GLOBAL HUMANITARIAN RESPONSE PLAN
COVID-19

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GHRP JULY UPDATE

Contents

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Front cover
Niger reported its first case of Covid-19 on March 19. Two months later, as of May 19th, the country has recorded 909 confirmed cases of coronavirus disease (COVID-19) and 55 reported deaths. Out of them, 714 people already recovered and 140 are currently under treatment.

UNICEF closely works with the Government and its partners to step up the response and prevent further proliferation of the COVID-19 virus in the country, already facing the consequences of multiple crisis including malnutrition, conflicts and natural disasters. *UNICEF/Juan Haro*

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Foreword by the Emergency Relief Coordinator

The pandemic and associated global recession are about to wreak havoc in fragile and low-income countries.

Unless we act now, we should be prepared for a series of human tragedies more brutal and destructive than any direct health impacts of the virus.

The response of wealthy nations – who have thrown out the rulebook to protect their people and economies – has been grossly inadequate. This inaction is dangerously short-sighted.

It will leave the virus free to circle round the globe, undo decades of development and create a generation's worth of tragic and exportable problems.

> "Without action, we'll see the first increase in global poverty since 1990 and 270 million people facing starvation by the end of the year."

Recent estimates suggest up to 6,000 children could die every day from preventable causes as a result of direct and indirect impacts of COVID-19.

Diverted health resources could mean the annual death toll from HIV, tuberculosis and malaria doubling. School closures will undermine productivity, reduce lifetime earnings, and widen inequalities.

Economic downturn, rising unemployment and reduced school attendance increase the likelihood of civil war, which drives famine and mass displacement.

It doesn't have to be like this. It can be fixed with money and leadership from the world's wealthier nations, and fresh thinking from the shareholders of international financial institutions and supporters of UN agencies, NGOs, and the Red Cross and Red Crescent movement.

We estimate the cost of protecting the poorest 10 per cent of the global population from the worst effects of the pandemic and global recession is US$90 billion – less than 1 per cent of the stimulus package wealthy countries have put in place to protect their own economies.

We know it can be done: after the financial crisis of 2008-2009, fundraising for UN-coordinated humanitarian appeals increased by more than 40 per cent the following year. This was an expression of solidarity but also of national interest. It makes economic sense to act early and generously, not wait until we hit rock bottom.

The unprecedented fiscal stimulus packages and social protection schemes enacted in the OECD economies are not an option for most developing countries. They just don't have the resources; they need our support.

The COVID-19 Global Humanitarian Response Plan is part of the solution. For $10.3 billion, it will support 63 vulnerable countries and cover the global transport system necessary to deliver the relief. This update includes a supplementary $300 million, beyond their country-level requirements, to bolster rapid response from NGOs, a new famine prevention envelope of $500 million, and a sharper focus on preventing gender-based violence.

I also want to call for support for other complementary initiatives to protect the most vulnerable people. These initiatives include the Red Cross and Red Crescent appeals, the Global Fund's programme to safeguard a decade of work to combat malaria, tuberculosis and HIV, and the Vaccine Alliance's (Gavi) work to keep future generations free from measles, polio and other vaccine-preventable diseases.

UN Women's Gender in Humanitarian Action programme is also crucial. With proper funding, it will support women and girls in 14 priority countries and increase women's leadership to protect those most at risk.

We face a massive problem. But it can be addressed with relatively little money and a modicum of imagination. Exceptional circumstances require exceptional measures, discarding some of the previous rules and approaches, just as many rich countries have done in their own countries to protect their own citizens.

This crisis – and the prospect of cascading crises down the road – forces us all to think out of our comfort zone. The stakes are high, and what we need to do has fundamentally changed.

Mark Lowcock
Emergency Relief Coordinator, United Nations

At a glance

REQUIREMENTS (US$)	FUNDING RECEIVED (US$)*	COUNTRIES
$10.3B	$1.64B	63

*As of 12 July. Funding does not reflect amounts received for new intersectoral plans. Refer to FTS for latests figures.

Since the launch of the Global Humanitarian Response Plan (GHRP) for COVID-19 on 25 March and its first update on 7 May, the pandemic has rapidly expanded in most of the 63 countries it includes. With many countries still in the early stages of their outbreak, heightened implementation of public health measures is critical to save lives and suppress transmission.

Over the past 3,5 months from end March to mid-July, the impacts of the pandemic on the lives and livelihoods of the most vulnerable people have worsened dramatically. Individuals and population groups who were already suffering from violence, stigma, discrimination and unequal access to basic services and living conditions, are bearing the brunt of this new crisis.

COVID-19 is deepening the hunger crisis in the world's hunger hotspots and creating new epicentres of hunger across the globe. The number of acutely food insecure people in countries affected by conflict, natural disaster or economic crises is predicted to increase from 149 million pre-COVID-19 to 270 million before the end of the year if assistance is not provided urgently. Recent estimates also suggest that up to 6,000 children could die every day from preventable causes over the next 6 months as a direct and indirect result of COVID-19 related disruptions in essential health and nutrition services.

Under the umbrella of the GHRP, Inter-Agency Standing Committee members and partners including FAO, IOM, UNDP, UNFPA, UN-Habitat, UNHCR, UNICEF, UNRWA, WFP, WHO, NGOs and the Red Cross and Red Crescent Movement have stepped up their response to address the most urgent humanitarian health, protection and socio-economic needs caused by the pandemic.

The GHRP is targeting nearly 250 million people with COVID-19 assistance. From the US$6.7 billion needed last May to implement this response, funding requirements have risen to **$10.26 billion**. The spread of the pandemic necessitates more intensive health prevention and treatment measures and increasing investments to maintain other essential health services. The deepening ripple effects of the pandemic are impacting all spheres of life and require substantially scaled up support to help the most vulnerable. The plan also includes a supplementary envelope of $300 million, beyond specific country requirements, to bolster a rapid and flexible NGO response, and a strategic envelope of $500 million to prevent famine from occurring in the most vulnerable countries.

One of the most nefarious consequences of the pandemic is the **rise of gender-based violence** (GBV). There has been a dramatic increase in reported cases of GBV and the number of calls to dedicated hotlines (60 to 770 per cent increase in different countries), while the provision of GBV services has regretfully been curtailed. UN Women estimates that globally in the past 12 months, 243 million women and girls aged 15–49 years were subjected to sexual and/or physical violence perpetrated by an intimate partner, while older women were also experiencing violence. Projections indicate that for every 3 months the lockdown measures continue, an additional 15 million cases of gender-based violence globally are expected.

GBV response services are facing major hurdles in their ability to reach survivors due to mobility restrictions and inadequate resources. The GBV response and funding allocation throughout the COVID pandemic have not been at the scale of the need. Across 40 reporting countries in the GHRP, 16 have reported significant interruptions in GBV services. While humanitarian actors have recognised the magnitude of the problem and advocated for greater priority to be given to awareness-raising and services for GBV survivors, long-standing neglect of the issue and insufficient resourcing continue to limit the ability of responders to prevent and mitigate the problem. Without targeted interventions,

COVID-19 will heighten pre-existing risks of GBV due to increased exposure to abusers at home, mobility restrictions, and heightened household tensions from health and economic shocks.

Recognizing GBV response as an essential protection activity and service in the COVID-19 national response plans is required to facilitate the movement of GBV service providers. GBV messaging also needs to be mainstreamed in key entry points such as hospitals and drugstores, especially during lockdown situations, and GBV risk mitigation needs to be integrated in the response implemented in other sectors and continue to adapt service provision to remote modalities. An immediate and substantial increase in the funding available to address issues of GBV is indispensable. As at end June, funding requirements for GBV in 16 countries with humanitarian response plans amounted to $487 million (including COVID-19 related-responses), of which only $34 million (7 per cent) were funded, leaving a gap of $453 million.

The **continuity of other essential health services** is also being interrupted. Facilities are overwhelmed with pandemic response, healthcare staff lack necessary personal protective equipment, and people cannot access services or may fear contagion. Across 26 countries that reported, 20 had facilities that showed a significant disruption in provision of maternal health care, with direct impacts on maternal and neonatal mortality and morbidity.

Several other especially vulnerable population groups hit hard with the effects of the pandemic are confronted with violence and abuse, such as **older people, LGBTI people, persons with disabilities, children and adolescents**, particularly girls, as a result of prolonged lockdowns, harsh implementation of emergency measures by authorities, or being associated with COVID-19. Their access to preventative measures and treatment for COVID-19 is more difficult, as well as for other essential health services they may require.

Mental health and psychosocial support services are more than ever required for these and other vulnerable groups who are discriminated against or losing their livelihoods. These services are often grossly insufficient and tend to be under-resourced. Integration of MHPSS in all sectors improves quality of humanitarian programming, enhances the coping of people with any crisis, speeds up the recovery and rebuilding of communities, and contributes to saving lives, improving wellbeing and reducing suffering.

The **cost of leaving the pandemic unmitigated** to people's lives and the economy is appalling. The COVID-19 virus could infect up to 640 million people and kill 1.67 million of the world's most vulnerable populations in 32 low-income countries. The direct medical costs of hospitalising 2.2 million patients in critical care beds could amount to an estimated $16.28 billion. At least 2 million preventable deaths could occur as a result of disrupted healthcare and resource diversion without appropriate mitigation.

The **socio-economic impact of the pandemic** is also becoming increasingly clear as domestic containment measures continue and economies are in deep recession. The cost of inaction against the public health, poverty, food security, education, economy, stability and conflict consequences will grow exponentially if the right combination of relief and recovery assistance, guided by human rights and the UN framework for the immediate socio-economic response to COVID-19, is not implemented quickly and at scale.

Inducing the first rise in **poverty** since 1990 and the first decline in global human development, the COVID-19 pandemic jeopardises gains in poverty reduction made over the past decade. At least 71 to 100 million could be pushed into extreme poverty under the $1.90 per day international poverty line. If no action is taken, these poverty traps are likely to become permanent due to the aggregate nature and sheer size of the shock. **The social economic impact of the pandemic takes a heavy toll on women and girls** in particular, as the vast majority of women's employment – 70 per cent – is in the informal economy with limited access to social protection, safety nets and fiscal stimulus, including women migrants and refugees.

Further, if left unaddressed, the large economic shocks induced by the COVID-19 pandemic are likely to exacerbate **drivers of conflict** in the medium term and generate even larger welfare losses as a result. The consequences would be huge as conflicts disproportionately affect vulnerable groups and drive 80 per cent of all humanitarian needs. A surge in conflict and violence would further undermine the response to COVID-19 and its worst effects on vulnerable populations.

School closures are likely to affect future earnings and human capital for students, increase educational and broader inequalities particularly for the poorest students, girls, and students with disabilities, and contribute to hunger and malnutrition from the suspension of school feeding

programmes. School closures also increase harmful practices such as child marriage and negatively affect the mental and psychosocial health of students. The most vulnerable students such as adolescent girls and young people with disabilities, might not ever return to school, jeopardizing their future and the future of their families.

Job losses, lack of access to markets and productive inputs (e.g. agricultural intrants) are affecting informal workers (with a large share of which are women and living in dense urban settlements), small-scale farmers, pastoralists and others dependent on an uncertain and meagre income in all of the countries included in this Plan. Many of these people were food-insecure before the pandemic due to insufficient income and limited food production.

The UN Secretary-General has warned of an **impending global food emergency** that could have long term impacts as COVID-19 challenges food systems, flattens the informal sector, and impacts economies – pushing millions more into extreme poverty and acute food and nutrition insecurity. . Every low or middle-income country faces this growing threat.

As food security worsens and access to health and nutrition services deteriorates, **malnutrition** is increasing particularly among population groups whose nutritional needs are higher such as pregnant and lactating women, women of reproductive age, adolescent girls, sick people, and older people. The number of severely malnourished children is projected to augment. Recent estimates indicate that in the absence of timely action the number of children under 5 with severe acute malnutrition could rise globally by about 15 per cent (7 million children) over the first 12 months of the pandemic. Certain areas in Africa may see up to 20-25 per cent increase.

A significant portion of the population is at immediate risk of COVID-19 simply because they lack **basic hand washing facilities**. Worldwide, three billion people – 40 per cent of the world's population – do not have a place in their homes to wash their hands with water and soap, including three quarters living in the poorest countries and amongst the most vulnerable such as children and families living in in informal settlements, migrant and refugee camps, or areas of active conflict situations.

Refugees, asylum seekers, IDPs and migrants find themselves at the intersection of many of the health and socio-economic problems caused by the pandemic. Due to their status, they face greater difficulty to access essential health and other services and are often excluded from national social protection mechanisms where these exist. Gender-based violence and food insecurity can be even worse in these population groups than in the host communities. Migrants also face increased protection risks when stranded at borders, placed in immigration detention or forcibly returned.

Limited capacities of health and social protection services before the crisis have constrained the ability of national governments to prevent, mitigate and respond to the health and socio-economic effects of COVID-19 for those most at risk. Restrictions on mobility imposed to contain the spread of the virus added to the pass-through effects of the global economic recession and compounded risks and shocks including conflict, civil violence and natural disasters, have aggravated the situation and further hampered access and delivery of humanitarian assistance and protection services.

Despite numerous challenges, humanitarian actors have adapted and ramped up the provision of essential health, food, nutrition, cash, water, hygiene and sanitation, livelihoods and shelter assistance to the most affected people, in coordination with and support of governments' own efforts. The success of these efforts must be attributed to UN agencies as well as to **national and international NGOs** who are playing an indispensable role in outreach and ensuring that no one is left behind.

Innovations and adaptations have been made to help comply with physical distancing requirements and address mobility constraints when distributing goods and cash, and when providing healthcare, nutrition, sexual and reproductive health, mental health and psychosocial support, and gender-based violence services. Digital technology and alternative means of communicating the direct and indirect risks of COVID-19 are being used. Increased efforts are being made to engage with diverse community and local actors to reach those most isolated with prevention and treatment messages on COVID-19 and assistance.

Significant challenges remain however to stem the spread of the pandemic in the most fragile contexts, many of which are affected by violence, armed conflict, floods, typhoons and desert locust infestation, among other scourges. **Funding for non-COVID-19 humanitarian responses** addressing these

shocks must be sustained and increased. Resources required for the pandemic must be in addition, and not in substitution of this funding.

This additional funding is required for all the components of the humanitarian response to COVID-19, including **funding for global services** to enable the transportation of humanitarian personnel and cargo, and for medical evacuation services to allow for humanitarian actors to 'stay and deliver'. Resources should also go to **gender-based violence, sexual and reproductive health,** and **mental health and psychosocial support services**, which are amongst the least funded aspects of the current COVID-19 response.

