mitigate the economic impacts of the crisis.

  Increased mobility will also contribute to the movement of humanitarian aid workers and enable staff rotation to avoid burnout.

- Suspended and disrupted access to services will lead to predictable increased health needs in the short and medium term, requiring creative solutions to secure the continuity of health care.

  Reduced humanitarian staff surge capacity and funding constraints are affecting the health response capacity. Health response interventions also need to be adapted in complex, high-density settings to protect and treat the most vulnerable and confirmed cases.

Immunization services should be prioritized for the prevention of communicable diseases so that it is not disrupted by the COVID-19 pandemic, where feasible. Immunization delivery strategies may need to be adapted so that they are conducted under safe conditions, without undue harm to health workers, caregivers and the community. Specifically, vaccine-preventable disease surveillance should be maintained and reinforced to enable early detection and management of vaccine-preventable disease cases and, where feasible, contribute to surveillance of COVID-19.

- There is increased reliance on local actors in many settings, as they maintain capacity and access to at-risk communities. However, the development of effective processes to support their work remotely must accelerate, as well as funding.

Supply chains [60]

- The provision of essential supplies including personal protective equipment and test kits has been a challenge due to the supply chain obstacles outlined earlier. This is compounded by the varied, extensive and ever-changing restrictions on entry/exit of the flow of cargo and humanitarian personnel across countries. This will improve with WFP air cargo services that began on 30 April as part of the GHRP. NGOs should access common supply chains for personal protective equipment and medical supplies procured by UN agencies and transported through WFP free-to-use upstream supply chain services. The platform to request service delivery is now active.

- Insufficient funding severely limits the ability to plan for and negotiate contracts, and to roll out logistics services at the scale required to ensure the supply chain needs and timely transportation of critical cargo for the global response. Without additional funding, support in ensuring the health and welfare of humanitarian personnel may be limited, including a reduction in medical evacuation services.

Early challenges in securing visibility of pipelines and the services required resulted in an underestimation of services. Initial plans considered twice-weekly connections (14 flights/month) between international consolidation hubs and regional staging areas. Based on updated demand planning from partners, the number of planned connections has increased to 50 flights/month. In addition, the initial GHRP included a small contingency of air cargo from international

and/or regional consolidation hubs onward to country points of entry. Based on the latest partner demands, medium-sized air freighters will be based in regional hubs connecting to countries (anticipated at 15-20 rotations per month from each hub). Since initial planning, the unit price of air freight has increased drastically.

All GHRP countries have travel restrictions in place now, with the majority introducing full restrictions including bans on air travel. The initial GHRP plan of five medium dedicated aircrafts positioned in regional hubs has been increased to 12, in addition to scheduled international long-haul connections from key strategic locations. WFP will provide passenger air services until the commercial market comes back online. In addition, medical evacuation services initially planned for two months have since been affirmed as a priority service by NGO partners and UN partners alike, and are now planned until the end of 2020.

Needs assessments and coordination

- Although challenging, data collection and conducting participatory mapping exercises should be scaled up together with national authorities and local communities to identify key mobility corridors and congregation areas, such as densely populated urban settlements, for targeted prevention activities and to inform regional and national preparedness and response plans (ensuring migrants and concepts of mobility are included in planning processes).

- Coordination among authorities, local communities and humanitarian partners needs to improve to ensure that COVID-19 responses are evidence-driven and do not impact negatively the implementation of essential health and other programmes.

- Where appropriate, connections should be sought with socioeconomic impact assessments supported by UNDP, and with Cash Working Groups to inform programming decisions including multipurpose cash transfers.

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[60] Challenges reported apply to both specific objectives 1.6 and 2.3.

Response monitoring

Response indicators were identified in the first iteration of the GHRP to monitor progress against strategic priority 1. A number of these indicators are being refined and cannot yet be reported against. Additional results will be provided in subsequent GHRP updates.

#	SPECIFIC OBJECTIVE	INDICATOR [61]	RESPONSIBLE ENTITY	TARGET	PROGRESS
1.1	**Prepare and be ready** Preparedness is key to decrease risks and prevent the spread of COVID-19	Proportion of GHRP countries that have a national Infection Prevention and Control programme including water, sanitation and hygiene (WASH) standards and WASH basic services operational within all health-care facilities	WHO UNICEF	-	-
		Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	UNICEF	-	-
1.3	**Prevent, suppress and interrupt transmission** Demonstrates the level of preparedness and operational readiness based on the implementation of 2005 International Health Regulations Indicates national government capacities to coordinate the response	Proportion of GHRP countries with COVID-19 national preparedness and response plan	WHO UNICEF	-	-
		Proportion of GHRP countries with a functional multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	WHO	100%	-
		Number and proportion of countries with COVID-19 Risk Communication and Community Engagement programming	UNICEF	104	83
1.5	**Learn, innovate and improve** Indicates efforts to improve knowledge and response effectiveness	Proportion of GHRP countries that agreed to participate to the Solidarity trial that have started the trial	WHO	-	-
1.6	**Ensure essential health service and systems** Continuity of health and humanitarian supply chain is crucial for life-saving response. Any interruptions will increase risks	Number of functional hubs for consolidation, and onward dispatch of essential health and humanitarian supplies	WFP	8	7

[61] Insofar as possible, indicator data should be collected disaggregated by sex, age and disability to allow for a meaningful measurement on the impact or response effects on key groups with special needs e.g. women and girls, older people, people with disabilities, etc.

#	SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
1.6	*(comes from previous page)*	Number of air cargo flights carrying essential commodities implemented under the GHRP	WFP	As needed	Free-to-user solidarity flights and on-demand services ongoing since beginning of crisis
		Proportion nad number of 3-plies medical masks distributed against need in GHRP countries	WHO UNFPA UNICEF UNHCR OCHA	-	Personal protective equipment distributed in 21 countries for health facilities with 118,637 workers (UNICEF) 6 million masks procured, of which 3 million for health workers (UNHCR)
		Number of GHRP countries with multisectoral mental health and psychosocial support technical working groups	WHO	32	22
		Number and proportion of GHRP countries where messaging was developed to notify survivors of intimate partner violence and children of available services (remote and static)	UNFPA UNICEF	-	-
		Number and proportion of GHRP countries where children and adults have access to a safe and accessible channel to report sexual exploitation and abuse.	UNICEF UNFPA	24 countries	6 countries supported to ensure safe and accessible channels to report sexual exploitation and abuse
		Number and proportion of GHRP countries in which critical child-protection services have been identified and continue to operate	UNICEF	-	-

Strategic priority 2

Decrease the deterioration of human
assets and rights, social cohesion,
food security and livelihoods

Progress by specific objective

A summary of the main responses (not exhaustive) undertaken by agencies and their partners is illustrated under each specific objective. Additional details by agency can be found in annexes 1 and 2. Responses to the humanitarian non-health effects caused by the pandemic are part of the revisions being done to ongoing HRPs, RRPs and regional refugee and migrant plans in countries covered by the GHRP. They aim to cover the additional needs caused by the pandemic and do not include operational adjustments to responses addressing other shocks.

Specific objective 2.1 - *Preserve the ability of the most vulnerable and affected people to meet the additional food consumption and other basic needs caused by the pandemic through their productive activities and access to social safety nets and humanitarian assistance.*

To protect against the loss of livelihoods, decreases of food availability and food access, and risk of malnutrition due to the pandemic, productive inputs, food distributions, cash transfers and technical support are provided to sustain crop and livestock production, and to secure the purchasing power of the most vulnerable groups, including rural producers, those forcibly displaced and migrants. Delivery modalities are adapted to comply with physical distancing measures and ensure safe access to all, including persons with disabilities and those located in camp and camp-like settings, such as shifting from cooked meals to take-home food baskets or commodity vouchers, or implementing household food-delivery services.

Emergency employment and public employment services are also supported, while efforts are made to strengthen social protection systems and advocate for the inclusion of refugees and other vulnerable groups usually excluded from Government social assistance mechanisms.

Assessments and remote monitoring of the impact of COVID-19 and the food security situation are guiding response programming decisions.