Adequate funding for **famine prevention** must also be urgently allocated to avoid a major catastrophe. Acute food insecurity and famine can and must be prevented. This requires scaling up interventions reaching the most food insecure populations. Crucially, it also requires supply chains to function across borders, and markets to be functioning within countries, including green corridors for food items and for agriculture and humanitarian aid. Prepositioning of food and cash ready for delivery despite mobility constraints is also essential.

Donors and the UN must ensure a larger share of the GHRP funding goes to NGOs directly. This can be done by channeling donor funds to NGOs, NGO consortia and NGO-managed pooled funds, as well as by using country-based pooled funds and flexible funding. This will enable an expansion of humanitarian interventions particularly for the hardest to reach population groups, as well as ensure that interventions also reflect the views and situations of affected populations. The restrictions on movement of international staff imposed by the pandemic also means local actors are best placed to ensure the continuity of essential services at the community level.

Existing coordination mechanisms have been leveraged to better link the humanitarian response with development actors including international financing institutions and private foundations. In many contexts, data from humanitarian needs assessments has been fed into the Socio-Economic Impact Assessments which are driving the socio-economic response plans. Funding for the **GHRP** should therefore be seen **as an essential complement to recovery and 'building back better' efforts.**

The OECD and the G20 countries have responded with a large stimulus package estimated at over $11 trillion. In comparison, the cost of protecting the most vulnerable 10 per cent of the world from the worst impacts of COVID-19 today is estimated at an additional $90 billion – less than 1 per cent of the current stimulus package. **It is better, cheaper and more dignified to frontload responses to the pandemic and the secondary impacts**. Waiting until the full impacts are visible is a more expensive proposition as delaying action not only shifts the burden of payment to the future, but the price of the response will also exponentially increase. Acting now to mitigate the impact saves money in the long term.

Containing COVID-19 in poorer countries is in the national interests of richer countries. However, the economic toll of lockdown measures in low-income countries where the majority of the working population depends on the informal sector is unbearable. Low-income countries need the fiscal space to build up their health systems and capacities, improve and expand their social safety nets, and implement urgent economic stimulus in packages, particularly for small and medium enterprises. Multilateral collaboration is also essential for increasing the limited global supply and access to vital medical and testing equipment.

Financial requirements (US$)

COVID-19 REQUIREMENTS

REQUIREMENTS
$10.3B

OF WHICH:
HEALTH: $2.86 B
NON-HEALTH: $7.44 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS
$40B*

OF WHICH:
COVID-19: $10.3 B
NON-COVID-19: $29.4 B

INTER-AGENCY APPEAL		ADJUSTED NON-COVID-19	COVID-19 REQUIREMENTS: HEALTH	NON-HEALTH	COVID-19 TOTAL	TOTAL HUMANITARIAN COVID + NON-COVID
Afghanistan	HRP	**735.4 M**	107.6 M	288.1 M	395.7 M	**1.1 B**
Burkina Faso	HRP	**318.4 M**	17.1 M	88.8 M	105.9 M	**424.3 M**
Burundi	HRP	**159.8 M**		38.0 M	38.0 M	**197.9 M**
Cameroon	HRP	**309.1 M**	18.2 M	63.5 M	81.7 M	**390.9 M**
CAR	HRP	**400.8 M**	7.7 M	145.2 M	152.8 M	**553.6 M**
Chad	HRP	**540.5 M**	38.1 M	86.1 M	124.2 M	**664.6 M**
Colombia	HRP	**209.7 M**	140.0 M	189.4 M	329.4 M	**539.1 M**
DRC	HRP	**1.79 B**	122.1 M	152.4 M	274.5 M	**2.1 B**
Ethiopia	HRP	**1.14 B**	100.0 M	406.0 M	506.0 M	**1.7 B**
Haiti	HRP	**327.6 M**	105.0 M	39.3 M	144.4 M	**472.0 M**
Iraq	HRP	**397.4 M**	65.4 M	199.4 M	264.8 M	**662.2 M**
Libya	HRP	**83.2 M**	16.7 M	29.9 M	46.7 M	**129.8 M**
Mali	HRP	**398.9 M**	2.1 M	73.3 M	75.4 M	**474.3 M**
Myanmar	HRP	**216.5 M**	21.6 M	37.2 M	58.8 M	**275.3 M**
Niger	HRP	**433.8 M**	15.7 M	66.7 M	82.3 M	**516.1 M**
Nigeria	HRP	**838.0 M**	85.3 M	157.1 M	242.4 M	**1.1 B**
oPt	HRP	**348.0 M**	19.1 M	23.3 M	42.4 M	**390.4 M**
Somalia	HRP	**784.3 M**	81.0 M	144.6 M	225.6 M	**1.0 B**
South Sudan	HRP	**1.5 B**	91.4 M	296.0 M	387.3 M	**1.9 B**
Sudan	HRP	**1.3 B**	128.0 M	155.6 M	283.5 M	**1.6 B**
Syria	HRP	**3.4 B**	157.5 M	226.7 M	384.2 M	**3.8 B**
Ukraine	HRP	**157.8 M**	27.6 M	19.3 M	46.9 M	**204.7 M**
Venezuela	HRP	**674.6 M**	50.4 M	37.5 M	87.9 M	**762.5 M**
Yemen	HRP	**3.0 B**	304.6 M	81.1 M	385.7 M	**3.4 B**
Zimbabwe	HRP	**715.8 M**	24.8 M	60.1 M	85.0 M	**800.8 M**
Burundi *Regional*	RRP	**209.9 M**	36.5 M	29.0 M	65.4 M	**275.4 M**
DRC *Regional*	RRP	**483.0 M**	94.7 M	61.0 M	155.7 M	**638.7 M**
Nigeria *Regional*	RRP					
South Sudan *Regional*	RRP	**1.2 B**	51.4 M	77.4 M	128.8 M	**1.3 B**
Syria *Regional*	RRP	**5.2 B**	87.4 M	670.9 M	758.3 M	**6.0 B**
Venezuela *Regional*	RMRP	**968.8 M**	132.4 M	306.4 M	438.8 M	**1.4 B**
Horn of Africa and Yemen	MRP	**45.0 M**	20.9 M	10.6 M	31.5 M	**76.5 M**
Rohingya	JRP	**876.7 M**	86.5 M	95.0 M	181.4 M	**1.1 B**
Benin	Other		10.9 M	7.0 M	17.9 M	**17.9 M**
DPRK	Other	**107.0 M**	20.0 M	19.7 M	39.7 M	**146.7 M**
Iran	Other		99.6 M	17.7 M	117.3 M	**117.3 M**
Lebanon	Other		96.3 M	40.2 M	136.5 M	**136.5 M**
Liberia	Other		17.5 M	39.5 M	57.0 M	**57.0 M**
Mozambique	Other		16.0 M	52.1 M	68.1 M	**68.1 M**
Pakistan	Other		37.4 M	108.4 M	145.8 M	**145.8 M**
Philippines	Other		28.9 M	92.9 M	121.8 M	**121.8 M**
Sierra Leone	Other		18.3 M	44.6 M	62.9 M	**62.9 M**
Togo	Other		2.3 M	17.43 M	19.8 M	**19.8 M**

Percentage of funding received

Financial requirements (US$) continued

COVID-19 REQUIREMENTS

REQUIREMENTS
$10.3B

OF WHICH:

HEALTH: $2.86 B
NON-HEALTH: $7.44 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS
$40B*

OF WHICH:

COVID-19: $10.3 B
NON-COVID-19: $29.4 B

INTER-AGENCY APPEAL		ADJUSTED NON-COVID-19	COVID-19 REQUIREMENTS: HEALTH	NON-HEALTH	COVID-19 TOTAL	TOTAL HUMANITARIAN COVID + NON-COVID
Bangladesh	Intersectoral		103.8 M	102.1 M	205.9 M	**205.9 M**
Djibouti	Intersectoral		11.1 M	18.9 M	30.0 M	**30.0 M**
Ecuador	Intersectoral		10.3 M	36.2 M	46.4 M	**46.4 M**
Jordan	Intersectoral					
Kenya	Intersectoral		56.5 M	198.4 M	254.9 M	**254.9 M**
Republic of Congo	Intersectoral		0.6 M	11.3 M	12.0 M	**12.0 M**
Tanzania	Intersectoral		46.1 M	112.8 M	158.9 M	**158.9 M**
Uganda	Intersectoral		71.2 M	129.0 M	200.2 M	**200.2 M**
Zambia	Intersectoral		20.1 M	105.5 M	125.6 M	**125.6 M**
Global Support Services	Global				1.0 B	**1.0 B**
Famine prevention	Global				500.0 M	**500.0 M**
NGOs - supplemental envelope	Global				300.0 M	**300.0 M**
Total		29.4 B	2.9 B	5.5 B	10.3 B	40 B

Percentage of funding received

*The total for GHRP countries (including COVID-19 plus non-COVID-19) is $39.7 billion. Total humanitarian requirements, including flash appeals covered under the Global Humanitarian Overview, is $40 billion. Refer to FTS for latest figures.

Funding requirement updated on 12 July 2020. The figures may change as the situation evolves and country offices review their projects and ongoing activities. For the most up-to-date figures, please refer to hpc.tools or fts.unocha.org.

The requirements for the Nigeria RRP are included in the Cameroon, Chad and Niger HRPs. Please refer to country and regional pages for more details.

The requirements for the Horn of Africa and Yemen MRP amount do not show amounts included in the Somalia and Ethiopia country plans. Please refer to the Horn of Africa and Yemen MRP plan page for further information.

The requirements for the Kenya and Uganda intersectoral plans do not include refugee multi-sector responses to avoid overlap with regional plans. Please see country page for full requirements and more information

The requirements for Jordan are under development and will be uploaded directly to FTS in mid-July, once consultations conclude.

Key achievements

HEALTH

Over 123,430 tests delivered to 18 Humanitarian Response Plan (HRP) countries, with an additional 1.06 million planned for 23 HRP countries.

4.7 million pieces of Personal Protective Equipment (PPE) delivered to 16 HRP countries and 1.2 million PPE to 11 Refugee Response Plan countries.

More than **18 million people** have been provided with essential health care services.

More than **9.5 million people** (including children, parents and primary caregivers) provided with mental health and psychosocial support services.

WATER SANITATION AND HYGIENE

At least **36 million people reached with critical WASH supplies** (including hygiene items) and services.

FOOD AND AGRICULTURE

Significant **scale-up of seed and agricultural input provision** ahead of planting seasons across GHRP countries to assist millions of people.

Food assistance scaled-up in 14 countries until persons of concern can be transitioned to existing social protection programmes.

EDUCATION

Approximately 93.6 million children and youth supported with distance/home-based learning in GHRP countries.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT

In excess of 1 billion people across 56 countries reached with COVID-19 messaging.

PROTECTION

More than 2.8 million people accessed protection services.

Over 23 million refugees, IDPs and migrants received COVID-19 assistance.

Almost 5 million women accessed Sexual Reproductive Health services in 25 GHRP countries.

Gender Based Violence services were maintained or expanded in more than 25 countries.

LOGISTICS

Common services supported **375 organizations**.

As of 29 June, the **passenger transport service was used by about 5,300 passengers** reaching 43 destinations.

Eight humanitarian response hubs in Belgium, UAE, China, Ethiopia, Ghana, Malaysia, Panama and South Africa were established to facilitate cargo movement to transport essential assistance including test kits.

SOCIAL PROTECTION

More than 5.7 million households assisted through social protection systems in a number GHRP countries.

DUTY OF CARE

COVID-19 MEDEVACs organized and arranged by a dedicated 24/7 UN MEDEVAC Cell. As of end June, **sixteen medical air evacuations were carried out**.

COVID-19 RESPONSE

SEE MORE RESPONSE ACHIEVEMENTS ON: WWW.UNOCHA.ORG

The achievements shown above are a non-exhaustive selection of humanitarian activities conducted since the launch of the GHRP. Further achievements will be presented in the next GHRP information updates and on www.unocha.org

“Over the last 3 months, the UN has mobilized to save lives, control transmission, and ease the economic fallout of COVID-19.

We will continue to fight the pandemic, with unity and solidarity.”

—

António Guterres
Secretary-General, United Nations

NIAMEY, NIGER

On 26 May 2020, Rafatou holds her son while waiting for him to be vaccinated, at Gamkalé health centre in Niamey, Niger. “Although I am still a little afraid to come to the centre, today I have come to vaccinate my son. I know it is important and I do not want him to miss [being vaccinated].” *UNICEF/ Juan Haro*

Introduction

The COVID-19 pandemic is a human crisis of proportions without precedent in the past eight decades. It encapsulates at once health, economic, human rights and social crises, with dire consequences for people and societies, particularly those already impacted by humanitarian crises. No country has been spared by the pandemic. People already in vulnerable situations or discriminated against their gender, age, disability, displacement status, sexual orientation and who are stigmatized and marginalised are suffering disproportionate impacts.

The Global Humanitarian Response Plan (GHRP) is the 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 humanitarian disaster. It aggregates relevant COVID-19 appeals from FAO, IOM, UNDP, UNFPA, UN-Habitat, UNHCR, UNICEF, UNRWA, WFP as well as WHO's Strategic Preparedness and Response Plan, and it complements other plans such as those developed by the International Red Cross and Red Crescent Movement. It also includes inputs from NGOs and NGO consortiums and seeks to convey local actors' perspectives and roles in the response.

The GHRP was launched on 25 March 2020 and first updated on 7 May. This document is the second update of the Plan based on country reports complemented by headquarters' perspective. From there, monthly progress reports on the GHRP will be issued in August, September and October 2020, complementing agencies' own reporting.

Part I confirms the 63 countries included in the Plan and clarifies the scope of the document, which covers the humanitarian needs and response to the COVID-19 pandemic without providing details on the broader humanitarian needs and response due to preexisting or concurrent shocks and stresses.

Part II provides details on the humanitarian situation and needs caused by the pandemic at macroeconomic and country levels, as well as for specific vulnerable groups with an emphasis on women and girls, older persons, children, persons with disability, IDPs, refugees, asylum seekers, migrants, and host communities who face the brunt of the health and socio-economic effects of the pandemic. While the broader humanitarian situation is not described, it is clear that the humanitarian needs due to COVID-19 cannot be dissociated from needs resulting from previous or new crises, given the spread and duration of the pandemic. The humanitarian response to the pandemic must therefore fully integrate the response to humanitarian needs resulting from other crises.

At the same time, the boundaries of the humanitarian response to the pandemic must be clear. Many identified needs arise from structural and deep economic, institutional, political, legal and social issues. These longer-term issues cannot be ignored as they contribute to the deterioration of people's lives and livelihoods and the persistence of humanitarian needs, but they cannot be addressed through humanitarian interventions. They require strong advocacy and cooperation with a range of stakeholders (governments, development actors, international financing institutions, private sector etc.) to implement complementary and longer-term programmes that can address needs sustainably and decrease the burden on the humanitarian system.

Part III illustrates the achievements and challenges of the collective humanitarian response to COVID-19 according to the three interrelated strategic priorities defined in the GHRP.

- 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, internally displaced people, migrants and host communities particularly vulnerable to the pandemic.

Part IV provides an update on funding received and remaining gaps, as compared to the early May estimated GHRP requirements of US$6.7 billion needed to address the additional humanitarian needs generated by the COVID-19 pandemic in the 63 countries included, on top of the funding needed for ongoing humanitarian response plans and preparedness to other disasters beyond COVID-19.

Country information is available in **Annex I**. Details on agency responses are provided in **Annex II.**

1.0

Objectives, scope and countries included

SYRIA

On 20 April 2020 in Al-Hol camp in northeastern Syrian Arab Republic, community volunteers lead a session outlining measures to prevent the spread of COVID-19, taking into consideration the importance of physical distancing. *UNICEF/Souleiman*

1.1

Objectives of the July update of the GHRP

The objectives of this update of the GHRP mirror those of the first, with an increased emphasis on changes at country level and response progress monitoring. Specifically, this update aims to:

- Reconfirm geographic coverage
- Reflect changes in the humanitarian situation and needs since the issuance of the previous update of the GHRP on 7 May.
- Report on progress towards achieving the strategic priorities and specific objectives at country and global levels and operational challenges.
- Reassert principles of response implementation, adaptation of humanitarian programmes and partnership.
- Acknowledge funding received and gaps, while reasserting the critical importance of funding the existing humanitarian response plans.

1.2

Scope of the third GHRP update

This update of the GHRP does not repeat the information provided in the previous one released on 7 May, nor in the original GHRP which remains the reference framework that guides the strategic approach to the pandemic and adheres to clear principles of humanitarian response implementation. The focus of the current update is on changes in the situation and needs since May, on the operational results already achieved, and on challenges faced in the countries included in the Plan (see 1.3 below).

The focus of the GHRP remains limited to the immediate additional humanitarian needs caused by the pandemic and related short-term responses and does not describe the whole humanitarian situation, needs and response to other shocks and stresses. This should not be interpreted, however, as minimising the scale and severity of humanitarian needs due to previous or new crises compounded by the COVID-19 outbreak.

The urgency to address these preexisting needs remains if we are to prevent further deterioration of the humanitarian situation, contribute to preparedness and resilience to other shocks, and protect development gains.

More country and agency details can be found in annexes I and II and in revised humanitarian plans issued at the country level that also capture broader humanitarian needs and response, including those pre-existing and those resulting from the pandemic.

1.3

Countries included in the July update of the GHRP

Worldwide the scale, speed of expansion, severity/mortality, and duration of the COVID-19 outbreak continue to vary across countries according to the timeliness and effectiveness of prevention-and-response measures, and capacities of the health system. Socio-economic and political effects are pervasive but also differ depending on countries' ability to implement social protection and other measures to alleviate losses of income, access to essential goods and services, to advance gender equality and to respect and prevent the violation of human rights.

The initial GHRP launched on 25 March included all countries with ongoing Humanitarian Response Plans (HRPs), countries that are part of 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) due to prevailing humanitarian needs and low pre-existing national response capacity. Iran was also added given the scale and severity of the outbreak and a Government request for international assistance.

In the 7 May update of the GHRP, an additional nine countries plus one country contained in the Regional Migrant Response Plan (RMRP) for the Horn of Africa and Yemen, were included, based on the impact of the outbreak on affected people's ability to meet their essential needs, consideration of other shocks and stresses (e.g. food insecurity, insecurity, population displacement, other public health emergencies etc.), the capacity of the Government to respond, and the possibility to benefit from other sources of assistance from development plans and funding.

For this next update of the GHRP, the Inter-Agency Standing Committee (IASC) decided not to include additional countries given the scale of the humanitarian response already ongoing, realistic operational capacities, and other plans progressively implemented, notably by development actors. However, the humanitarian components of existing intersectoral COVID-19 response plans in any of the 63 countries have now been included to the fullest extent possible to ensure the most coherent view of current and estimated humanitarian requirements across the countries listed in the Plan. Concretely, this means that stand-alone, intersectoral plans for Bangladesh, Djibouti, Ecuador, Jordan, Kenya, Republic of the Congo, Tanzania, Uganda and Zambia are now reflected in the document.

The list of all **countries included in the GHRP** since 25 March 2020 is shown below:

Countries included in the GHRP in March

- **Countries with HRPs**: Afghanistan, Burkina Faso, Burundi, Cameroon, CAR, Chad, Colombia, DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, 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 (JRP), DPR Korea and Iran.

Countries that were added as part of the May update of the GHRP

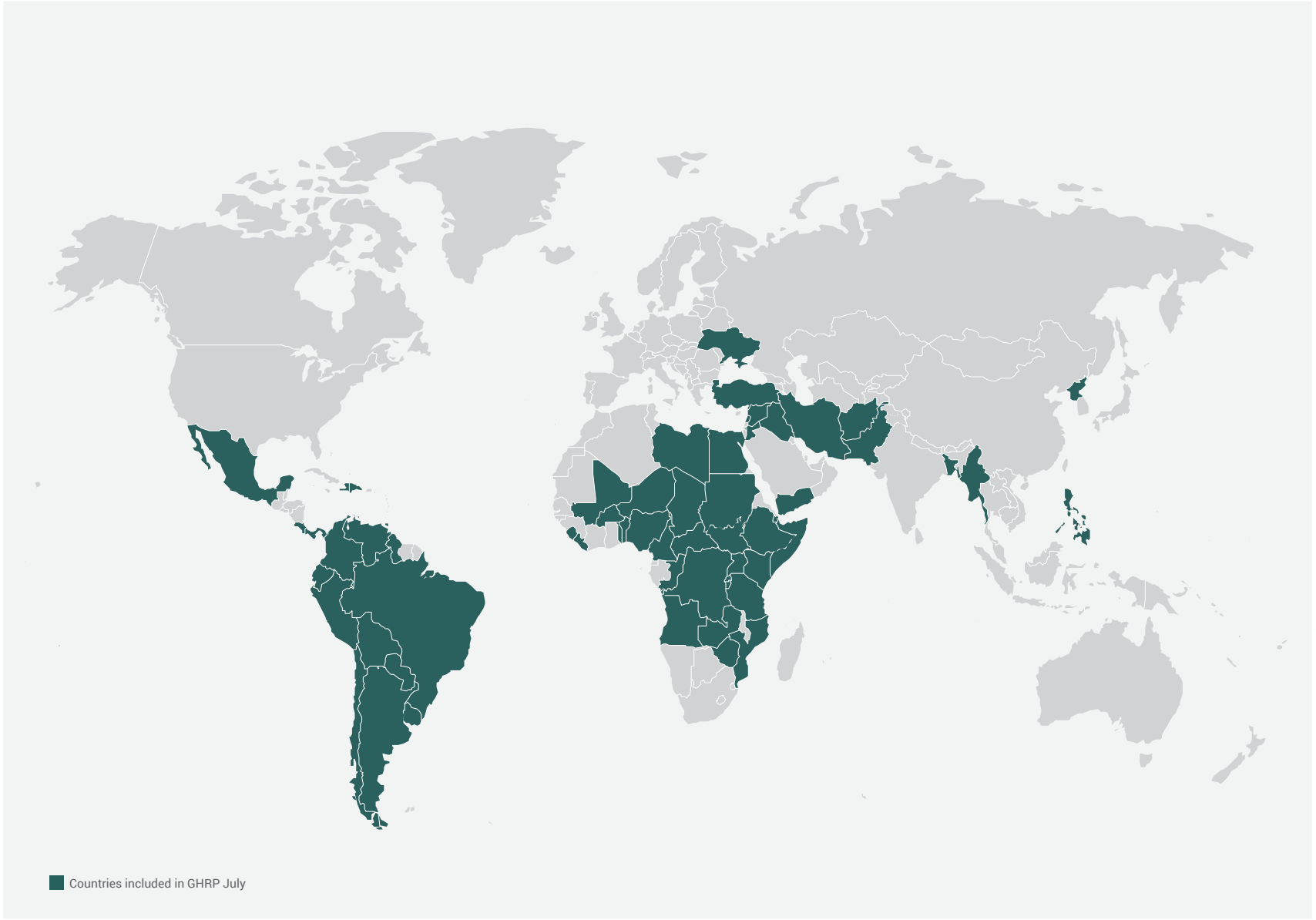
Benin, Djibouti (part of the RMRP[1]), **Liberia, Lebanon** (also part of the 3RP for Syria), **Mozambique, Pakistan, the Philippines, Sierra Leone, Togo** and **Zimbabwe**.

In addition, the following **countries are in the 'at-risk and to watch' list** and warrant continuous attention in the coming months due to the evolution of the pandemic, vulnerabilities linked to the demographic and economic profile of the country, and capacities of national institutions to address the health and socio-economic impact of the crisis: Côte d'Ivoire, Ecuador, Guinea, Indonesia, Malawi, Nepal, Northern Triangle of Central America (El Salvador, Guatemala and Honduras), Papua New Guinea, and Small Island Developing States in the Caribbean and the Pacific[2].

1 Ethiopia, Somalia and Yemen are also part of the RMRP for the Horn of Africa but already included in the GHRP as they have ongoing HRPs.

2 UNHCR budget of US$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: July update



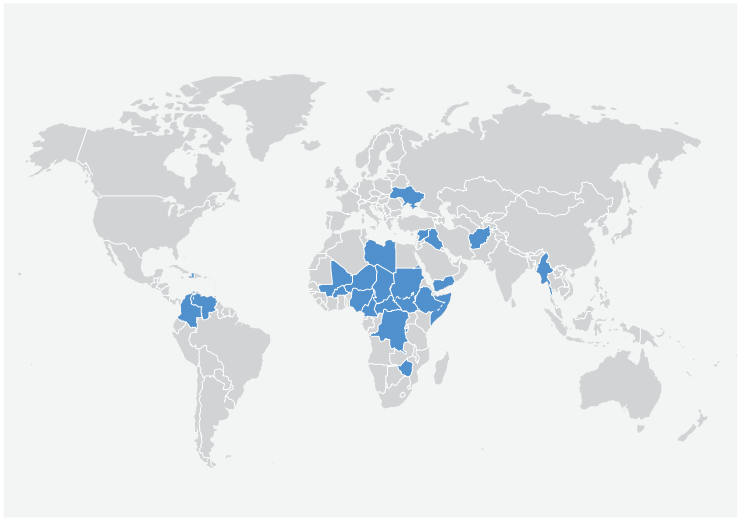
NUMBER OF COUNTRIES
GHRP JULY

63

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

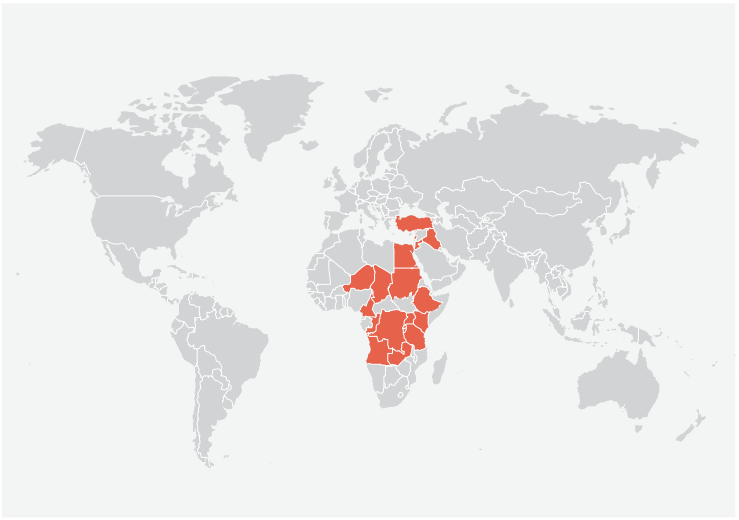
GHRP countries: per type of humanitarian appeal



HUMANITARIAN RESPONSE PLANS (HRP)

25

Afghanistan, Burkina Faso, Burundi, Cameroon, CAR, Chad, Colombia, DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, oPt, Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela, Yemen, Zimbabwe



REGIONAL REFUGEE RESPONSE PLANS (RRP)

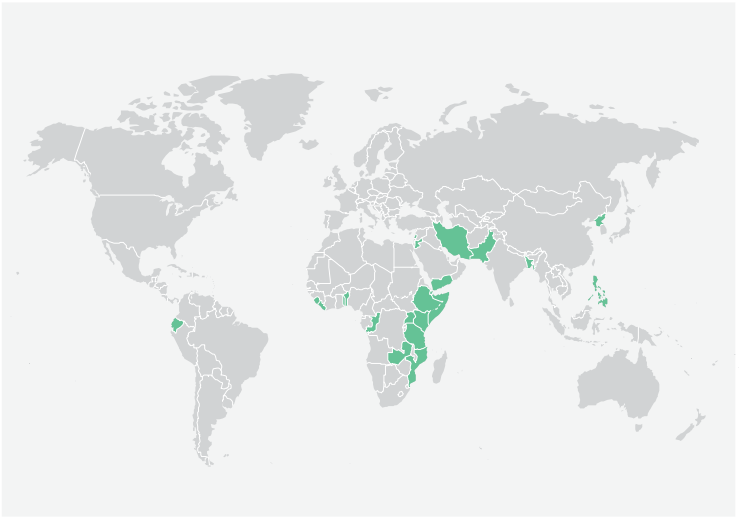
19

Angola, Burundi, Cameroon, Chad, Congo, DRC, Egypt, Ethiopia, Iraq, Jordan, Kenya, Lebanon, Niger, Rwanda, Sudan, United Rep. of Tanzania, Turkey, Uganda, Zambia

REGIONAL REFUGEE AND MIGRANT RESPONSE PLANS (RMRP)

15

Argentina, Aruba* Bolivia, Brazil, Costa Rica, Curaçao*, Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, Uruguay



OTHER APPEALS

22

Bangladesh (JRP), Benin, Congo, Djibouti (MRP), DPR Korea, Ecuador, Ethiopia (MRP), Iran, Jordan, Kenya, Lebanon, Liberia, Mozambique, Pakistan, Philippines, Sierra Leone, Somalia (MRP), Togo, Uganda, United Rep. of Tanzania, Yemen (MRP), Zambia

Note: the total of the numbers of countries by appeal types shown here is greater than the number of countries included in the GHRP (63) as some countries have more than one appeal. **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).

1.4

Forward-looking risk analysis approaches

Efforts have continued to adjust or develop models and scenarios to project the evolution of the pandemic and its direct health and indirect socio-economic impacts, in order to be better prepared by adapting the response and triggering anticipatory action. A few of these efforts are summarised below acknowledging that many more models and scenarios than possible to represent here have been developed including by agencies and academia according to their areas of expertise.