Specific objective 2.2 - *Ensure the continuity and safety from risks of infection of essential services including health (immunization, HIV and tuberculosis care, reproductive health, mental health care and psychosocial support, gender-based violence services), water and sanitation, food supply, nutrition, protection, and education for the population groups most exposed and vulnerable to the pandemic.*

Equipment, supplies and training are provided to health-care providers and facilities to enable the provision of life-saving primary health care, immunization, treatment of infectious and chronic diseases, nutrition, sexual and reproductive health, gender-based violence services, HIV and tuberculosis treatment, and mental health and psychosocial support. Water, sanitation and hygiene services and the promotion of infection prevention and control measures are also strengthened in communities as well as in camp and camp-like settings.

Changes in the delivery of education and other interventions are made to adapt to the physical distancing and other mobility restriction measures, such as using television and radio messages, e-learning, virtual outreach, mobile clinics and hotlines.

Awareness-raising sessions and training on COVID-19 prevention are delivered to farmers, livestock herders and other actors along the food chain to minimize the risk of infection, and thus preserve the functioning of the food chain.

Specific objective 2.3 - *Secure the continuity of the supply chain for essential commodities and services, such as food, time-critical productive and agricultural inputs, sexual and reproductive health and non-food items.*[62]

Essential health supplies have been procured and delivered to safeguard the functioning of essential supply chains, including for sexual and reproductive health, water, sanitation and hygiene, and equipment for infection prevention and control. Efforts are also made to protect the critical food supply chain, with the procurement and distribution of crop and animal health inputs and income support to rural producers and other actors along the food supply chain.

Logistics support, technical advice and information management services are provided to governments to mitigate congestion and ensure the continued flow of humanitarian cargo. See also specific objective 1.6 above, as many interventions for this specific objective are combined for health and non-health commodities and staff-related supply chain responses.

Response gaps and challenges

The main areas that require further improvement and scale-up, and some of the challenges, include:

Inclusivity, older age, gender and disability

- As mentioned for strategic priority 1, consultations must take place with older persons, children, adolescents, women, persons with disabilities, and people with mental health and psychosocial needs to better understand their specific risks and ensure meaningful participation in the response, with targeted actions to reduce risks and a robust monitoring framework. Regular visits by community health workers for households with higher support needs should take place where the situation allows.

- The analysis of risks posed to older people must be strengthened at country level, recognizing that older people face a combination of disproportionate incidence of serious illness and death, risk of discrimination in the allocation of scarce resources, psychological distress from losing life-long partners and friends to the virus, and pre-existing and systematic barriers to accessing information, services and assistance provided through the humanitarian system.

- In line with the UN Secretary-General's call to governments to make the prevention and response of violence against women a key part of their national response plans for COVID-19, gender-based violence services and responses to protect women and girls must be further prioritized and designated as an essential service within COVID-19 response plans

Scaling up of responses to address the impact of COVID-19

- Mental health and psychosocial support should also be scaled up for all population groups most affected by the pandemic. A priority should be given to integrate mental health and psychosocial support and services in different sectoral coordination mechanisms and responses. Effective communication and basic psychosocial support skills that promote well-being among all affected population groups should be used by all COVID-19 responders. Addressing the mental health needs of health-care and social-care workers and other emergency responders should be an integral component in all countries.

- In addition to sectoral water, sanitation and hygiene responses, particularly in urban slums, multisector comprehensive interventions should be encouraged, such as rehabilitation or construction of WASH facilities in health centres, markets, schools and public places.

- Cash and voucher assistance programmes, particularly multi-purpose cash grants, should be implemented wherever possible, as they are an efficient and often preferred mechanism to help people meet their basic needs and decrease the adoption of negative coping mechanisms, especially in a situation of restricted mobility that prevents many from reaching their sources of labour and income. Such transfers can address health (strategic priority 1) and non-health needs (strategic priority 2). Many humanitarian actors have worked quickly to adjust standard operating procedures and guidelines for cash and voucher assistance programming to ensure they can deliver safely in COVID-19 settings.[63] Some country operations (Iraq, Yemen, Ethiopia, Afghanistan, among many others) are using multipurpose cash grants to cover purchase of basic needs and public health items, including masks, soap and hand sanitizers.

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[62] As mentioned, specific objective 1.6 above and specific objective 2.3 overlap. Each is spelled out under their respective Strategic Priority due to the importance of maintaining the supply chain for both the direct health response and the response to urgent indirect humanitarian needs.

[63] www.calpnetwork.org/publication/cva-in-covid-19-contexts-guidance-from-the-calp-network/

- Social protection systems across crisis contexts should be set up or expanded in collaboration with government and development actors as appropriate. This includes a vertical expansion (to adjust for increased local market prices and multisector needs, as appropriate) to capture populations on the brink of acute vulnerability as well as those not previously covered (e.g. migrants, refugees). Recommendations from the Grand Bargain sub-workstream on Cash and Social Protection for working with and alongside social protection systems as part of the COVID-19 response are under development.[64]

- Early action is indispensable to avert a potential food crisis. A scale-up of assistance to food security and livelihoods is essential to avoid further deterioration of needs, particularly in fragile contexts and where the approaching lean season and hurricane/monsoon season further threaten household food access. Upcoming planting and harvesting seasons represent a critical opportunity to ensure small-scale producers' food security and contribute to wider food availability for their communities and beyond. Collective advocacy and action are needed to facilitate the functioning of agricultural input supply chains at critical times in the season, as well as to ensure that people along the food supply chain are not at risk of COVID-19 transmission.

  Activities must ensure the functioning of the food supply chain, including between rural, peri-urban and urban areas, focusing on vulnerable smallholder farmers and food workers. People along the food supply chain must be protected from the risk of COVID-19 transmission by raising awareness of actors about food safety and health regulations as well the rights and responsibilities of workers. Food losses due to movement restrictions and limited access to markets should be avoided by supporting local storage and processing facilities and keeping local markets functioning in compliance with national hygiene regulations. Efforts must be stepped up to stabilize incomes, access to food, livelihoods and food production for the most acutely food insecure, as they tend to suffer disproportionately from restricted access to markets.

- Increased attention should be paid to education interventions including distance learning and support to teachers in the context of this pandemic. Experience from previous public health crises has shown that once older children lose access to education, they are less likely to return. This is particularly the case for the most vulnerable children, who end up in child labour, child marriage and face other life-threatening protection risks. For younger children, even a few months of missed education can have long-term effects on their lifelong learning, requiring additional and intensive remedial efforts to catch up.

  Education also plays a critical role in keeping children protected through supportive learning opportunities and nutrition/school meals.

Mobility, access and delivery capacities

- The humanitarian response is hampered by movement restrictions and closure of internal and international borders. Delays and price increases are affecting the procurement and delivery of goods and services.

- Concurrent epidemics, such as acute watery diarrhoea and cholera in countries such as Djibouti and Yemen, and recurrent natural disasters such as floods in Bangladesh and Nigeria, will further compound humanitarian needs across all areas of intervention, including health, WASH, food security, nutrition, protection, gender-based violence services, mental health and psychosocial support.

Supply chains

- Logistics constraints remain extremely acute. Procurement, consolidation, prioritization and delivery of critical items require visibility of pipeline requirements and service demands. Operational partnership with private actors and governments, efficient coordination and prioritization, and appropriate resourcing allow WFP to provide essential supply chain services to the humanitarian community.

- Competition is high between humanitarian actors and governments over essential items such as masks, with quotation of prices only valid for a few days. Payment capacities are also directly affected by the closure of banks in some countries.

- The majority of the suppliers of personal protective equipment and other related items are not located in the affected areas. Sending the purchased material to the destination is complicated by the lack of available cargo, increasing cargo prices, high customs taxes, and preemption by local authorities upon arrival if specific measures are not implemented to secure the delivery.

[64] www.calpnetwork.org/wp-content/uploads/2020/04/CCD-Social-Protection-Working-Group-Advocacy-in-Response-to-COVID-19-April-2020.pdf

• Prior to COVID-19, the global supply of specialized nutritious foods was expected to be in shortfall in 2020. As COVID-19 drives the need for nutritious products, the manufacturing lines for products are also at risk.

Monitoring

• Funding is lacking for real-time situation, needs and response monitoring at the country level. Reliance on models and projections is risky and affects responders' ability to quickly adjust their interventions.

Response monitoring

Response indicators were identified in the first iteration of the GHRP to monitor progress against strategic priority 2. A number of these indicators are being refined and cannot yet be reported against. Additional results will be provided in subsequent GHRP updates.