To guide countries on the use of models developed by different entities, WHO along with partners formed the COVID-19 Multi-Model Comparison Collaboration to present the strengths and caveats of existing COVID19 models and seek to improve current models particularly for low and middle-income countries. Models that clearly articulate their assumptions and that offer multiple scenarios can provide a useful view on the potential disease trajectory and the impact of different interventions. Models are ultimately supporting tools, not suited as a direct basis for public health policy development.

None of the models below are meant to represent a blueprint for the GHRP. A range of organisations and academia are developing other projections. The aim is only to illustrate some models that can be of use to guide the humanitarian response and priorities for COVID-19.

OCHA in collaboration with experts and academia worked on three country-level risk indexes to capture health vulnerability and risk, economic risk and compound risk to the pandemic[3]:

- The **COVID-19 composite Vulnerability and Risk Index** combines indicators on country susceptibility and vulnerability to the pandemic, and capacity to respond with influencing factors. The results help identify countries most susceptible and vulnerable to COVID-19 for example due to the population structure, prevalence of comorbidities or lack of handwashing facilities.
- The **COVID-19 composite Economic Risk Index** identifies the various country-level vulnerabilities and pathways of the economic impact of COVID, including dependence on remittances, tourism, food imports and primary commodity exports, alongside foreign currency reserves and level of indebtedness. The outputs support decision-making on country prioritisation based on economic consequences.
- The **COVID-19 Compound Risk Index** combines epidemiological and economic vulnerabilities and their impacts, together with compounding factors and access to international finance. The outputs contribute to a better understanding of the multifaceted dimensions of the pandemic risk, to inform decisions on anticipatory action and crisis response. It supports the identification of countries most at-risk, enhances the understanding of how risks compound and interact amongst each other, and the associated factors that response and financing should target at macro level.

The OCHA-managed Centre for Humanitarian Data[4] has established a partnership with the Johns Hopkins University Applied Physics Laboratory to develop a **COVID-19 model** which will provide projections and insights related to:

- The scale of the crisis (total number of cases, hospitalizations and deaths) at the sub-national level and in specific locations such as refugee and internal displacement camps.
- The duration of the crisis in a specific location, including the time when the peak is going to be reached and the expected rate of decrease/ increase of the number of cases and deaths.

3 Contact: OCHA Humanitarian Financing Strategy and Analysis Unit (ocha-hfrmd-hfsa@un.org).

4 https://centre.humdata.org/

- How different response interventions are expected to impact the epidemic curve

This model is being developed in collaboration with WHO and modeling and subject matter experts to ensure that its outputs are operationally useful.

The **INFORM**[5] **COVID-19 Risk Index** is based in part on the work already done to incorporate epidemic risk into the INFORM Risk Index. It prioritises countries by their risk of health and humanitarian impacts resulting from COVID-19 in the case of community transmission of the disease in a country. Its outputs have been used by donors, development and humanitarian partners to support initial identification and prioritisation of countries for additional support.

The reliance of INFORM COVID-19 Risk Index on structural factors that existed before the start of the pandemic limits its usefulness for monitoring changing health and humanitarian risks as the situation evolves. An INFORM COVID-19 Warning product is under development to allow users to monitor how risks of health and humanitarian impacts are changing dynamically. As a result, it will be more suited to support decisions on ongoing response and preparedness.

The World Bank has also projected the macroeconomic impact of the pandemic on global and regional growth (see Box, Part II). This economic model can help shape the public health and social measures instigated by governments, and the careful calibration needed to alleviate the adverse impact of the pandemic on the economy.

5 INFORM is a collaboration of the Inter-Agency Standing Committee Reference Group on Risk, Early Warning and Preparedness and the European Commission. The European Commission Joint Research Center is the technical lead of INFORM.

“This pandemic is unlike anything we have dealt with in our lifetime. Extraordinary measures are needed. Our response must be proportionate to the scale of the problem we face.”

—

Mark Lowcock
UN Under- Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator

COX’S BAZAR, BANGLADESH

On 20 May Cyclone Amphan made landfall in Bangladesh heavily impacting 19 districts with more than 2.4 million people and 500,000 livestock evacuated to 15,000 cyclone shelters by the Government of Bangladesh. Bangladesh is facing a growing number of COVID-19 cases and the impact threatens to reverse development gains made over the past five decades. *WFP/Nihab Rahman*

2.0

Humanitarian situation and needs analysis

HASSAKEH, SYRIA

On 16 April 2020, UNICEF-supported volunteers speak with a family about preventive measures to stem the spread of the novel coronavirus that causes COVID-19, in Hassakeh, Syrian Arab Republic. *UNICEF/Souleiman*

2.1

Evolution on the public health impact of COVID-19

Evolution of health effects on people

COVID-19 remains a grave public health emergency of global concern. Since the last GHRP update early May, the incidence of COVID-19 has continued to accelerate. By the end of June 2020, global counts exceeded 11.6 million confirmed cases from 215 countries, territories and areas, including close to 540,000 deaths, more than tripling over the past 2 months. As of 8 July, the 63 countries included in the GHRP accounted for about a third (n=4,151,897, 36 per cent) of cases and deaths (n=165,270 31 per cent) of deaths. Outside of European and Western Pacific GHRP countries, the incidence of new cases continues to accelerate, most notably in South and Central American, and Eastern Mediterranean regions (Figure A)[6]. GHRP-included countries within the Americas account for 70 per cent of cases and 77 per cent of deaths. All but three GHRP countries report ongoing local transmission, self-assessing their transmission classification[7] status as: ongoing community transmission (39 countries), clusters of cases (16 countries) or sporadic cases (5 countries) (Figure B and Table D)[8].

Strengthened COVID-19 surveillance and response capacities have contributed to increased detection of cases within countries included in the GHRP. While a degree of underestimation is represented in all figures, these provide an indication of underlying epidemiological trends. In vulnerable and fragile settings, greater emphasis is and should continue to be placed on early warning and detection of clusters for response[9], as opposed to comprehensive testing of every case. Absolute counts of confirmed COVID-19 cases and deaths must be interpreted with this consideration in mind.

Within most countries included in the GHRP, the observed acceleration in new case incidence is expected to continue in the coming months, with uncertainty as to when the peak incidence may be reached or the respective trajectories thereafter. Several countries that had successfully reduced transmission rates, are now experiencing sustained (relatively high) incidence, multimodal epidemics, and continued detection of clusters of cases in vulnerable population groups. With the gradual easing of more stringent public health and social measures, all countries remain at high risk of resurgence if proven control measures are relaxed too quickly or in other cases not strengthened

The upcoming southern hemisphere influenza season is anticipated to add an additional burden and further stretch fragile clinical and public health resources, necessitating preventative steps. WHO has alerted countries to maintain vigilance and prepare for the upcoming influenza season, strengthen influenza surveillance mechanisms and undertake preventive vaccination programmes.

COVID-19 cases have increased in recent weeks in some conflicts and hard-to-reach areas as well as in refugee camps and camp-like settings, Predictions for areas where physical distancing is difficult to apply and water, hygiene, sanitation and health services are scarce are particularly bleak. Furthermore, in a number of countries affected by humanitarian crises government restrictions are being relaxed despite rising cases.

6 WHO coronavirus disease (COVID-19) dashboard. Geneva: World Health Organization, 2020. Available online: https://covid19.who.int/

7 Coronavirus disease (COVID-19) technical guidance: Surveillance and case definitions. Geneva: World Health Organization, 2020. Available online: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definition

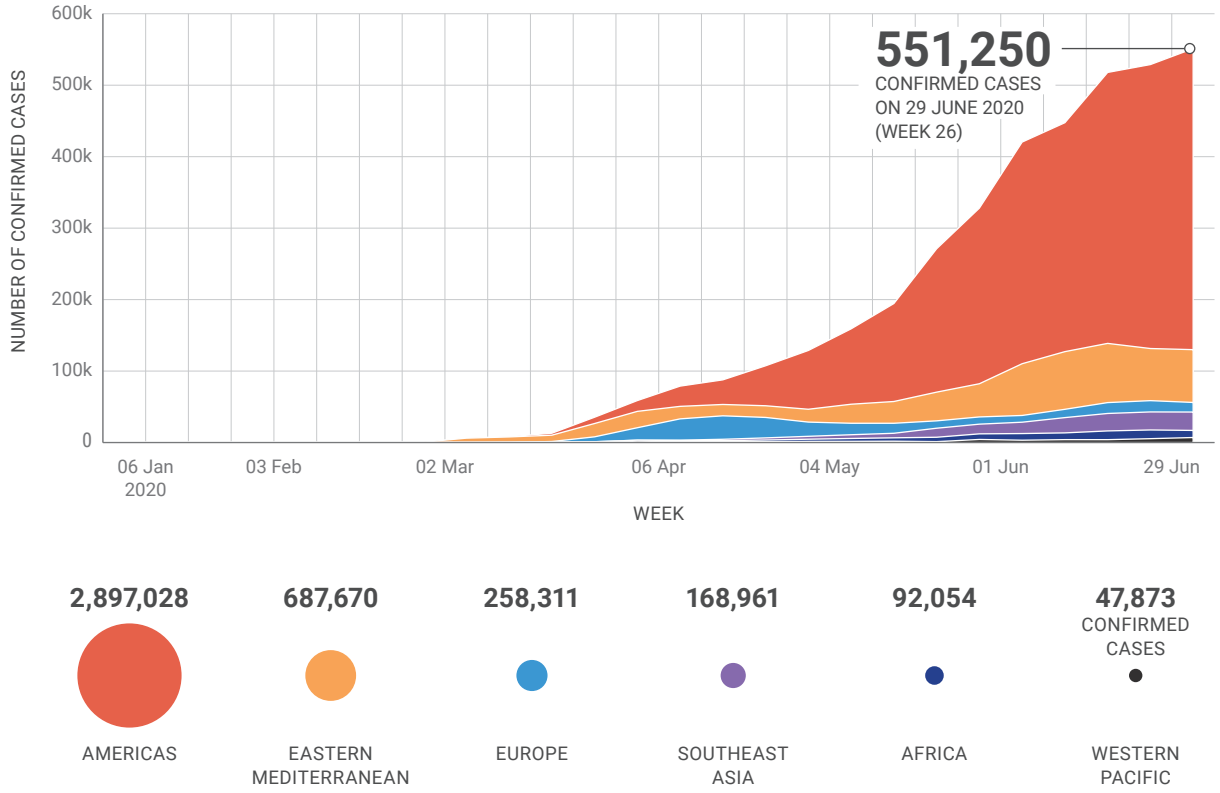
8 WHO coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization, 2020. Available online: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

9 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. Geneva: World Health Organization, 2020. Available online: https://covid19.who.int/https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/humanitarian-operations-camps-and-other-fragile-settings

COVID-19: Number of confirmed cases by week and region as of 8 July 2020* *(figure A)*

WHO coronavirus disease (COVID-19) dashboard. Geneva: World Health Organization, 2020. Available online: https://covid19.who.int/

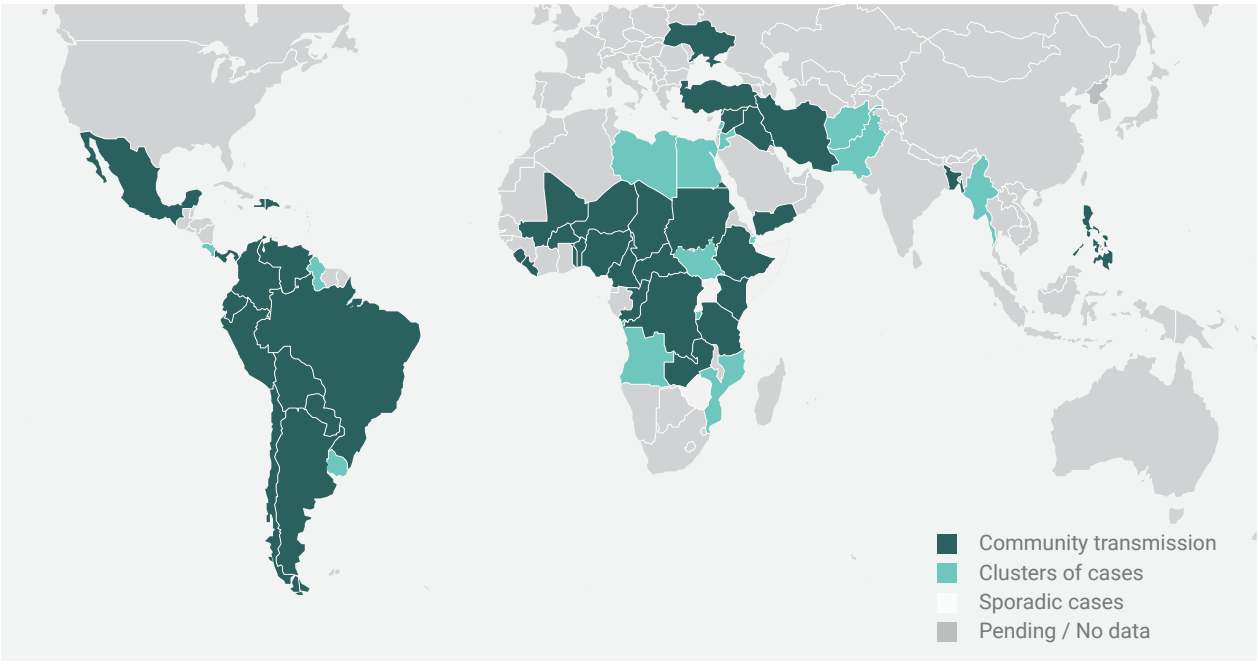
*Week of 6 July incomplete, n=207,806 cases reported 6–8 July excluded from the epidemic curve.