#	SPECIFIC OBJECTIVE	INDICATOR [65]	RESPONSIBLE ENTITY	TARGET	PROGRESS
2.1	**Preserve the ability of people most vulnerable to the pandemic to meet their food consumption and other basic needs,** through their productive activities and access to social safety nets and humanitarian assistance.	Number and proportion of people most vulnerable to COVID-19 who have received livelihood support, e.g. cash transfers, inputs, technical assistance	FAO IOM UNDP UNICEF UNHCR	FAO IOM UNDP UNICEF UNHCR	400,000 (UNHCR)
		Number and proportion of people most vulnerable to COVID-19 who benefit from increased or expanded social safety net	FAO IOM UNDP UNICEF UNHCR UNRWA	8,411,816 households (UNICEF) 850,000 Palestine refugees (UNRWA)	-
2.2	**Ensure the continuity of safety from infection of essential services** including health, water and sanitation, nutrition, shelter protection and education for the population groups most exposed and vulnerable to the pandemic.	Proportion of population with access to safe, functional and non-infected essential services	IOM UNFPA UNHCR UNICEF UNRWA	533,000 Palestine refugees in UNRWA schools 2.2 million Palestine refugees receiving UNRWA cash and food assistance 3 million Palestine refugees who use UNRWA's health services	6.4 million masks for 25 countries, of which 3 million are for health-care workers (UNHCR)
		Proportion of countries that postponed vaccine-preventable diseases mass immunization campaigns due to COVID-19	WHO	-	-
		Number of people reached with critical WASH supplies (including hygiene items) and services	UNICEF	64,103,210	8,612,380

[65] Insofar as possible, indicator data should be collected disaggregated by sex, age and disability to allow for a meaningful measurement on the impact or response effects on key groups with special needs e.g. women and girls, older people, people with disabilities, etc.

#	SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
		Number of children supported with distance/ home-based learning	UNICEF	272,239,500	29,110,400
2.3	**Secure the continuity of the supply chain for essential commodities and services** such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non-food items	Number of air cargo flights carrying essential commodities	WFP	-	Solidarity flights and on-demand services ongoing since beginning of crisis; on 30 April the first free-to-user flight as part the COVID-19 supply chain backbone of the GHRP, took place
		Number and proportion of sexual and reproductive health facilities that received reproductive health kits and other pharmaceuticals, medical devices and supplies to implement the life-saving sexual reproduction and health services of the Minimum Initial Service Package	UNFPA	-	24 countries received Interagency Reproductive Health kits between 10 January and 22 April
		Number and proportion of child protection services continuing to provide specialized response during the COVID-19 crisis	UNICEF	-	703,000 children and caregivers reached with community-based MHPSS in 70 countries 52 countries addressing needs of children without parental care; over 180,000 provided alternative arrangements
		Number and proportion of gender-based violence response services continuing or newly established to provide specialised gender-based violence response to the COVID-19 crisis[66]	UNFPA UNHCR	-	15 of 18 reporting countries have adapted and/or upscaled gender-based violence services
		Number and proportion of countries where messages on gender-based violence risks and available gender-based violence services were disseminated at community level	UNFPA	-	18 of 18 reporting countries have disseminated messages at community level

[66] Expected disaggregation in future GHRP update: health facilities providing care to survivors of rape and intimate partner violence; basic psychosocial support; case management including referral; continuing/new.

Strategic priority 3

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

Progress by specific objective

A summary of the main responses (not exhaustive) undertaken by agencies and their partners is illustrated under each specific objective. Additional details by agency can be found in annexes 1 and 2. Responses to the humanitarian non-health effects caused by the pandemic are part of the revisions being done to ongoing HRPs, RRPs and regional refugee and migrant plans in countries covered by the GHRP. They aim to cover the additional needs caused by the pandemic and do not include operational adjustments to responses addressing other shocks.

Specific objective 3.1 - *Advocate and ensure that the fundamental rights of refugees, migrants, IDPs, people of concern and host population groups who are particularly vulnerable to the pandemic are safeguarded, and that they have access to testing and health-care services, are included in national surveillance and response planning for COVID-19, and are receiving information and assistance.*

The impact of COVID-19 prevention-and-response measures is closely monitored to protect the rights of forcibly displaced populations and migrants, including the most vulnerable among them such as women, children, older persons and persons with disabilities. Community-based activities are implemented to foster the participation of refugees, IDPs, Stateless persons and host populations in prevention-and-response activities.

Advocacy efforts are undertaken to influence local authorities so that these groups are not discriminated against and their needs are met, and to encourage their inclusion in national health services and response plans. Where needed, essential supplies have been directly delivered to refugees, IDPs, migrants and other vulnerable groups.

Specific objective 3.2 - *Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia towards refugees, migrants, IDPs and people of concern by enhancing awareness and understanding of the COVID-19 pandemic at community level.*

Risk-communication and community-engagement efforts continue at all levels to inform refugees, IDPs, migrants and persons of concern while also raising awareness of the general population to prevent xenophobia and discrimination. Local networks and social media, including videos, are used to further disseminate these messages. Local governments are supported to deliver basic services in an inclusive manner to mitigate sources of tension while mainstreaming social cohesion and conflict sensitivity.

Guidance and tools have been prepared to strengthen COVID-19 preparedness and response in key areas such as health, water, sanitation and hygiene, shelter, nutrition and mental health, including in camps and camp-like settings.

Response gaps and challenges

The main areas that require further improvement and scale-up, and some of the challenges, include:

Inclusivity, older age, gender and disability

- Efforts must increase to prevent and address risks of violence (including gender-based violence) and of discrimination, marginalization and xenophobia towards persons of concern. Stigmatizing and xenophobic narratives accusing migrants of being disease carriers are emerging and require pro-migrant inclusion advocacy.

- Advocacy should continue for the inclusion of vulnerable and marginalized groups, such as stranded migrants regardless of legal status, and IDPs to be included in national response plans and have access to COVID-19 testing and care in line with the Sustainable Development Goals and Universal Health Coverage.

- As COVID-19 amplifies some of the protection threats and risks for IDPs, refugees, migrants and asylum seekers, life-saving protection responses including for gender-based violence must be maintained and expanded.

Mobility, access and delivery capacities

- Border closures and movement restrictions have resulted in limited access to territory and asylum procedures including reception, registration and refugee status determinations, as well as suspension of asylum procedures and violations of principle of non-refoulement. Restrictions on freedom of movement and other rights are maintained for longer than necessary.

- Restrictive measures imposed by authorities often prevent organizations from delivering aid in line with global humanitarian principles. Such challenges are leading donors to delay new funds while many humanitarian organizations are forced to close their programmes in countries such as Yemen.

- Collective shelters face particular constraints to effectively implement physical distancing. To overcome this, humanitarian partners in several countries including Afghanistan and Iraq are supporting quarantine for contact/travel history cases and establishing isolation spaces within IDP sites.

- Surge response capacities need to be strengthened, especially technical support, supplies and delivery.

Scaling up of response to address the impact of COVID-19

- Public health services must be bolstered in low-income settings, including urban slums and humanitarian crises, to better prevent and respond to the pandemic. Health systems, including for mental health services, that have entered this pandemic with already weak capacities (e.g. Syria, Yemen, Afghanistan, Somalia, South Sudan and Sudan) face an exacerbation of poor access to services for migrants, as well as constraints in health financing. This, along with barriers to access hard-to-reach populations and maintain supply chains, threaten the continuity of care to migrants on essential health services.

- Migrants, refugees, asylum seekers and IDPs also require mental health and psychosocial support to mitigate the additional stress and challenges caused by the pandemic, considering that human and financial resources for mental health services are often very limited in some of the GHRP countries.

- Technical guidance and tools must be developed to ensure risk communication messages are culturally and linguistically tailored, and that migrants, displaced populations and other vulnerable groups are included in national, regional and global outreach campaigns to avoid stigmatization. Gaps in literacy levels and in access to digital tools between men and women must also be factored in. Activities must ensure that displaced populations and migrants living in urban areas and out-of-camps settings, as well as in border areas, have access points to assistance and information during movement restrictions and to health services.

- Specialized training is needed for operational partners who are playing an increasingly prominent role, including to set up quarantine and isolation facilities in displacement sites and at points of entry, and support families and broader communities of those under quarantine or isolation.

- Preparedness for response on a no-regrets basis must increase specifically for those countries not yet badly hit but very likely to be affected, and with ill-prepared health and social safety net structures. Ongoing efforts to decongest densely populated refugee camps and settlements need to be further scaled up in anticipation of COVID-19 to facilitate a measure of physical distancing.

Needs assessment and monitoring

- Data collection and participatory mapping exercises together with national authorities and local communities should be strengthened to identify key mobility corridors and congregation areas, such as densely populated urban slums, for targeted prevention activities and to inform regional and national preparedness and response plans.

Response monitoring

Response indicators were identified in the first iteration of the GHRP to monitor progress against strategic priority 3. A number of these indicators are being refined and cannot yet be reported against. Additional results will be provided in subsequent GHRP updates.

#	SPECIFIC OBJECTIVE	INDICATOR [67]	RESPONSIBLE ENTITY	TARGET	PROGRESS
3.1	**Advocate and ensure that refugees, migrants, IDPs, people of concern and host population groups** who are particularly vulnerable to the pandemic receive COVID-19 assistance	Number of refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic who receive COVID-19 assistance[68]	IOM UNHCR UNICEF	-	-
3.2	**Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia** towards refugees, migrants, IDPs and people of concern by enhancing awareness and understanding of the COVID-19 pandemic at community level	Number of communities with established hotlines (phones, email and SMS) functioning and increased access to timely, safe and accurate information on COVID-19 from credible sources	UNDP UNFPA UNRWA UNHCR	Palestine refugees in all 5 fields of operation	-
		Number and proportion of refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic who receive adequate information on risks and available services	IOM UNFPA UNHCR UNICEF	-	-
		Number of communal conflicts in affected communities	IOM	-	-
		Proportion of affected population expressing satisfaction on access to services, rights and information	IOM UNHCR	-	-

[67] Insofar as possible, indicator data should be collected disaggregated by sex, age and disability to allow for a meaningful measurement on the impact or response effects on key groups with special needs e.g. women and girls, older people, people with disabilities, etc.

[68] The type of COVID-19 assistance will vary. It is fine to disaggregate this indicator according to different broad types of assistance, e.g. productive inputs, cash transfers, mental health and psychosocial support services, nutrition rehabilitation etc.

3.2
Adherence to the guiding principles and key considerations for the response

Application of the guiding principles for the response

In the first iteration of the GHRP, the below set of overarching guiding principles was agreed upon to ensure that the response was implemented in a way that was respectful of humanitarian principles and other global commitments:

- Respect for humanitarian principles.

- People-centred approach and inclusivity, notably of the most vulnerable people, stigmatized, hard-to-reach, displaced and mobile populations that may also be left out or inadequately included in national plans.

- Cultural sensitivity and attention to the needs of different age groups (children, older people), as well as to gender equality, particularly to account for women's and girls' specific needs, risks and roles in the response as care providers (including caring for those sick from the virus), increased exposure to gender-based violence with confinement measures, large numbers of front-line female health workers in the response, and key role as agents at the community level for communication on risks and community engagement.

- Two-way communication, engagement with and support to capacities and response of local actors and community-based groups in the design and implementation of the response, using appropriate technology and means to account for mobility restrictions and physical distancing.

- Complementarity and synergies between agency plans and responses, including with development actors.

- Preparedness, early action and flexibility to adjust the responses and targets to the fast-evolving situation and needs.

- Building on existing coordination mechanisms.

- Duty of care for agency staff and volunteers.

Some examples of how organizations are applying these guiding principles in their interventions include:

IOM has elaborated internal instructions, frameworks, approaches and tools on protection (including gender-based violence, persons with disabilities, children and protection against sexual exploitation and abuse) that are being adapted to the context of the COVID-19 response, as well as engagement with medical evacuations in support of humanitarian workers and their families.

UNFPA has adopted contingency measures for emergency staffing through standby partner arrangements, affording the Standby Personnel the same protection and physical security measures which UNFPA affords its staff. Where possible, remote-based surge is employed. Mental health and psychosocial support at regional levels is also being scaled up for country offices through surge assignment remotely.

UNHCR has issued guidance on accountability to affected people and on age, gender and diversity considerations in the COVID-19 response. In view of the disproportionate impact that COVID-19 is having on women, children, older persons, persons with disabilities and other groups at risk of marginalization, UNHCR continues to apply an age, gender and diversity lens in the monitoring of protection risks, the analysis and reporting on trends that emerge, programme design and delivery, and interventions with the relevant authorities.

Existing online platforms and call centers allow refugees to receive and share information in a language they understand as well as to file complaints and receive feedback. In Jordan, for example, between mid-March and mid-April, the **UNHCR** Helpline received 206,000 calls, while in Lebanon, **UNHCR/WFP** call centres and UNHCR hotlines have received over 80,000 calls during the same period.

UNICEF is implementing its duty of care to staff through provision of greater flexibility around entitlements such as leave, rest and recuperation, provision of salary advances where needed. It has also utilized staff counselors for psychosocial support and on-line mental health resources while also expanding virtual learning opportunities for staff.

WFP has redefined its obligations to do no harm and ensure duty of care for staff and partners. It has recruited dedicated health advisors and leveraged its experience in delivery in Ebola to put in place dedicated Standard Operating Procedures and health mitigation measures along the supply chain, be it WFP chartered shipping and air services, WFP managed warehouses, or WFP food distribution sites and retail shops. This expertise has been shared with governments, transport partners, cooperating partners, and through WFP's cluster partners (logistics, emergency telecommunications, and food security with FAO). Through its Emergency Telecommunications partner network, two-way dedicated COVID-19 hotlines have been established in conflict affected areas where access challenges are most acute. To ensure commitments of duty of care for health and humanitarian workers, and reduce the burden on host governments, WFP is contracting medical evacuation services, procuring road ambulances, and establishing field hospital infrastructure where no alternative is available; in coordination with health partners and governments.

Complementarity across agencies and plans, and engagement with local actors and international partners

Integration, complementarity and synergies between agencies and global response plans for COVID-19

Interagency collaboration
Under the Inter-Agency Standing Committee auspices, a series of guidance document were produced jointly to advise on responses to specific populations groups vulnerabilities and particular settings.[69] This includes guidance on how to respond to COVID-19 in camp and camp like settings, on education, on distribution of food assistance, among many others.

- UNICEF, WHO and IFRC developed a Risk Communication and Community Engagement (RCCE) Action Plan guidance to support risk communication, community engagement staff and responders working with national health authorities, and other partners. This comprehensive guidance presents tools and information on how to develop, implement and monitor an action plan for communicating and engaging effectively with communities, local partners and other stakeholders.. A draft global RCCE guidance has been produced and currently under finalization.

- Through the coordination mechanisms established for the COVID-19 Response, including the UN Crisis Management Team, the Supply Chain Task Force and the Supply Chain Inter-Agency Coordination Cell, UN and non-UN actors are working closely together to set up the system required to identify, certify, source, allocate, direct and deliver essential supplies where they are needed most. In a collaborative effort across UN and non-UN actors, WHO is leading the prioritization and destination of medical equipment while WFP is serving as logistics lead. Through this, WFP is coordinating the delivery of prioritized health and humanitarian cargo while leveraging existing infrastructure, partnerships, and capabilities. UNICEF is leading the WHO-administered "COVID-19 Global Supply Coordination platform" which collates all agency supply requests into one forum.

- Through these coordination forums and WFP's existing partnership with the private sector and engagement with governments (including military), the collective assets, services and expertise of actors will be leveraged to deliver the supply chain backbone of the response. Where militaries are mobilized and/or peacekeeping operations are present in-country, WFP may provide dedicated expertise to coordinate and minimise any duplication or gaps, such as supporting the humanitarian community in the use of national military and civil defence assets where appropriate, and coordinating the use of foreign military assets where required.

69 https://interagencystandingcommittee.org/covid-19-outbreak-readiness-and-response

- IOM is working with partners and stakeholders at community, national, regional and global levels to ensure coordination and synergy between various actors and responses, and avoid duplication of efforts. It is planning to set up a support facility to global clusters to utilize existing Displacement Tracking Matrix datasets for country-level sectoral or multi-sectoral analysis as needed.