Source: World Health Organization, as of 8 July 2020

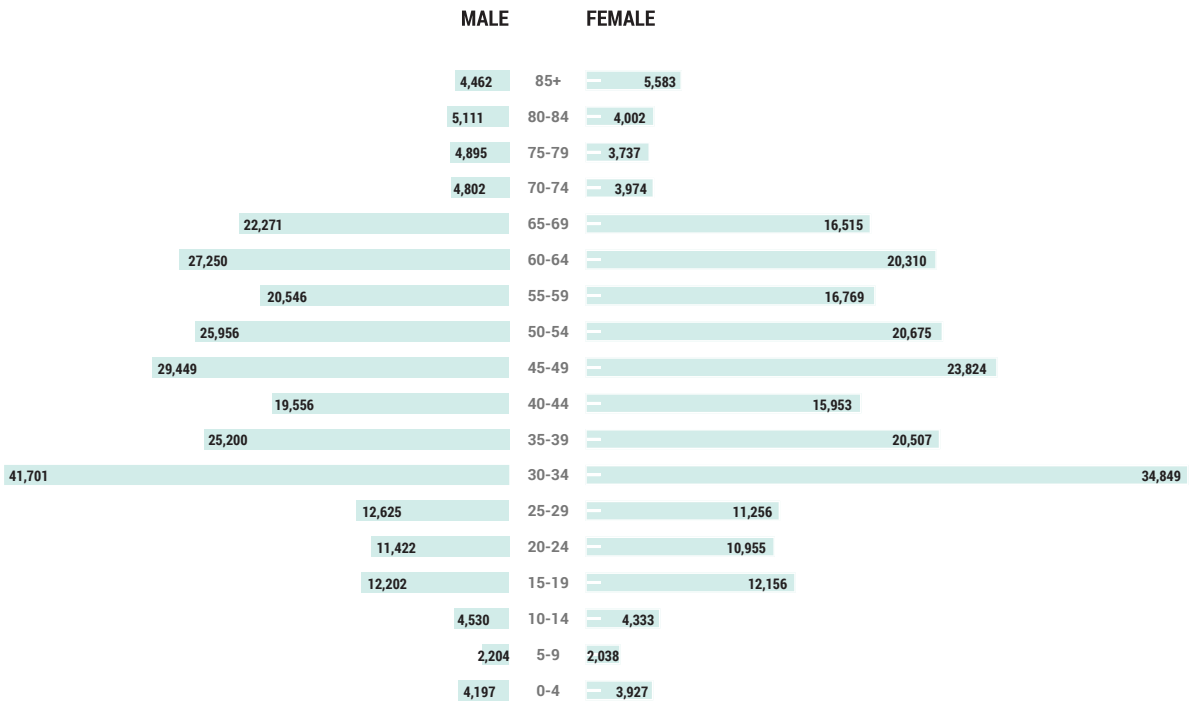
COVID-19: Transmission classification in GHRP countries as of 8 July 2020 *(figure B)*

WHO coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization, 2020. Available online: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-re coronavirus-2019/situation-reports



Source: World Health Organization, as of 8 July 2020

COVID-19: Reported cases by age and sex *(GHRP countries) (Figure C)*



Number of cases and deaths *(Table D)*

WHO coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization, 2020. Available online: https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-re coronavirus-2019/situation-reports

NUMBER OF CASES
GHRP COUNTRIES
4.15M

NUMBER OF DEATHS
GHRP COUNTRIES
165k

GHRP COUNTRY	NUMBER OF CASES	NUMBER OF DEATHS	DEATH RATIO	TRANSMISSION CLASSIFICATION
Afghanistan	33,594	936		Clusters of cases
Angola	386	21		Clusters of cases
Argentina	80,447	1,602		Community transmission
Aruba	105	3		Sporadic cases
Bangladesh	168,645	2,151		Community transmission
Benin	1,285	23		Community transmission
Bolivia	40,509	1,476		Community transmission
Brazil	1,623,284	65,487		Community transmission
Burkina Faso	1,003	53		Community transmission
Burundi	191	1		Clusters of cases
Cameroon	14,916	359		Community transmission
Central African Republic	4,071	52		Community transmission
Chad	873	74		Community transmission
Chile	301,019	6,434		Community transmission
Colombia	120,281	4,210		Community transmission
Congo	1,757	44		Community transmission

GHRP COUNTRY	NUMBER OF CASES	NUMBER OF DEATHS	DEATH RATIO	TRANSMISSION CLASSIFICATION
Costa Rica	5,241	23		Clusters of cases
Curaçao	25	1		Sporadic cases
DPR of Korea	-	-		No cases
Dem. Rep. of the Congo	7,659	182		Community transmission
Djibouti	4,878	55		Clusters of cases
Dominican Republic	38,430	821		Community transmission
Ecuador	63,245	4,873		Community transmission
Egypt	77,279	3,489		Clusters of cases
Ethiopia	6,774	120		Community transmission
Guyana	278	16		Clusters of cases
Haiti	6,371	113		Community transmission
Iran (Islamic Republic of)	245,688	11,931		Community transmission
Iraq	64,701	2,685		Community transmission
Jordan	1,169	10		Clusters of cases
Kenya	8,250	167		Community transmission
Lebanon	1,907	36		Clusters of cases
Liberia	917	41		Community transmission
Libya	1,182	35		Clusters of cases
Mali	2,348	119		Community transmission
Mexico	261,750	31,119		Community transmission
Mozambique	1,040	8		Clusters of cases
Myanmar	316	6		Clusters of cases
Niger	1,094	68		Community transmission
Nigeria	29,789	669		Community transmission
oPt	5,092	22		Clusters of cases
Pakistan	237,489	4,922		Clusters of cases
Panama	39,334	770		Community transmission
Paraguay	2,502	20		Community transmission
Peru	305,703	10,772		Community transmission
Philippines	47,873	1,309		Community transmission
Rwanda	1,172	3		Sporadic cases
Sierra Leone	1,572	63		Community transmission
Somalia	3,015	92		Sporadic cases
South Sudan	2,106	40		Clusters of cases
Sudan	9,997	622		Community transmission
Syrian Arab Republic	372	14		Community transmission
Togo	689	15		Community transmission
Trinidad and Tobago	133	8		Sporadic cases
Turkey	207,897	5,260		Community transmission
Uganda	971	0		Sporadic cases
Ukraine	50,414	1,307		Community transmission
United Rep. of Tanzania	509	21		Community transmission
Uruguay	960	29		Clusters of cases
Venezuela	7,411	68		Community transmission
Yemen	1,307	349		Community transmission
Zambia	1,895	42		Community transmission
Zimbabwe	787	9		Sporadic cases

Source: World Health Organization covid19.who.int, as of 8 July

WHO has advised countries to systematically collect data on COVID-19 case-patient age, sex/gender, and pre-existing conditions, amongst other data. It has further advised targeting surveillance toward high-risk groups such as those in closed residential facilities, healthcare settings, prisons or other places of detention[10], or in humanitarian contexts. Despite these efforts data on the most affected population groups is not yet universally available at the global level.

As of 9 July 2020, WHO's global database of 4,856,819 cases (representing 42 per cent of all globally reported cases) from 135 countries, territories and areas, indicates an equal reporting of males and females. The sex distribution however varies considerably with age (see figure below). Looking at age, most cases have been reported in persons aged 50-54 years. with children under 5 years of age making up 1.3 per cent of all reported cases. Those 60 years and over constitute 29.5 per cent of reported cases.

Of the approximately 1,200,000 case report forms submitted to date from countries included in the GHRP and which have age and sex disaggregated data, 53 per cent are male, similar to the ratio reported globally. Reported cases tend to be younger than global average (median 41 years, interquartile range 30-54 years; versus median 46 years, interquartile range 32-61 years globally). The most affected age groups are 25-39 years, accounting for 31.4 per cent of reported cases; 1.2 per cent are under 5; and 17.1 per cent are aged 60 years and over[11]. This difference is at least partially explained by the younger population structures found in countries included in the GHRP, as well as other factors such as unequal access to health services, testing and treatment.

As of 13 July 2020, amongst 51 315 fatalities reported into the case-based surveillance from GHRP countries and for which age is available, the case fatality proportion amongst cases appears to rise steadily with age, with all age groups below 35 years exhibiting less than 1 per cent case fatality, rising up to over 25 per cent in ages 80+ years.

In addition to advanced age, several other risk factors have been identified as being associated with severe disease and death from COVID-19. These include smoking, diabetes, hypertension, cardiac disease, cerebrovascular disease, chronic lung or kidney disease, immunosuppression and cancer. Less data is available on the impact of undernutrition, HIV/AIDS, and tuberculosis on mortality risk, largely due to the paucity of data from low resource settings. Preliminary data suggest that these conditions may also be associated with an increased risk of severe disease and death. More research is needed from these settings.

People affected by humanitarian crises, those living in low capacity settings or deprived of their liberty are differently impacted by the COVID-19 pandemic. In these settings, critical measures for COVID-19 prevention and control may be difficult to implement and some of them potentially harmful to the socio-economic survival of many community members. Public health and social measures in these settings need to be balanced against other risks affecting their communities. This includes higher rates of other diseases, malnutrition and poverty. In most GHRP settings, crude case fatality ratios are comparable or below global averages yet vary considerably, from 0–27% (median 3 per cent).

Until recently, relatively few confirmed cases have been reported in humanitarian settings but this is changing and concerns are high that the pandemic will spread quickly. In addition, underreporting is likely and testing capacities are low. Confirmed cases have now been reported in Daadab refugee camp in Kenya; in Cox's Bazar, Bangladesh; amongst Palestinian refugees in several countries in the Middle East; and in Syria and Yemen. Due to the extremely austere situations found in most humanitarian settings managing COVID-19 will be a major challenge.

The impact of the pandemic on health workers is also worth emphasising; the cumulative number of healthcare workers infected is most likely grossly underestimated. As of 9 July, an (under-)estimated 115,205 health care workers were reported as having been infected by COVID-19 in 36 of 63 GHRP countries[12].

10 UNODC, WHO, UNAIDS and OHCHR joint statement on COVID-19 in prisons and other closed settings https://www.who.int/news-room/detail/13-05-2020-unodc-who-unaids-and-ohchr-joint-statement-on-covid-19-in-prisons-and-other-closed-settings

11 The greater number of cases among women aged 85+ years compared to men is deemed to reflect global demography; where life expectancy trends mean women often outlive men in many countries. The age/sex pyramid for countries included in the GHRP reflects their life expectancy trends.

12 Source: WHO - Countries: Angola, Burkina Faso, Burundi, Cameroon, CAR, Chad, Côte d'Ivoire, DRC, Ethiopia, Guinea, Kenya, Liberia, Niger, Nigeria, Republic of Congo, Rwanda, Sierra Leone, South Sudan, Togo, Uganda, Tanzania, Zambia, Zimbabwe, Colombia, Dominican Republic, Mexico, Panama, Djibouti, Iraq, Jordan, Lebanon, Sudan, Syria, Bangladesh & Cox's Bazaar, Myanmar

Evolution of the pandemic effects on public health services

WHO continues to assess the impact of the COVID–19 pandemic on **essential health services**. Early results from a survey of 103 countries in May-July 2020 showed that more than half have limited or suspended outpatient service (56 per cent) and community-based care service delivery platforms (52 per cent), as a result of mobility restrictions and diversion of resources to more urgent COVID-19 services. On average, approximately half of the 25 assessed health services were disrupted partially or completely in country[13].

Most frequently reported service disruptions were in dental services (74 per cent, including 15 per cent countries reporting full disruption), rehabilitation services (73 per cent, including 15 per cent full disruption), routine immunization services (outreach 71 per cent, including 17 per cent full disruption; facility-based 60 per cent, including 11 per cent full disruption), non-communicable disease diagnosis and treatment (66 per cent), and family planning and contraception (64 per cent). In Peru for example, Family Planning services that are offered for free were all discontinued due to closure of primary health care centers in response to COVID-19 leaving women, notably vulnerable refugee women, without access to family planning services, throughout the confinement.

Treatment of mental health conditions was disrupted in 61 per cent of surveyed countries, antenatal care in 56 per cent, and management of moderate and severe malnutrition, and non-COVID outbreak detection and control in 51 per cent and 45 per cent of surveyed countries respectively. In Liberia for example, the utilization rate of health services has decreased by 36 per cent in April 2020, notably in areas most affected by COVID-19. Facility-based births services were disrupted in 34 per cent of countries.

Between March and June 2020, compared to the same period in 2018 and 2019, 3 countries out of 26 countries included in the GHRP (representing 2812 facilities and areas) saw a drop in institutional births in less than 10 per cent of facilities/areas, 7 countries in 10-25 per cent of facilities/areas, and 10 countries in more than 25 per cent, and up to 61 per cent of the facilities/areas. Although interpretation of any changes in institutional births would require an understanding of population movement, these results are concerning as they indicate potential disruptions in emergency obstetric and neonatal health care services, have a direct effect on the continuity of essential sexual and reproductive health care, and point to serious potential implications for maternal and neonatal morbidity and mortality. In Sudan for example, the limited antenatal care in the initial phase of COVID-19 led to limited detection of at-risk pregnancies; Reports from maternity hospitals' managers show an increasing trend of complicated pregnancies/deliveries.

Although two thirds of surveyed countries have defined a core set of essential health services to be maintained prior to the COVID–19 outbreak, 54 per cent provided additional government funding for the maintenance of the essential health services during COVID–19.

Several factors underlie these changes in health services supply and demand, including a decrease in outpatient volume due to patients avoiding health facilities and in inpatient volume due to cancellation of elective care, government or public transport lockdowns hindering access to health services, and insufficient personal protective equipment available for health care providers.

Travel restrictions – both domestic and international – and interruptions in refugee resettlement processes have severely compromised access to preventative and curative health care for migrants and refugees. All of IOM's Migration Health Assessment Centres have been impacted, having either closed or reduced their services (as of 3 July, 31 per cent were closed, 19 per cent had reduced services and 50 per cent recently reopened with reduced services following temporary closure). Stranded migrants and migrants in irregular situations continue to face barriers in accessing services including basic health care (see also Section 2.3 below). While it is expected that the next three months will see some reduction in such restrictions, the restrictive mobility environment is expected to remain in place.

As the COVID-19 caseload and associated pressure on the health system decrease in future months, many services that were suspended will need to be restored. This includes services for the treatment of non communicable diseases, among others.

13 Partial disruption is reported when 5% to 50% of patients do not get treated as usual. Complete disruption is when 50% of patients are not treated as usual.

Decisions about when and how to restore services safely will differ by condition and population.

COVID-19 poses grave detrimental impacts on WASH service provision and sustainability if not adequately mitigated. The on-going effort of the WASH sector for and before the COVID-19 response to ensure availability of WASH services in health care facilities should be sustained and strengthened to ensure the population does not divert itself from existing services. WASH is a key preventative measure in reducing the spread of COVID-19 and is one of the principal public health recommendations.

Gender-based violence and services *(see also Sections 2.2 and 2.3 for more on GBV)*

Evidence from countries most affected by COVID-19 indicates that there is an increased risk of exposure to gender-based violence, in particular domestic and intimate partner violence. Gaps in the scale-up and adaptation of service delivery to ensure the availability, accessibility, and appropriateness of health sector response to GBV persist. In many countries included in the GHRP, medical facilities were insufficiently prepared even before the pandemic.

In some locations, GBV services have severely reduced their operating capacity, either because they have not been issued the necessary permissions to operate or because they are not included on the list of "essential services". Among 40 reporting countries, 16 reported significant service disruptions in targeted areas for humanitarian support.