- IOM aims to support UN outpatient clinics and provide staff through its global network of qualified health workers, including physicians, nurses and laboratory staff, across 40 tentatively identified locations where IOM already has medical presence. IOM is a member of the UN medical evacuation Task Force and has been closely working with UN partners at all levels to jointly find effective solutions to support UN staff in the most effective way possible during the peak of the pandemic.

- UNFPA is coordinating with WHO and other UN partners at the global and local level to ensure access to personal protective equipment to prevent person-to- person transmission of COVID-19 in sexual and reproductive health and gender-based violence lifesaving service delivery points. UNFPA is also working to ensure an uninterrupted supply chain for lifesaving sexual and reproductive health commodities to the last mile, particularly in humanitarian settings, despite the immense international and local challenges caused by the COVID-19 pandemic.

Humanitarian and development collaboration
The COVID-19 pandemic is having both humanitarian immediate effects and socio economic and political impacts that require the coherent and concurrent engagement of humanitarian, development and peace actors. Humanitarian and development action to address these impacts in fragile contexts should be connected rather than sequential, using complementary and flexible funding, to prevent COVID-19 related risks escalating and to seize opportunities, such as the UN Secretary General's call for a global ceasefire to deliver a lasting peace, and a coordinated economic response to ensure that no one and no place is left behind. The overlapping objectives and areas of focus between the WHO SPRP, the UN Development Group Framework for the Immediate Socio-Economic Response to COVID-19 and the GHRP offer a direct possibility for such a coordinated and collaborative response.

It should be noted that many NGOs have already to a considerable extent adapted their existing development programmes to support the humanitarian response, such as through community-based public health messaging and education programming.

Community engagement

The COVID-19 pandemic requires effective consultation and engagement with communities to prevent the spread of the virus and minimize risks to communities. UN agencies and NGOs are working closely with affected communities including through faith-based and refugee led organizations, private sector, and local authorities, among others.

IOM is utilizing technology to ensure continuity of care and case management for communities. For example, the continuity of care for persons living with HIV/AIDS in the cross-border communities in Uganda is supported through the use of SMS technologies that link health facilities to community peer networks.

UNFPA builds upon households' and communities' knowledge and capacities to protect themselves. For instance, women's frontline interaction with communities positions them to positively influence the design and implementation of prevention activities and community engagement. In Yemen, women-led organisations have prepared community focal points as first responders and hotline staff prior to quarantine implementation. To ensure continuity of access to services and strengthen gender-based violence risk mitigation an online learning platform has been set up providing training on how to support survivors in the absence of gender-based violence specialized services and via tele-counselling (hotlines).

UNFPA is also strengthening the capacity of youth organizations to engage safely, effectively and meaningfully in ways that enable young people to augment their knowledge on the virus and play an effective role in the prevention and response, including as social and community workers and as assistants to professional health staff, where needed and possible. Measures are put in place to mitigate risk of all forms of violence against adolescents and youth, particularly adolescent girls and young women, in quarantine settings, isolation processes and procedures.

UNHCR is broadening the scope of ongoing communication and community engagement to ensure remote engagement of communities, two-way communication and ensuring that all persons have access to feedback, complaint and suggestion mechanisms. Through this, persons of concern have access to protection counselling and essential risk communication in their own languages and through preferred and trusted online and offline channels.

Physical distancing and movement regulations have affected how UNHCR reaches out to refugees and other forcibly displaced persons, and vice versa. Two-way communication is crucial to address social isolation and distress and to ensure programmes are responsive and tailored to the needs of diverse groups, in particular for those who often do not have a voice – people with specific needs and profiles, such as women and girls, members of the Lesbian, Gay, Bisexual, Transgender and Intersex community, people living with disabilities, persons with mental health and psychosocial distress, ethnic minorities, older people, unaccompanied children, people living with HIV and other chronic diseases, as well as stateless persons who may already be less visible by virtue of their legal status. While face-to-face methods may be restricted, virtual and remote tools are being adapted and enhanced to deliver protection services and information in multiple languages, and with them identify persons at risk, design services, and engage the broader host community.

Volunteers also play a key role in supporting the humanitarian response to COVID-19. This includes community-based refugee and IDP volunteers and the large network of Red Cross Red Crescent volunteers, as well as UN Volunteers.

Engagement with and role of local and national organizations (including faith-based)

Local and national organizations are on the frontline of the COVID-19 response, particularly given movement and mobility restrictions which force international humanitarian staff to work remotely. These organizations range from specialized humanitarian organizations to older people's association, organizations for persons with disabilities, women-led and faith-based organizations. International humanitarian organizations recognize the importance of the local and national organizations both as part of their Grand Bargain commitments and their role in COVID-19 response including but not limited to delivering aid to some of the most vulnerable groups in remote locations and working with older people and people with disabilities.

UN agencies and international NGOs are enhancing their collaboration with local and national organizations in the context of COVID-19 as outlined below:

- UNDP is working in close collaboration with national, municipal and local authorities to support inclusive and integrated crisis management, supporting business continuity actions (especially teleworking and procurement support) for key public crisis management services, and reinforcing existing public services, for example expanding shelters for survivors of domestic violence, and advising on appropriate virus transmission reduction models, as an alternative to lockdowns. National partners are in a leadership role on UNDP supported multi-stakeholder socio-economic impact assessments.

- UNFPA is working closely with national ministries, national Red Cross Red Crescent societies, and local NGOs including women's led and youth organizations under the existing cluster/sector coordination system while utilizing pre-existing and contingency partnerships with NGO partners.

- Recognizing that more than 61% of refugees live in urban environments, UNHCR has developed a Live Resource Guide for Municipal Migrant and Refugee Sensitive COVID-19 responses in partnership with Mayors Migration Council. It has also reached out to refugee-led organisations, faith-based organisations and other civil society actors to seek new and innovative ways of collaborating to reach out to all segments of society, combat misinformation and enhance global solidarity.

- UNICEF is strengthening its collaboration with civil society organisations through cash programming.

- UNRWA is planning to increase its community engagement activities and mobilize Palestinian youth to disseminate messages in their communities to prevent the spread of the COVID-19

- As frontline actors, NGOs and local partners are collaborating and rapidly scaling to respond to the direct and secondary impacts of COVID-19. NGOs have mobilized networks of community health workers, faith leaders and women's led organizations to support preparedness, prevention, and continuity of ongoing life-saving services. NGOs are also adapting their existing humanitarian operations to ensure continuity of life-saving response to existing crises while respecting national COVID-19 policies and ensuring a Do No Harm approach for affected populations.

Partnership with NGOs

In addition to being integrated into IASC coordination structures and significant independent humanitarian actors in their own right, International, national and local NGOs are on the frontline of humanitarian response and also play a critical role in last-mile implementation for many UN agencies. In a message sent on 20 April to all Resident/Humanitarian Coordinators (RCs/HCs), and a subsequent message to IASC Principals, the Emergency Relief Coordinator stressed that (i) NGOs should be included in ongoing revisions of country HRPs including dedicated meetings with NGO forums, (ii) Country-Based Pooled Funds should be allocated quickly and flexibly to NGO partners, and (iii) UN agencies should prioritize channeling funds to frontline NGO partners as quickly as possible.

UN agencies have already started to implement these principles. For instance, UNFPA, UNHCR and UNICEF simplified their partnership agreements or arrangements while also calling for and implementing flexible funding measures for their partners. IOM initiated a set of additional steps to improve flexible funding to NGO partners to effectively respond to COVID-19 while continuing the critically important ongoing humanitarian work.

> **"COVID-19 has changed every aspect of our lives. But women and girls are shouldering a double burden made heavier by lingering inequalities and harmful gender stereotypes."**
>
> —
>
> **Henrietta H. Fore**
> Executive Director, UNICEF

QAMISHLY, SYRIA
Volunteers hang posters providing important instructions on how to protect against the COVID-19 as part of a campaign in the city of Qamishly, Syria. *UNICEF*

4.0 | Financial requirements and funding status

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JAMJANG, SOUTH SUDAN
Sudanese refugees observing physical distancing while
listening to health and sanitation messages broadcasted
through a speaker system. *UNHCR/Elizabeth Stuart*

4.1
Funding overview

The GHRP is the primary vehicle for raising resources for the immediate COVID-19 health needs, and directly related initial multi-sectoral humanitarian needs of the most vulnerable population groups in all countries already facing a humanitarian crisis, and other countries at high risk. The resources necessary to meet the additional COVID-19 humanitarian needs are also reflected in an increased global humanitarian ask (revised Global Humanitarian Overview funding requirements) encompassing country HRPs, RRRPs and RMRPs which also address pre-existing and emerging humanitarian needs.