As movement restrictions have affected the delivery of protection services in most countries, in particular in critical sectors such as gender-based violence and child protection, protection staff and social workers should be categorised as essential and exempted from access restrictions alongside other humanitarian workers.

Sexual and reproductive health services

Comparing March to May with previous years, a significant drop in health-facility deliveries and antenatal care and family planning attendances has been observed. An 8 per cent reduction in antenatal care attendance was reported in Uganda, while it decreased by 54 per cent in South Sudan including a decline of skilled birth attendance by 10 per cent, and a decline of postnatal care by 19 per cent. In Pakistan, service coverage of essential maternal health care (antenatal and postnatal care) is estimated to have declined by 10-20 per cent and may result in an increase of maternal deaths of up to 1,056 -2,135 cases respectively.

This and other reported concerns have been attributed to continued denials of sexual and reproductive health and rights, including barriers facing women and girls to access sexual and reproductive health services, the fear of infections at health facilities, refusal of care, demotivated health workers without personal protective equipment and reduction in community-level activities especially in areas with limited health-care facilities, and refugee and internally displaced persons camps/settlements. Sexual and reproductive health services in line with the Minimum Initial Service Package are often not included in the list of "essential services" despite being life-saving.

In some other countries like in Yemen, the health system including the reproductive health services is on the verge of collapse following the rapid spread of COVID-19, with far-reaching and life-threatening consequences on women and girls. Nearly half of health facilities are either not functioning or only partially functioning. Further, only 20 per cent functioning health facilities provide maternal and child health services due to staff shortages, lack of supplies, inability to meet operational costs or damage due to conflict.

In Sudan, it is estimated that the currently available health workforce is only sufficient to serve 20 per cent of the population. Continued worldwide disruptions in supplies of key medicines for maternal healthcare, such as antibiotics to treat infections and oxytocin, a drug for preventing excessive bleeding after childbirth, remain highly concerning. If the situation does not improve as many as 47 million women in total 114 low- and middle-income countries, including GHRP countries, could lose access to contraception, this could lead to nearly 7 million unintended pregnancies in the next 6 months[14].

Immunisation and vaccination services

Globally, 99 countries reported the suspension or disruption of immunization campaigns for measles/measles rubella, polio, meningococcal A, yellow fever, typhoid, cholera and tetanus/diphtheria in early May, according to a monthly survey conducted jointly by WHO, UNICEF, and Gavi. Measles and polio

14 https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues

vaccination campaigns, in particular, have been badly affected, with measles campaigns suspended in 27 countries and polio campaigns for an estimated 117 million children in at least 38 countries. Shipments of campaigns vaccines have also been put on hold by many countries, as borders are closed and/or attention and resources are redirected towards COVID-19. In addition, substantial disruption in routine immunization services has been noted in 68 countries, affecting approximately 80 million children under the age of one year living in these countries.

Even before the pandemic an increase of vaccine preventable diseases had been observed. An increase in the number of polio cases was recorded between 2019 and 2020 according to the Global Polio Eradication Initiative. Globally, the 2020 year-to-date number of wild poliovirus cases is 62 compared to 51 in 2019, while the number of and circulating vaccine-derived poliovirus cases is 134 in 2020 compared to 47 in 2019. Pakistan has the single largest number of cases with Afghanistan, Ethiopia and Chad also noting tens of cases in 2020[15]. Mali and Niger have both officially reported outbreaks of polio. Ethiopia, Burundi, Cambodia, Ethiopia, and Nigeria have officially reported measles outbreaks. Yellow fever outbreaks have been reported by Ethiopia, South Sudan, and Uganda.

Immunization campaigns have been disrupted or delayed in several countries as governments enforce measures to control the pandemic including in Afghanistan, Bangladesh, CAR, Niger, Syria and Yemen. Routine health services, including disease surveillance and response, have been negatively impacted in Cameroon, DPRK, the Philippines, Sudan and Venezuela as health staff and resources have been diverted to help fight COVID-19.

Families tend to also seek less vaccination services as observed in Bangladesh, Mali, the Philippines, and Ukraine. Fear of COVID-19, rumors, mistrust, stigma, and domestic movement restrictions are reported to play a role in Côte d'Ivoire and DRC.

Guidance from WHO has removed the blanket recommendation for suspension of campaigns and replaced them with a recommendation for a detailed risk-benefit analysis to determine if and when an immunization campaign should be conducted, and guidance was provided on how to conduct them safely in the context of COVID-19. This has resulted in a number of countries resuming their planning for immunization campaigns in the coming months. However, while some encouraging signs of resumed immunization services are being noted in some locations, such as Myanmar, the immunization gap created by the disruptions may have set the immunization agenda back by many years or more.

Disruption of the global vaccine supply chain also complicates the resumption of immunization services and campaigns. Supply and demand for vaccine supplies have both been significantly disrupted since March 2020, resulting in critical levels of vaccines in some countries, potential expiry of available vaccines in other countries, inability to transport vaccines from manufacturers to receiving countries at scale, an increase in costs, and a slowdown in production.

Countries in sub-Saharan Africa and in East and South Asia are of particular concern when it comes to vaccine shortages. As of 2 June, at least 20 countries[16] are officially reporting stock-outs or informally indicating concerns about vaccine supply sufficiency for the period June to August. However, the slow increase in commercial flight availability is improving the trend in deliveries, with 36 shipments delivered to 20 countries in the week preceding 2 June.

Mental health and psychosocial support (MHPSS) and services

Major stressors such as the COVID-19 pandemic and living in conflict settings are potent risk factors for the development, exacerbation and relapse of a range of mental health conditions. COVID-19 is associated with neurological and mental manifestations, such as delirium, agitation, stroke, insomnia, anxiety and depression. Social isolation, reduced physical activity and reduced cognitive stimulation may increase the risks of cognitive decline and dementia, and people with dementia have higher susceptibility to COVID-19 and higher rates of death associated with the disease[17] [18].

15 http://polioeradication.org/polio-today/polio-now/this-week/ Although the causal relationship between COVID-related immunization disruption and polio outbreak is not directly established for all countries, the pandemic is nevertheless a major hindrance in responding to any outbreak, be it new or ongoing.

16 On 2 June, Gavi noted reports of stock-outs at the central or sub-national level in Benin, Burkina Faso, Democratic Republic of the Congo, Ethiopia, Guinea, Lesotho, Pakistan, Sao Tome and Principe, and Senegal. In addition, there are concerns over the sufficiency of vaccine supplies for the next three months in Afghanistan, Burundi, Central African Republic, DPR Korea, Iraq, Libya, Mozambique, Myanmar, Philippines, South Sudan, and Zimbabwe.

17 Maintaining essential health services: operational guidance for the COVID-19 context, WHO, Available at: https://www.who.int/publications/i/item/10665-332240

18 Clinical Management of COVID-19, WHO, Available at: https://www.who.int/publications/i/item/clinical-management-of-covid-19

The disruption of care for mental, neurological and substance abuse conditions can be life-threatening, particularly of treatment for epilepsy, unaddressed suicide risk, harm reduction services, and unmanaged opioid overdose and severe alcohol withdrawal syndromes. At a time when it is needed at a scale, mental health and psychosocial support services in all humanitarian settings suffer from low investment in human and financial resources as well as stigma and limitations to access due to services disruption[19].

Current utilization of MHPSS services varies depending on context. While some countries included in the GHRP show major disruption in services, some others are showing higher utilization. In Jordan for example, a significant rise in MHPSS consultations was reported, by over 50 per cent, in April. According to the latest Multi-sectoral Rapid Needs Assessment jointly conducted by WFP, UNICEF, and UNHCR in Jordan, 41 per cent of all respondents witnessed a negative impact on their children's well-being due to the COVID-19 crisis and curfew.

An increase of almost 55 per cent in MHPSS consultations was also noted in the Zataari and Azraq refugee camps[20]. In north-west Syria, reports indicate that the number of new patients in and around Idleb receiving mental health consultation in April and May has doubled compared to the same time period last year. In South Sudan, MHPSS service utilization in Juba and Malakal in April-May decreased by 50 per cent between 2019 and 2020 due to limited access, service disruption and economic burden.

19 Maintaining essential health services: operational guidance for the COVID-19 context, WHO, Available at: https://www.who.int/publications/i/item/10665-332240

20 Before the pandemic, respectively 170 and 149 mental health consultations were held prior to March 2020, while 274 and 222 mental health consultations were conducted afterwards.

COVID-19 Health situation and needs monitoring indicators

All efforts should be made in future progress reports to disaggregate and analyse indicator data by sex, age and disability to allow for a meaningful measurement of the impact as well as of response effects on key groups with special needs e.g. women and girls, older people, people with disabilities, etc.

Spread and severity of the pandemic

The incidence informs on the trajectory of the epidemic

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION*
Number of confirmed COVID-19 cases in GHRP countries	Weekly	**WHO**	Increasing from 159,109 (early May) to 528,899 cases/week
Total number of deaths among confirmed cases in GHRP countries	Weekly	**WHO**	Increasing from 7,732 (early May) to 20,163 deaths/ week
Number and proportion of new confirmed cases in health care workers	Weekly	**WHO**	115,205

*Situation as of 29 June 2020 (same applies to the following tables).

Sexual and reproductive health

COVID-19 containment measures and high COVID-19 incidence rates affect pregnancy and safe delivery

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number of institutional births in COVID-19 affected areas globally	Monthly	**WHO**	Data from 6 African countries: average 12% decline in number of facility births during February-April 2020, compared to the same period in 2019. Range of decline in 5 countries is between 9%-31% with no decline (3% increase) in one country[1]
		UNFPA	Institutional birth data from 26 countries shows declines in 20 of them.
Proportion of countries where pre-COVID levels of family planning/ contraception services are maintained	Quarterly	**WHO**	Efforts to gather information on this indicator are underway. Relevant information will be presented in future reporting.

1 Facility-based birth services have been mostly partially disrupted in 34% of countries surveyed by WHO.

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Proportion of countries where pre-COVID-19 levels of institutional births are maintained	Monthly	**UNFPA**	Decline in institutional births in 20 of the 26 countries, including 3 countries with less than 10% of facilities//areas with drops in institutional births, 7 countries with 10 to 25%, and 10 countries with between 25 and 61% per cent of facilities/areas with drops

2.2

Evolution of the socio-economic impact of the COVID-19 pandemic

Evolution of the main macroeconomic effects

Economic growth

Most of the countries included in the GHRP are low-income countries (LICs) with a few middle-income countries. Growth among the LICs in general is expected to slow markedly in 2020, the slowest pace in at least 25 years. A rebound is expected in 2021 depending on the pace and timing of the projected recovery, including in major trading partners. However, prospects are on the negative side. In addition to the dire human consequences of a larger-scale domestic outbreak, previous epidemics among LICs suggest economic activity could collapse[21].

The box below provides an overview of the economic prospects at global level as a result of the pandemic.

21 Global Economic Prospects, World Bank Group Flagship Report, June 2020.

Summary of the pandemic macroeconomic impact and outlook

The economic outlook for 2020 and beyond is fundamentally uncertain due to the unprecedented nature of the COVID-19-induced crisis. Forecasts rest on assumptions difficult to ascertain, such as the duration of containment measures and their effects on productivity and supply.

The global GDP is projected to experience the deepest recession and collapse in per capita incomes since 1870. As of 24 June, the IMF projects a -4.9 per cent contraction in global GDP in 2020, followed by a protracted and uneven recovery. IMF simulations suggest that containment measures in response to a second wave of COVID-19 outbreak in early 2021 could lead to a further decrease in world output of -4.9 per cent in 2021 relative to baseline, rather than a path to recovery.

While all regions are subject to negative growth projections in 2020, there is significant

heterogeneity across regions, with Latin America and the Caribbean (-7.2 per cent), and Middle East and North Africa (-4.2 per cent) and Europe and Central Asia (-4.7 per cent) expected to contract the most, followed by Sub-Saharan Africa (-2.8 per cent) and South Asia (-2.7 per cent) . East Asia and the Pacific will grow by a mere 0.5 per cent.

Due to lockdown measures and the global recession, unemployment is projected to increase in 2020. Compared to pre-crisis levels in the last quarter of 2019, a 14 per cent deterioration in unemployment is expected, equivalent to the loss of 400 million full-time jobs.

The economic contraction will materialise in rising levels and depth of poverty, jeopardising the significant progress made on extreme poverty and human in recent decades. Between 71 and 419 million people could fall under the $1.90 international poverty line, although the persistence of this deterioration remains unclear.

The main drivers of the global economic crisis include:

- Containment measures, restriction of movements, closure of markets and mandatory physical distancing have severely restricted domestic activity, impacting low-skilled workers, informal workers, women and migrants most. The International Labour Organization estimates that close to 80 per cent of approximately 2 billion informally employed workers worldwide have been profoundly hit, particularly women.
- Containment measures and spillovers from weaker external demand have disrupted global trade, which has contracted by about -11.9 per cent this year, tourism and global supply chains. The World Tourism Organization expects an annual decline of 60 to 80 per cent in international tourism relative to 2019, with countries like Ethiopia, Nepal, Rwanda and Tanzania most at risk given their reliance on tourism exports (25 per cent of GDP).
- Global remittances are projected to fall by about 20 per cent to $445 billion in 2020. This will affect countries particularly reliant on remittances, such as Haiti, Kyrgyz Republic, the Philippines, South Sudan, Tajikistan, the Pacific Island States and Nepal.
- Oil prices are volatile and low, while global supply storage is nearly exhausted, impacting countries with budgets that depend on oil export revenue such as Angola, Iraq, Libya, Nigeria and South Sudan.

Strong multilateral cooperation and international financial assistance remain essential. The World Bank, the IMF, Regional Development Banks and European Union Devco have been swift in providing emergency assistance of around US$95 billion, albeit largely in the form of loans and unequally distributed across countries. Two-fifths of low-income countries are at high risk of debt distress and the crowding out of non-health social and capital expenditures. OCHA has estimated the cost of protecting the most vulnerable 10 per cent people from the worst impacts of COVID-19 at approximately $90 billion – or less than 1 per cent of the current global stimulus package put in place by OECD and G-20 countries (estimated at over $8 trillion).

Source: Global Economic Prospects, World Bank Group Flagship Report, June 2020.

Poverty

Even before the pandemic, it was challenging to achieve the Sustainable Development Goal of reducing global extreme poverty to 3 per cent of the population by 2030 and this goal may be now further out of reach. Poverty could rise by 500 million people globally, with 70-100 million at risk of falling back into extreme poverty.

Household incomes are expected to be weighed down by sharp income losses from decreased employment opportunities and lost earnings due to illness, lockdowns and restriction of movements as well as reduced remittance receipts. Particularly in countries with high shares of informal employment, lockdowns have led to joblessness and abrupt income losses for many of those workers (often where migrants work far from home, separated from support networks). Women are likely to be severely affected due to their high level of participation in informal employment (see Section 2.3 below). Further, due to these economic stressors, many households turn to harmful coping mechanisms, such as child labor, family separation, and child marriage.

In Mali for example, the global economic recession is expected to lead to a drop in GDP of more than 80 per cent, with an additional 800,000 people living in poverty due to a sharp increase in job and livelihood losses, especially in the informal sector and urban areas. In Afghanistan, the GDP is expected to contract by 5.5-7.4 per cent. With 9 per cent of Afghans living in poverty and more than 80 per cent of workers in the informal economy, lockdowns in response to the pandemic are having immediate unemployment and poverty impacts, particularly for IDPs, returnees and other vulnerable people living in informal settlements. In Pakistan, poverty is expected to rise from 50 million to 125 million people, while in Lebanon poverty levels may reach 50 per cent and extreme poverty double from 10 to 20 per cent in 2020.

The crisis is also likely to worsen pre-pandemic inequalities as the people living in poverty, women, informal workers, migrants, refugees , IDPs and other groups are more vulnerable to the effects of the pandemic, due to their limited access to health care and to formal safety nets and lack of resources to cope with income losses[22]. While remittances will normally serve as an important informal safety net in times of hardship, COVID-19 has impacted people on the move with many refugees and migrants, including those stranded, deprived in their ability to contribute to the economic recovery in countries of destination and origin. This is compounded in this crisis by the lack of access to services for sending and receiving money, as many service providers have closed or have seen their operations limited due to lockdown restrictions. The World Bank estimates remittances globally will fall by 20 per cent in 2020, affecting particularly countries highly dependent on these monetary flows and increasing vulnerabilities of migrant families at home.

Fiscal measures

According to the IMF, the fiscal response of many low-income countries to the pandemic has been modest, at 1.2 per cent of GDP on average and mostly through budgetary measures, due to tight financing constraints. For example, Nigeria provided tax relief for employers to retain workers and raised health care spending (0.3 per cent of GDP), while Ethiopia has expanded its in-kind provision of food and shelter (1.8 per cent of GDP). Support measures in Vietnam have included cash transfers to the poor and higher benefits in existing social protection programs (1.2 per cent of GDP)[23].

Labour market

The steep decline in activity has led to a catastrophic contraction of the global labor market. According to the International Labour Organization, the global decline in work hours in 2020:Q1 compared to 2019:Q4 was equivalent to the loss of 130 million full-time jobs. The decline in 2020:Q3 is likely to be equivalent to more than 400 million full-time jobs. The hit to the labour market has been particularly acute for low-skilled workers who do not have the option of working from home. Income losses also appear to have been uneven across genders, with women among lower-income groups bearing a larger brunt of the impact in some countries. Of the approximately 2 billion informally employed workers worldwide, the International Labour Organization estimates close to 80 per cent have been significantly affected.

Job losses are particularly severe in the informal economy, upon which the vast majority of poor and food-insecure people rely. The International Labour

22 Global Economic Prospects, World Bank Group Flagship Report, June 2020.

23 https://www.imf.org/en/Publications/WEO/Issues/2020/06/24/WEOUpdateJune2020

Organization estimates that earnings for informal workers will decline by 82 per cent in low and lower-middle income countries, with Africa and Latin America to face the largest decline. Women and young people will be disproportionately affected.

Trade

The synchronized nature of the downturn has amplified domestic disruptions around the globe. Trade contracted by close to –3.5 per cent (year over year) in the first quarter, reflecting weak demand, the collapse in cross-border tourism, and supply dislocations related to shutdowns (exacerbated in some cases by trade restrictions).

Global agricultural production

Despite agricultural production levels and stocks for more staple foods being near all-time highs globally, there are growing concerns about food security. Supply chain disruptions and restrictions on movement are straining food availability [24]. Although ample supplies will to stabilize prices at the global level, localised price spikes could erode food security, especially in countries with a large number of poor people who have lost their income due to disruptions in economic activity[25].

The pandemic is also overlapping with a locust infestation that is damaging crops in DRC, Eritrea, Ethiopia, Pakistan, Somalia, South Sudan, Uganda and Tanzania among others. While in most countries the first wave of infestation did not coincide with the peak growing season, it has not yet been brought under control. Supply chain disruptions have also been delaying delivery of pesticides. The next wave of locusts is falling into the May-June growing season resulting in longer term effects on vulnerable people's food security situation. Localised food shortages may also occur in the aftermath of other natural disasters and climate events.

Furthermore, lockdowns are slowing down agricultural activities, leaving millions of seasonal workers without livelihoods. As of the end of May, farmers in central regions of Liberia were falling behind schedule on the farming season, possibly leading to a below average harvest this year. In Ethiopia, as of mid-May the area planted for *Belg* crops was below average, in part due to the delays in agriculture input distribution associated with COVID-19 restrictions and the slow start of the season. In South Sudan a survey conducted in June 2020 by FAO indicates significant impacts on the current season (harvest in August – September) crop production. Households surveyed anticipate that current season crop production will be negatively impacted (both in terms of area cultivated and production). Production impacts are estimated at a 10 to 20 per cent reduction from normal year production according to key informants. More than 60 per cent of respondents indicated that they will be forced to purchase low quality and expensive seed. This, together with a limited number of casual laborers, and a decline in other sources of income, will constrain standard farming activities, resulting in late sowing and a reduction in planted area.

Physical access to food is also affected as markets are being closed due to COVID-19 outbreaks, or their working hours are being reduced, causing major losses in perishable agricultural commodities and hindering access to fresh fruits, vegetables, meat and fish especially in urban centers. Surveys conducted in the Philippines by the National Economic and Development Authority showed that agriculture lost about US$1.9 million so far from unsold produce, with about 39 per cent of the total losses being high-value crops. In Mozambique, about 30 per cent of the population reported challenges in access to markets as of 15 June. In Palestine, fish trade in March and April 2020 declined by 35 and 70 per cent, respectively, compared to the equivalent period in 2019.

Input prices (e.g. seeds, fertilizers, pesticides, animal feed, animal treatment) are increasing due to supply chain disruptions in many countries. Such a trend – combined with loss of income and purchasing power by farmers, pastoralists, fishers – is seriously compromising the continuation of agricultural activities. In Colombia, animal feed prices have increased significantly and are forcing vulnerable livestock keepers to slaughter their animals or to sell them for low prices to cover basic needs. In Pakistan, a shortage of certified seeds, fertilizers and other agricultural inputs is likely to affect planting for the *Rabi* season 2020/21. In Syria, breeders could continue to have limited or no access to necessary feeds to maintain milk production during the critical July to September period, which could result in below average body conditions and reduced milk production.

24 Migrant Workers and the COVID-19 Pandemic, FAO, April 2020.

25 Global Economic Prospects, World Bank Group Flagship Report, June 2020.

Agricultural prices

Agricultural prices of coarse grains have varied according to regions and countries depending on the extent of disruption to food supply chains due to movement restrictions and trade limitations, consumer buying behaviour including panic-buying related to the COVID-19 pandemic, 2019 agricultural production level, seasonality,, and aggravating factors such as persisting civil conflict[26]. Prices of basic foods are rising in some countries at a time when unemployment is increasing, making access to food difficult for many vulnerable households. For example, food commodity prices have increased by 10 to 20 per cent in Afghanistan compared with the same period last year.[27] In Sudan, prices of staple cereals increased between 35 and 60 per cent in May 2020. In Mozambique, food prices have been following an inflating trend since the onset of the pandemic in February (+6.1 per cent as of 24 June)7.

FAO Food outlook of June 2020 indicated that food markets will face many more months of uncertainty related to the COVID-19 pandemic. While most markets are braced for a major global economic downturn, the agri-food sector is likely to display more resilience to the crisis than other sectors. For instance, global wheat production in 2020 is forecast to fall slightly below the 2019 level, while the dampening effect of the COVID-19 pandemic on demand could still push up global inventories.

The prospect of a modest gain in 2020/21 world trade, amid tighter export availability, could support international wheat prices. World rice production is set to recover in 2020, boosting rice utilization and keeping carry-overs at their third highest level on record. While economic constraints and firm prices may curb trade growth in 2020, a more robust trade expansion is projected for 2021.

That said, current and projected effects of COVID-19 and its secondary impacts at the local level are severely affecting the most vulnerable, and are likely to continue having a detrimental effect on food security (see 2.2 b) below).[28] Border closures and suspension of weekly and open-air markets in many countries throughout Sub-Saharan Africa have led to reduced regional trade and prevented farmers selling their produce, sometimes leading to localized food scarcity and increased prices. Restrictions imposed by several exporting countries have put pressure on food import-dependent countries, while plummeting primary commodity prices, containment measures and weak economic activity have led to depreciating currencies and contributed to domestic price increases in Nigeria as well as several countries in Southern Africa and the Middle East.

Evolution of socio-economic effects on people

Effects on livelihoods and food security

Magnitude and intensity of food insecurity

The COVID-19 crisis unfolds at a time when the number of acutely food insecure people in the world had already risen nearly 70 per cent over the past four years, largely due to conflicts, climate change and economic downturn. The world now faces an impending global food emergency[29] of unknown, but very large proportions.

Even before the pandemic hit, a large number of people in the countries included in the GHRP were already experiencing an acute food insecurity crisis due to human-induced conflicts, climate change and economic downturn[30]. The pandemic has further increased food insecurity through disruptions to imports and the effect of mitigation measures on supply chains and distribution networks. Prices of certain staples have risen in some countries, further eroding the purchasing power of persons living in poverty. In other contexts, farmgate prices have dropped, resulting in income losses for farmers. Food insecurity could also be prolonged by the lack of access to critical inputs such as seeds and fertiliser or labour shortages, which could weigh on upcoming harvests[31].

The spill-over effects of COVID-19 and disruptions due to containment efforts will further increase the number of people facing acute hunger as jobs are lost, the flow of remittances slows down, and food systems are under stress or disrupted. Low and middle-income countries will be disproportionately

26 FAO GIEWS (http://www.fao.org/giews/food-prices/regional-roundups/en/)

27 http://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Afghanistan_AcuteFoodInsec_2020AprilNov_report.pdf

28 FAO Food Outlook, June 2020 (http://www.fao.org/3/ca9509en/ca9509en.pdf)

29 A food emergency is defined as "an extraordinary situation in which people are unable to meet their basic survival needs, or there are serious and immediate threats to human life and well-being [https://reliefweb.int/sites/reliefweb.int/files/resources/sg_policy_brief_on_covid_impact_on_food_security.pdf]

30 Global Report on Food Crises, Food Security Information Network (FSIN), Rome, 2020.

31 Global Economic Prospects, World Bank Group Flagship Report, June 2020.

affected by these primary "impact channels". Food shortages could also trigger social unrest.

As of end June 2020, WFP estimates, based on real-time food security and market monitoring, that the number of acute food insecure people in its countries of operation could increase from 149 million pre-COVID-19, to 270 million before the end of the year[32], a 82 per cent increase compared to the number of acutely food insecure pre-COVID[33]. The timing could not be worse as countries are entering their annual lean season when access to food is most constrained; the hurricane and monsoon seasons loom; new spikes in conflict are displacing families; and a plague of locusts threatens livelihoods.

In Afghanistan for instance, the food crisis has been exacerbated by the COVID-19 pandemic with over 10 million acutely food insecure.[34] In the Central African Republic, a recent update in Integrated Phase Classification of Food Security (IPC) projections shows an increase of the population in need of assistance by up to 50 per cent in Bangui for the May-August period.[35] In Somalia, food insecurity is expected to nearly triple compared to pre-COVID-19 estimates, aggravated by the triple threat of COVID-19 consequences, flooding and the worst Desert Locust upsurge in decades.[36] In Burkina Faso, an update of projected acute malnutrition shows that the effects of COVID-19 are expected to cause a deterioration from *Stressed to Crisis* phase in 6 provinces for the period April-July[37]. In Niger, the number of food-insecure people requiring assistance is estimated to increase to 5.6 million during the upcoming lean season, from 3 million anticipated before. In Sudan, an estimated 9.6 million people (21 per cent of the population) are experiencing Crisis or worse levels of food insecurity (IPC Phase 3 or above) and are in need of urgent action. This is the highest figure ever recorded in the history of IPC in Sudan compared to previous years[38]. In South Sudan, the secondary effects of COVID-19 may push an additional 1.6 million people into severe acute food insecurity.

In Lebanon, a recent report by WFP[39] showed that the COVID-19 outbreak and related containment measures have pushed nearly one out of every three Lebanese into unemployment since. Syrian refugee women felt more drastic changes in employment status than Syrian refugee men, as 61 per cent reported losing their jobs due to COVID-19 compared to 46 per cent of Syrian men. Hyperinflation impacted households' ability to access food. For Lebanese respondents, 41 per cent reported not having stockpiled food due to their inability to afford the costs and 15 per cent reported not doing so as the prices are changing on a weekly basis. Findings were even more concerning for refugees, with 44 per cent of Palestinian respondents and a staggering 64 per cent of Syrians reporting the inability to have emergency stocks, mainly due to unaffordability. With food prices soaring in Lebanon, food is a major source of concern for a large proportion of respondents across all three groups. Fifty per cent of Lebanese, 63 per cent of Palestinians and 75 per cent of Syrians felt worried they would not have enough food to eat over the past month.

See Section 2.3 below for population groups most vulnerable to food insecurity.

Regional food security trends

In **East Africa**, the impact of COVID-19 measures on access to inputs and extension services is contributing to projected below-average long rain harvests in some areas. Reduced income, higher prices, conflict and recurrent natural disasters in some countries are expected to significantly affect food security. Closure of livestock markets, reduced export demand for live animals and border closures affecting transhumant pastoralists are having significant implications for household incomes. The

32 The Global Report on Food Crises (GRFC) estimated 135 million people in acute food insecurity in 2019 in 55 countries; WFP's June 2020 baseline is updated with latest assessment data for up to 79 countries.

33 The updated June analysis covers 79 countries (all countries with WFP presence, except for DPRK, India, Pacific, Iran and Morocco). The projected 270 million figure is comprised of 149 million people acutely food insecure pre-COVID and 121 million additional people at risk to become food insecure before the end of the year. The baseline was updated to reflect all newly available data for 2020 and expanded country coverage to all WFP countries where data on acute food insecurity was available.