International Financing Institutions (IFIs) also play a significant role in responding to the consequences of the pandemic, as demonstrated by the IMF's announcement of immediate debt service relief for 25 countries[70] (many of which are in the GHRP) and the World Bank's first allocation of $1.9 billion also to 25 countries. Much of the medium and longer-term response to COVID-19 will need to be done in partnership with the IFIs.

In parallel, the Secretary General's report on "Responding to the socio-economic impacts of COVID-19" provides a preliminary analysis of the longer-term socio-economic impact of the COVID-19 crisis and priorities governments need to consider in order to mitigate its impact. Funding for these needs will be mobilised through other, non-humanitarian, funding sources including national resources, the international financing institutions, bilateral assistance, the UN development system and (for populations not covered by the GHRP) the Secretary-General's UN COVID-19 Multi Partner Response and Recovery Fund (MPTF).

The MPTF is a multi-donor UN financing instrument established to support low- and middle-income countries to:

- Tackle the health emergency.
- Focus on the social impact and the economic response and recovery.
- Help countries recover better.

It aims to underpin the UN's longer term multi-sectoral support to national recovery/development responses to the socio-economic impact of COVID-19. The Fund's coverage extends to all low and middle income programme countries. In the first round, the following 46 countries, all of which were outside the GHRP, received funding: Bhutan, Cambodia, Comoros, Gambia, Guinea, Guinea-Bissau, Kiribati, Lao PDR, Lesotho, Madagascar, Malawi, Mauritania, Nepal, Sao Tome and Principe, Senegal, Solomon Islands, Timor-Leste, Tuvalu, Vanuatu, Armenia, Cabo Verde, Côte d'Ivoire, El Salvador, Eswatini, Georgia, Ghana, Guatemala, Honduras, India, Indonesia, Kosovo[71], Kyrgyzstan, Micronesia, Moldova, Mongolia, Morocco, Nicaragua, Papua New Guinea, Sri Lanka, Tajikistan, Tokelau, Belize, Jamaica.

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[70] Afghanistan, Benin, Burkina Faso, Central African Republic, Chad, Comoros, DRC, The Gambia, Guinea, Guinea-Bissau, Haiti, Liberia, Madagascar, Malawi, Mali, Mozambique, Nepal, Niger, Rwanda, São Tomé and Príncipe, Sierra Leone, Solomon Islands, Tajikistan, Togo, and Yemen.

[71] References to Kosovo in this document shall be understood to be in the context of the Security Council Resolution 1244 (1999).

4.2
Financial requirements

Overview of GHRP cost components

REQUIREMENTS (US$) [73]

$ **6.71** billion

	COVID-19 TOTAL	OF WHICH: HEALTH	NON-HEALTH	NUMBER OF PLANS
Global support services	1.01 B	–	–	–
Humanitarian Response Plans (HRPs)	3.49 B	1.30 B	2.18 B	25
Regional Refugee Response Plans (RRPs)	993.6 M	265.1 M	728.5 M	5
Regional Refugee and Migrant Response Plan (RMRPs)	438.8 M	132.4 M	306.4 M	1
Other plans	156.9 M	91.5 M	65.3 M	2
New plans	628.8 M	235.2 M	393.6 M	9
TOTAL	$6.71 B	$2.03 B	$3.67 B	42

The total funding required for the GHRP has risen to $6.69 billion, from the initial $2.01 billion estimated at the launch of the plan on 25 March as a result of four factors:

- The addition of new priority countries.
- Refined country-level estimates based on revisions of HRPs, RRPs and other refugee and migrant plans to reflect the health and urgent non-health needs caused by the pandemic
- Agencies' review of their headquarters' financial requirements to include solely the cost of shared services benefitting the collective response.
- The increased cost of essential health and other supplies and air and sea transportation.

Given the ambition of the GHRP and the number of people assisted across 63 countries, this should be put in perspective of the $8 trillion mobilized to assist OECD economies and populations.

The GHRP funding requirement includes:

- $5.69 billion for the COVID-19 response in the countries included in the GHRP. This amount includes requirements of UN agencies and NGOs implementing the response at country level.[74] See Annex 3 for details by country.

- $1 billion for global shared services benefitting the collective COVID-19 response, such as logistics, air bridge, central procurement, field hospitals, medical evacuations and data facility. This amount excludes those estimated in the first iteration of the GHRP for country-level costs, which are now counted in the country requirements above.

The following table shows the following information for each country included in the GHRP (see also Annex C):

The original funding requirement for the humanitarian response prior to the pandemic (for countries where a response plan had been formulated).

The increase or decreased funding requirement from the revision of the pre-COVID-19 response for operational reasons reflecting the reprioritisation or adjustment of the previous response in light of the measures taken internationally and domestically to prevent the pandemic. These adjustments do not address new needs caused by the pandemic, but pre-existing needs, and can result in a reduction or an increase of the original funding requirement. In some cases, the revision reflects new needs caused by an unforeseen shock (e.g. locust infestation, flash floods). The funding requirements for these adjustments are not counted in the GHRP funding requirements.

The additional funding requirements due to the additional health and multisectoral humanitarian needs caused by the pandemic. These requirements are over and above the requirements for the pre-COVID-19 humanitarian response. They do not include costs to adjust the pre-COVID-19 response due to the operational consequences of the measures taken internationally and domestically to prevent and contain the pandemic. These costs are the only country-level requirements counted in the GHRP.

The funding required at agency headquarters' level to provide shared services for all COVID-19 humanitarian responders. These costs are counted in the GHRP total funding requirement.

Global support services for the COVID-19 humanitarian response

The nature of the COVID-19 pandemic requires cross-agency, global services to support delivery of the response in the GHRP countries. These support services include, among others:

- Establishing international and regional staging hubs to facilitate consolidation, prioritization and onward distribution of supplies,
- Humanitarian air and sea transport services for cargo and passengers to overcome current travel and movement restrictions
- Supporting logistics services for humanitarian partners.
- Setting up air medical evacuation services and construction of field hospitals.

Financial requirements (US$)

COVID-19 REQUIREMENTS

REQUIREMENTS

$6.71B

OF WHICH:

HEALTH: $2.03 B
NON-HEALTH: $3.67 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS[1]

$36.75B

OF WHICH:

COVID-19: $6.71 B
NON-COVID-19: $30.04 B

INTER-AGENCY APPEAL		COVID-19 TOTAL	OF WHICH: HEALTH	NON-HEALTH	ADJUSTED NON-COVID-19	TOTAL HUMANITARIAN COVID + NON-COVID	
Afghanistan	HRP	108.1 M	21.7 M	86.4 M	695.7 M	803.8 M	
Burkina Faso	HRP	60.0 M	15.0 M	45.0 M	311.6 M	371.6 M	
Burundi	HRP	36.7 M	-	36.7 M	131.7 M	168.4 M	
Cameroon	HRP	99.6 M	23.0 M	76.6 M	292.7 M	392.4 M	
CAR	HRP	152.8 M	7.7 M	145.2 M	400.8 M	553.6 M	
Chad	HRP	99.5 M	6.0 M	93.5 M	610.7 M	710.2 M	
Colombia	HRP	197.0 M	152.7 M	44.4 M	209.7 M	406.7 M	
DRC	HRP	287.8 M	119.4 M	168.4 M	1.82 B	2.11 B	
Ethiopia	HRP	322.6 M	100.0 M	222.6 M	1.00 B	1.32 B	
Haiti	HRP	105.0 M	105.0 M	-	319.3 M	424.3 M	
Iraq	HRP	263.3 M	65.4 M	197.9 M	397.4 M	660.7 M	
Libya	HRP	38.8 M	14.9 M	23.9 M	90.9 M	129.8 M	
Mali	HRP	42.3 M	10.1 M	32.2 M	350.7 M	393.2 M	
Myanmar	HRP	46.0 M	18.1 M	27.9 M	216.3 M	262.3 M	
Niger	HRP	76.6 M	9.9 M	66.7 M	433.3 M	509.8 M	
Nigeria	HRP	259.8 M	85.2 M	174.6 M	839.0 M	1.10 B	
oPt	HRP	42.4 M	19.1 M	23.3 M	348.0 M	390.4 M	
Somalia	HRP	176.4 M	72.1 M	104.4 M	1.08 B	1.25 B	
South Sudan	HRP	217.2 M	21.0 M	196.2 M	1.55 B	1.77 B	
Sudan	HRP	87.5 M	87.5 M	-	1.35 B	1.44 B	
Syria	HRP	384.2 M	157.5 M	226.7 M	3.42 B	3.81 B	
Ukraine	HRP	47.3 M	16.6 M	30.7 M	157.8 M	205.1 M	
Venezuela	HRP	72.1 M	44.1 M	28.0 M	677.9 M	750.0 M	
Yemen	HRP	179.1 M	101.6 M	77.6 M	3.20 B	3.38 B	
Zimbabwe	HRP	84.9 M	35.0 M	49.9 M	715.8 M	800.7 M	
Burundi *Regional*	RRP	65.4 M	36.5 M	29.0 M	209.9 M	275.4 M	
DRC *Regional*	RRP	155.7 M	94.7 M	61.0 M	483.0 M	638.7 M	
Nigeria *Regional* [2]	RRP	-	-	-	-	-	
South Sudan *Regional*	RRP	128.8 M	51.4 M	77.4 M	1.21 B	1.34 B	
Syria *Regional* [3]	3RP	643.8 M	82.6 M	561.1 M	5.56 B	6.21 B	
Venezuela *Regional*	RMRP	438.8 M	132.4 M	306.4 M	968.8 M	1.41 B	
Rohingya Crisis [4]	JRP	117.2 M	71.8 M	45.3 M	-	-	
DPR Korea	Other	39.7 M	19.7 M	20.0 M	107.0 M	146.7 M	
Benin	New	17.2 M	10.9 M	6.3 M	-	17.2 M	
Iran	New	89.5 M	64.4 M	25.1 M	-	89.5 M	
Lebanon	New	94.0 M	53.8 M	40.2 M	-	94.0 M	
Liberia	New	57.0 M	17.5 M	39.5 M	-	57.0 M	
Mozambique	New	68.2 M	16.0 M	52.2 M	-	68.2 M	
Pakistan	New	126.8 M	29.2 M	97.6 M	-	126.8 M	
Philippines	New	96.2 M	23.2 M	73.0 M	-	96.2 M	
Sierra Leone	New	60.5 M	16.8 M	43.7 M	-	60.5 M	
Togo	New	19.4 M	3.3 M	16.0 M	-	19.4 M	
Global Support Services		1.01 B	-	-	-	1.01B	
TOTAL		**6.71 B**	**2.03 B**	**3.67 B**	**30.04 B**	**36.75 B**	

[1] Funding requirement updated on 11 May 2020. The figures are expected to change as country offices continue revising their projects and ongoing activities. For the most up-to-date figures, please refer to hpc.tools or fts.unocha.org.

[1] The requirements for the Nigeria RRP are included in the Cameroon, Chad and Niger HRPs.

[2] The existing 3RP 2020 budget is 5.56 billion. A full prioritization exercise is ongoing in and an adjusted non-COVID-19 figure is pending

[3] Revised new COVID-19 related requirements, plus total 2020 JRP requirement adjusted to COVID response, will be presented in the June GHRP update

4.3
Funding status

Funding received against the GHRP requirements

As of 5 May, funding reported towards the GHRP requirements totaled $923 million, representing 46% of the plan's original requirement and 13% of the revised requirement. Of this amount, $166 million are pooled funds contributions, including $95 million from the Central Emergency Response Fund (CERF) and $71 million from Country Based Pooled Funds (CBPFs).

An additional $608 million have been reported for the COVID-19 emergency, including funding to UN agencies, NGOs, the Red Cross and Red Crescent Movement and bilateral funding to affected governments, bringing the total for the COVID-19 humanitarian response to $1.5 billion. Any flexible funding provided by donors is being tracked on the COVID-19 emergency page until organizations are able to determine whether or which part of the funding will contribute to planned activities/countries. For the latest figures on GHRP and other coordinated response plan funding, see: https://fts.unocha.org/appeals/952/summary.

Consequences of funding gaps to achieve the strategic priorities

Common services for supply chains and medical evacuations

Funding is urgently needed to provide critical support to the supply chain without which services will not be rolled out at the scale required to ensure the supply chain needs of the global response. The number of air rotations transporting critical health and humanitarian cargo between hubs will be immediately impacted, risking the effective and efficient delivery of critical health and humanitarian relief items to those in need. Lack of medical supplies and equipment will result in increased health risks thus limiting progress on the GHRP strategic priorities. Support to ensure the health and welfare of humanitarian personnel will be severely limited, including a reduction in medical evacuation services.

Shared services, personal protection equipment, medical evacuations, UNHAS and cargo flights are essential for the continuity of operations by all organizations including NGOs. Without functional supply chains, NGOs are likely to be forced to halt operations and possibly pull out of critical response locations.

Humanitarian response to COVID-19

Humanitarian organizations have adapted their pre-COVID-19 humanitarian response and services, however, they cannot implement these interventions without sufficient funding. Thousands of clinics, health, water and sanitation services to millions of people will be disrupted in coming weeks and months if funding is not provided urgently.

Without funding, provision of pregnancy-related and newborn health care would have disastrous implications for the lives of women and their newborns. Research suggests[75] that even a modest ten per cent decline in these services would mean an additional 1.7 million women who give birth and an additional 2.6 million newborns would experience major complications in case they do not receive the care they need, resulting in an additional 28,000 maternal deaths and 168,000 newborn deaths.[76]

Lack of funding has so far limited humanitarian agencies' ability to implement time critical emergency employment and basic livelihood support to address the immediate humanitarian needs caused by the pandemic, as well as interventions to promote social cohesion and help address stigma and discrimination issues. Funding deficits will have particular severe impacts on countries presenting high levels of food insecurity, including those affected by the locust infestation, natural disasters and conflicts. Further underfunding of these priorities will contribute to exacerbate the socio-economic effects of the crisis, putting additional lives at risk.

[75] Guttmacher Institute, Estimates of the Potential Impact of COVID-19 on Sexual and Reproductive Health in Low and Middle Income Countries, Available at: www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health
[76] WHO. Health Cluster. Gender-based Violence in Health Emergencies. www.who.int/health-cluster/about/work/othercollaborations/gender-based-violence/en

Securing funding for the country level HRPs and RRPs is essential, as these remain the primary funding vehicles for the wider pre- and post-COVID-19 humanitarian needs of refugees, IDPs, migrants, and other vulnerable groups such as persons living with HIV/AIDs, pregnant and lactating women and young children, and the 135 million people already in acute food insecurity hunger prior to COVID-19.

Monitoring of situation, needs and response

If additional resources are not mobilized, humanitarian agencies will not be able to maintain even current real-time monitoring. Without the ability to collect real-time, representative data at scale, agencies will continue to rely on macro-level projections, which is insufficient to rapidly identify, and respond to acute humanitarian needs at sub-national and population group levels.

4.4
Funding flows and partnerships

Funding flows between Pooled Funds, UN agencies and partners

Pooled funding has been instrumental in supporting preparedness and response through emergency allocations and reprogramming pre-existing projects to assist 37 countries.

CERF has made three allocations since 27 February totaling $95 million. The second announcement on 25 March of $60 million – one of the fund's largest-ever allocations - kickstarted the GHRP. A third allocation of $20 million on 9 April supported severely underfunded critical supply chain activities, including humanitarian passenger transport and medical evacuation services for the whole humanitarian community including NGOs. Of total CERF funding, a significant proportion has been provided to supporting logistics, supply chains and common services (42%) as well as to health response (36%). The CERF has also put in place some flexibility measures to allow implementing partners to extend their implementation timeframes, and to reprogram funds from existing projects.

CBPFs have made a total allocation of $71 million to COVID-19 response as of 30 April, expected to target 13.9 million people. Twelve (out of 18) CBPFs have allocated funding for COVID-19 or are in the process of doing so – of these ten are granting funding directly to NGOs. An overwhelming majority of projects being considered by the CBPFs (81%) have been submitted by NGOs (164 out of 202 projects as of 30 April), showing the high level of engagement and buy-in from NGOs. It is expected that about half of the CPBFs allocations will benefit directly NGOs (30% to INGOs and 21% to national NGOs and Red Cross/ Red Crescent Societies). These numbers are preliminary and expected to evolve as allocation decisions and project selections are finalized. Many of the allocations made at the beginning of the COVID-19 emergency focused on the procurement of medical equipment and support to national authorities in detection and treatment, resulting in higher allocations to UN agencies, than typical for CBPFs. This was very much linked to the unique nature of the COVID-19 response and the initial/early focus on the bulk purchase of costly medical equipment and collaboration with health authorities.

For the countries with CBPFs, in line with agreed guidance, donors should be encouraged to ensure that at least 15% of the contributions for the response in those countries be programmed through the CBPFs. Based on current requirements for the 18 countries with CBPF, this would be equivalent to $2.49 billion. OCHA has also issued "flexibility guidance" for use of CBPF funding that allows for flexibility and fast-tracking of funds.

This is an excellent way to ensure that national NGOs receive funding (26% of allocations in 2019 were directly given to local NGOs) and international NGOs (which received a further 46% of allocated funding in 2019). As per the Grand Bargain, a global, aggregated target of at least 25% of humanitarian funding should go to local and national responders as directly as possible to improve outcomes for affected people and reduce transactional costs, by end 2020. OCHA has also put in place a set of "flexibility measures" for implementing partners in their use of CBPF funding, to allow for added flexibility and fast-tracking of funds.

Out of the $71 million released by CBPFs for the COVID-19 response, about half will be allocated directly to NGOs (30% to INGOs and 21% to national NGOs and Red Cross/ Red Crescent Societies). These numbers are preliminary (as of 30 April) and expected to evolve as allocation decisions and project selections are finalized. Many of the allocations made at the beginning of the COVID-19 emergency focused on the procurement of medical equipment and support to national authorities in detection

and treatment (e.g. Afghanistan, oPt, Sudan). This resulted in higher allocations than typical to UN agencies – which are better placed to undertake the bulk purchase of costly medical equipment and to work with health authorities in handling infectious diseases.

Flexible and fast-tracked funding has been provided for humanitarian response to the pandemic, supported by guidance developed by the IASC and aligned with the Grand Bargain principle of improving the effectiveness and efficiency of humanitarian action.[77] Many donors have heeded the call, and recipients are able to use the funding where and how it is most needed as the situation evolves. On their side, agencies have committed to more transparency on funds used for the GHRP and cascading more flexibility to their partners.

UN agencies are also taking action to enhance partnerships with NGOs including through greater flexibility and simplification of processes:

- **IOM** will increase funding to local partners while also encouraging NGOs to tap into more funds from the IOM Rapid Response Fund mechanisms grant facilities in places such as Ethiopia, South Sudan and Sudan. IOM has also initiated a set of additional steps to improve funding flexibility that will help ensure that NGO partners - local, national and international– can effectively respond to COVID-19 while continuing the critically important ongoing humanitarian work. IOM has put in place temporary measures to ensure fast-track, simplified and flexible funding arrangements that help NGO partners to focus on the situation on the ground and respond to evolving needs in a timely and effective manner.

- **UNFPA** has continued to provide more support and funding tools to NGOs, with a strong focus on localization. CERF allocation for COVID-19 response released early in April 2020 is playing a key role in enabling UNFPA to deliver against the commitments of the Grand Bargain on localization. In particular, it has enabled UNFPA to strengthen its partnership with local responders and served as a catalyst to enhance gender-based violence-sub-cluster coordination with all partners (notably national NGOs, government counterparts and INGOs) and strengthened capacity of implementing partners providing life-saving interventions.

- **UNHCR** has provided partners greater flexibility to make discretionary budget allocations; issued guidance that permits country operations to accelerate release of financial installments; allowed partners to charge the UNHCR projects for costs already incurred in respect of activities that will not be completed due to physical distancing measures and travel restrictions, reduced reporting requirements, and has issued instructions on how to accept documents digitally.

- **UNICEF** is making use of much needed simplification/flexibility in partnership processes to amend some of the 2,000 partnership agreements already active when the pandemic struck.

- **WFP** supply chain services directly serve the NGO community which faces increasing restrictions that inhibit their ability to mobilize, position, and transport supplies and staff due to the curtailment of commercial transport and cargo services. Historical trends show that on average 65% of passengers on UN humanitarian air services are I/NGOs. During the West Africa Ebola response – which put in place a supply chain backbone at a sub-regional level – approximately half of the volume of cargo transported was on behalf of UN Partners, the remainder was for NGOs, International Organizations, Red Cross/Red Crescent Societies, and governments. On 21 April 2020, a consortium of NGOs [Interaction and the Steering Committee for Humanitarian Response] warned that without the supply chain services laid out in the GHRP, NGOs will be forced to halt operations and possibly pull out of critical response locations. It should be noted that significant support to the COVID-19 response is being provided in terms of shared procurements services benefitting operational partners, including NGOs and partners. For example, to date UNICEF estimates that 72% of its response resources have been spent on procurement of specialized supplies in support of itself and partners.

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[77] https://interagencystandingcommittee.org/system/files/2020-03/IASC%20Interim%20Guidance%20on%20COVID-19%20-%20Key%20Messages%20on%20Flexible%20Funding.pdf

Funding requirements of NGOs

Long-term, flexible and unearmarked funding is critical so that humanitarian organizations – particularly international and national NGOs – can respond rapidly in new hotspots and focus fully on the COVID-19 response.[78]

Agencies are asked to ensure that this quality and unearmarked funding received for this response is reported as against the GHRP. As per the Grand Bargain, a global, aggregated target of at least 25% of humanitarian funding should go to local and national responders as directly as possible to improve outcomes for affected people and reduce transactional costs, by end 2020.

Country Based Pooled Funds have also introduced new flexibility measures to adapt to the challenges posed by COVID-19, as have several UN organizations (e.g. UNFPA, UNHCR and UNICEF). As in all humanitarian responses, it is important that funding is provided to agencies with capacity to respond. It is important that whenever appropriate share of the GHRP funding goes as directly as possible to frontline NGOs through Country-Based Pooled Funds, other mechanisms, and direct funding from donors to organizations. This is in addition to secondary granting through UN agencies. INGOs will also channel funds to national NGOs.

Under the OCHA-NGO Dialogue Platform, SCHR is exploring approaches that would allow donors to fund a central country pooled fund top-up which could provide flexible funding directly to NGOs through CBPFs in-country and cover requirements for flexible funding in countries included in the GHRP that do not currently have CBPFs.

A significant portion of the common logistical shared services will support NGO operations. Experience in existing operations shows that typically some 65% of UNHAS capacity is utilized by NGO partners while during the Ebola emergency up to half of the volume of shipments was for NGOs and Red Cross Red Crescent societies.[79] A minor share of the GHRP funding should be allocated to support training, capacity building and technical guidance, including through Sphere's global network and community of practice. This would have a significant multiplier effect on the quality of programmes as members and partners of the various quality assurance initiatives, such as Sphere in turn support and guide government agencies and thousands of local, national and regional organisations, networks and groups.

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[78] Current summary requirement for SCHR members as of April 24th is $1.902 billion to December 2020 ($1.084 billion when the separately appealed $818 million requirement for the International Red Cross Red Crescent Movement is taken out). This includes separate appeals by individual SCHR members and will also include funding obtained through national appeals such as the potential UK DEC appeal. This is provisionally divided 33% on Strategic Priority 1, 64% on Strategic Priority 2, and 3% on Strategic Priority 3. Much of this requirement is reflected in country level inputs to the GHRP update and thus deducted from the headline total. SCHR has also supported efforts to estimate a global NGO requirement including non-SCHR members, which estimates the total NGO requirement at $1.56 billion by end December 2020.

[79] As per WFP historical data.

ALEPPO, SYRIA
A girl collects a bread bag containing messages raising awareness on issues around COVID-19, in the al-Zebdieh neighbourhood of Aleppo, Syria. *UNICEF*

"A world free of COVID-19 requires the biggest public health effort in global history: data must be shared, resources mobilized and politics set aside.

We are in the fight of our lives.

We are in it together.

And we will come out of it stronger, together."

———

António Guterres,
Secretary-General, United Nations