34 IPC –Afghanistan, May 2020:

http://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_Afghanistan_AcuteFoodInsec_2020AprilNov_report.pdf

35 IPC Central Africa Republic, May 2020

http://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_CAR_AcuteFoodInsec_2020MayAug_Report_French.pdf

36 FAO, Somalia Food Security and Analysis Unit (https://www.fsnau.org/node/1755)

37 IPC Burkina Faso, June 2020 http://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_BurkinaFaso_AcuteMalnutrition_ProjectionUpdate_2020AprilJuly_French.pdf

38 http://www.ipcinfo.org/ipcinfo-website/resources/resources-details/fi/c/1152719/

39 https://reliefweb.int/report/lebanon/assessing-impact-economic-and-covid-19-crises-lebanon-june-2020

impact of floods and desert locusts on crops and pastures is further exacerbating a deteriorating food security situation.

Access to affected populations can be a challenge The region has not seen sustained lockdowns, leading to a more slow-onset impact; nonetheless, according to WFP, COVID-19 is expected to drive the number of acutely food insecure up by 73 per cent. The crisis will impact on the urban poor who rely on informal sources of income. Half of the population in the larger urban areas is estimated to live in slums or informal settlements. Working poverty is extremely high, nearly 45 per cent, as is dependence on remittances. Many refugees and IDPs have limited alternative means of survival.

In **Southern Africa**, the impact of restrictions on income opportunities is exacerbating food insecurity, especially among communities that have seen their coping capacity decreased as a result of consecutive years of climate and economic stressors. In 2019, repeated extreme climatic shocks resulted in the highest peak acute food insecurity of the past decade.

The situation is aggravated by widespread poverty, chronic malnutrition and macro-economic shocks in countries like Zimbabwe, where food inflation stands at 950 per cent. With the main agricultural season expected to start in October 2020, further restrictions on trade and movement could make it difficult for small-scale farmers to access markets, both to obtain essential inputs such as seeds and fertilizers and to sell final products.

Conflict continues in Eastern DRC and northern Mozambique. COVID-19 will deepen and increase poverty and food insecurity. Constrained government resources could lead to a curtailment of public services and diminish response capacities. Pending the outcome of 2020 official assessment results, an initial WFP analysis at regional level projected 42 million people in 12 countries with WFP presence will be food insecure. Should a worst-case scenario materialize (wide scale economic disruption, declining remittances, severe deterioration in terms of trade, health impacts) this figure could rise to as many as 52 million.

In **West and Central Africa,** weather and climate variabilities have historically been the main drivers of food insecurity notably in the Sahel where recurrent drought leads to chronic food production deficit and pasture failure. In coastal countries, above average rainfall causes regular flood events. In recent years, conflict in the region has escalated – disrupting livelihoods and forcing families into protracted displacement.

Pre-COVID estimates of acute food insecurity already indicated an important increase from 2019 linked primarily to conflicts in Central Sahel, northern Nigeria, Central African Republic, and Cameroon. COVID-19's compounded impact could drive a further increase of 135 per cent. poverty is high, and commodity market volatility and supply chain disruptions will impact access and availability of food. COVID-19 unfolds at the peak of the lean season when hunger and malnutrition are most severe.

In **West Africa**, cross-border transhumance activities are severely disrupted, affecting in particular the livelihoods of vulnerable pastoralists. Access to inputs and agricultural labor is being negatively impacted by COVID-19 mitigation measures in Burkina Faso, Chad and Nigeria. Falling oil prices are likely to increasingly affect government response capacity in several countries including Cameroon, Chad, Gambia and Nigeria.

In **Central Africa,** COVID-19 induced market closures, movement restrictions and cross-border trade disruptions are likely to limit people's access to markets with the approach of off-season harvest. Millions of farmers will see their income and purchasing power shrink due to declining demand, increased food prices and potential harvest losses.

In the **Middle East, Central Asia and North Africa** region, people's purchasing power is being affected by imposed COVID-19 curfews and reduced working hours, with significant consequences especially for small businesses and casual labour opportunities, and for access to an adequate diet. Restrictions on aid delivery are preventing medical supplies and personnel from reaching vulnerable areas.

Food price increases have been reported across the region. Countries affected by conflict and instability in the region, most notably Yemen, the Syrian Arab Republic and Libya, are likely to descend further into food insecurity, as well as those affected by pre-existing macroeconomic difficulties such as Lebanon, Palestine and Sudan. The presence of plant pests such as desert locust in Sudan and Yemen[40] will further affect the agriculture sectors.

40 At the time of writing, a nation-wide IPC is ongoing in Yemen; the increase in food insecurity may be significant.

The region's heavy dependence on oil and gas exports and on food imports leaves it sensitive to price fluctuations and trade restrictions, and food importers and exporters are similarly affected. Remittance losses will be particularly pronounced in Kyrgyzstan and Tajikistan where remittances account for 30 per cent of GDP[41] [42].

In **Asia and the Pacific**, reduced purchasing power for daily food items by those most affected by reduced livelihood and incomes, in particular those relying on informal/daily wages in urban and rural areas, is resulting in less diversified and nutritious diets, contributing to food insecurity and malnutrition. The spread of COVID-19 and domestic restrictions left a large share of the region's workforce under lockdown early on. This is further compounded by border restrictions or limited/no market access which hinders food access.

The pandemic situation is still evolving towards a first or even second peak in South and West Asia, contributing to limited access to agricultural inputs for the upcoming rice cropping season in South Asia. Conversely, mainland Southeast Asia has mostly overcome the first peak and countries are easing or ending lockdowns.

The pandemic has the potential to increase the number of food insecure people by more than 80 per cent as the incomes of already economically stressed populations fall further. The crisis strongly affects those who work in casual, informal labour in vulnerable sectors like tourism (e.g. Cambodia, Pacific Island Countries), the garment industry (e.g. Bangladesh), and who rely on remittances (e.g. Nepal). The increasing frequency and severity of natural hazards (monsoon floods, cyclone, drought), a new locust invasion (Pakistan, Afghanistan), and gender-based inequality will exacerbate the situation.

The **Latin America and the Caribbean** region suffers from consecutive droughts, the second largest refugee and migration crisis in the world, and political and economic instability which prompted widespread social unrest in 2019. The intense spread of COVID-19 – outpacing the capacity of the health system – has been met with sustained confinement measures, curtailing livelihoods and causing a direct loss of livelihoods and purchasing power.

Gaps in food availability and increases in food prices are also hampering access to food and seriously affecting food systems and food security of the population. The region projects the highest relative increase in severe food insecurity (269 per cent) with FAO estimating that another 20 million people could fall into food insecurity because of the pandemic. The combination of this with the ongoing Atlantic hurricane season (June-November) could be detrimental for the most vulnerable countries and further aggravate food insecurity,

The most vulnerable people are those who rely on daily wage labor, informal business, petty commerce and/or remittances. Daily workers in rural areas and smallholder farmers have not yet recovered from cyclical drought in the Dry Corridor and have been unable to sell produce due to movement restrictions. Compounding the situation, an above average storm season already observed in June could drive needs further.

Effects on protection and human rights, including gender-based violence

Violence, forced displacement, human rights violations and abuses and negative coping mechanisms are on the rise while access and operational capacity to respond are deteriorating. This concerns in particular countries with ongoing conflicts such as Libya, Syria and Yemen, as well as regions such as the Sahel and the Lake Chad Basin. Active and increasing conflict and/or political instability is occurring in over 80 per cent of operations (17 out of 21 operations) over the past two months, with 11 countries reporting attacks on humanitarian staff, assets or infrastructure).

Ongoing or increased conflict and violence hamper prevention, control and treatment responses to the pandemic. The UN Secretary-General called for a global cease-fire[43] on 23 March 2020, urging parties to conflicts worldwide to pull back from hostilities. The appeal has been supported by a vast majority of Member States as well as over 20 armed movements and other entities, and various regional, faith-based, civil society and non-governmental organisations. A global call has also been made to end all violence against women and girls including in the home[44].

41 https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=KG

42 https://data.worldbank.org/indicator/BX.TRF.PWKR.DT.GD.ZS?locations=TJ

43 https://www.un.org/press/en/2020/sgsm20018.doc.htm

44 https://www.un.org/sg/en/content/sg/statement/2020-04-05/secretary-generals-video-message-gender-based-violence-and-covid-19-scroll-down-for-french

However, many ceasefires are now elapsing or being reversed, and in a number of countries the violence has intensified as COVID-19 toll has continued to mount. In Ethiopia for example, there are risks that armed groups might incite political or ethnic violence around misperceptions of the virus being associated with an ethnic group, resulting in new waves of conflict or displacement.

In many countries covered by the GHRP, COVID-19 emergency measures have been extended. Worrying signs of erosion in the respect for civil and political rights have been monitored, with emergency measures often imposed without the necessary safeguards, or in contravention of international norms and standards on the use of force. These can result in adverse effects on low-income households, daily-wage and informal workers, and persons living in poor and informal settlements who are increasingly exposed to violence, fines or charged with criminal offences in the enforcement of lockdowns or restrictions of movements[45].

The main protection concerns are reported below, with additional information on specific vulnerable groups provided in Section 2.3 below.

Gender-based violence (GBV) *(see section 2.3 below - Women - for additional information)*

As the COVID-19 pandemic deepens economic and social stress coupled with restricted movement and social isolation measures, gender-based risks are increasing exponentially. Over 240 million women and girls aged 15-49 have been subjected to sexual and or physical violence perpetrated by an intimate partner in the previous 12 months. Violence is also affecting older women. The number is likely to increase as security, health, job loss, and money worries heighten tensions and strains are accentuated by cramped and confined living conditions. The COVID-19 context is increasing risk factors that drive the regularity, intensity, and frequency of violence against children and women globally.

Different countries have seen an increase in reported incidences of GBV since the outbreak, such as Lebanon, Somalia, Venezuela and Zimbabwe; although numbers of survivors accessing services fluctuated. However, it is important to note that limitations in service accessibility and availability, lack of information and increased isolation may result in a reduction of reported cases. As such, fluctuations are not indicative of a reduced risk of GBV. In Lebanon, for example, the Gender-Based Violence Information Management System reports increases of several forms of GBV during the first quarter of 2020 compared to the same period months of 2019 including disproportionate violence against women and girls (99 per cent female survivors) and an increase of violence perpetrated by an intimate partner or family member since the lockdown (69 per cent). More than half were committed by current and former partners.

There has also been a marked increase in reported incidents of physical assault that occurred in the survivors' home (65 per cent). About 37 per cent of women and girls, out of a total of 250, reported feeling less safe since the COVID-19 lock down in Lebanon. In addition, the closure of local courts increased impunity for acts of GBV and exploitation, such as in Liberia and Venezuela.

Venezuela reported a 65 per cent increase in femicides in April 2020, when the containment measures began, compared to April 2019. In Zimbabwe, the national GBV Hotline reported an increase of over 70 per cent from pre-lockdown trends. In Somalia, there was a rapid rise in reports of Female Genital Mutilation perpetrated against girls. In Ukraine, there was a 72 per cent rise compared to the pre-quarantine month and 67 per cent growth of GBV survivors seeking care compared to the month prior the COVID-19 outbreak.

In East and Southern African region with already high rates of GBV[46], those seeking assistance for GBV have increased since COVID-19. For example, Kenya's National Council on the Administration of Justice has seen a significant spike in reports of sexual offences during COVID-19, constituting 36 per cent of the criminal matters registered by police during the last two weeks of March 2020[47]. In Yemen, GBV actors are concerned that families

45 E.g. Zimbabwe, Liberia, Kenya, Nigeria, Mali, Guinea Bissau, South Africa

46 The regional prevalence of physical and/or sexual intimate partner violence among all ever-partnered women is 37 per cent, compared to the global prevalence level of 30 per cent. This figure masks significant variation between and within countries, and prevalence levels are often higher in poorer and fragile communities – those least able to deal with shocks such as COVID-19, which will exacerbate drivers of GBV. See WHO (2013) Global and Regional Estimates of Violence Against Women https://apps.who.int/iris/bitstream/handle/10665/85241/WHO_RHR_HRP_13.06_eng.pdf?sequence=1

47 http://ncaj.go.ke/statement-on-justice-sector-operations-in-the-wake-of-the-covid-19-pandemic/

struggling to feed their children may increasingly resort to arranging early marriages as the ban on social gatherings has made it more affordable to marry off young girls.

GBV, and sexual and reproductive health considerations are not prioritized as essential services, especially in public hospitals, thereby affecting particularly survivors' access to critical services including legal institutions needed for adequate response. Projections from UNFPA indicate that for every 3 months the lockdown measures continue, an additional 15 million cases of gender-based violence globally are anticipated. GBV response services to support survivors are facing major hurdles in their ability to reach survivors due to mobility restrictions and diversion of resources, and the GBV response throughout the COVID pandemic has not been at the scale of the need (see 2.3 above)[48].

Alongside the increase in numbers, GBV is taking on new complexity: exposure to COVID-19 is being used as a threat; abusers are exploiting the inability of women to call for help or escape; women also risk being thrown out on the street with nowhere to go. At the same time, support services are struggling. With the mobility restrictions, key responders are limited to national government in some locations and may include local actors in others, who do not have enough trained service providers to meet the increasing need, and even the pre-existing space is shrinking as they are re-allocated to COVID-19 response. Civil society groups, particularly women-led organizations and human rights defenders at the grassroots, are affected by lockdown and reallocation of resources. Some safe spaces/ shelters have restricted the numbers of women who can enter due to requirements for physical distancing, while others have had to close or have been repurposed as health centres. This is mainly due to lack of recognition of GBV services in many countries as essential services within the national COVID19 response strategy and security workforce has not been sensitized on mobility of GBV service providers, which is coupled with transport unavailability and reduced service accessibility. Adolescents and girls are also at increased risk of online exploitation and abuse during confinement.

The most striking concern is that COVID-19 and related measures affect women and girls' access to their basic rights and freedoms in the immediate and long term, reinforcing gender inequalities. In Afghanistan, women and girls often face restrictions regarding their movement and social life due to traditional and patriarchal norms, which prevent them (particularly in rural and conservative areas) from accessing education, healthcare, employment and deprives them of public participation and freedom of movement. With lockdown and restrictive measures, the situation is worsening and progress made is being reversed, restricting women and girls from accessing public space and services. Male GBV survivors are also experiencing new vulnerabilities, placing them at more risk of rape and sexual violence, both from the general public and employers.

Initial rapid assessment exercises conducted by the Health Cluster in Somalia and Iraq indicate an increase in health service utilization by GBV survivors, particularly women enduring intimate partner violence. In Somalia, over 52 per cent of participating partner organizations observed an increase in demand for GBV-related health services (13 of 25 organizations). Of these organizations, nearly 92 per cent reported provision of health care services to women experiencing intimate partner violence (23 of 25 organizations). In Iraq, nearly 40 per cent of health facilities, hospitals, and mobile medical clinics responding to the assessment indicated an increase in women survivors of GBV seeking assistance during the COVID-19 outbreak (40 of 48).

In Iraq, a sharp increase in domestic violence has been reported since the outbreak of COVID-19, including rape, sexual harassment of minors and suicide related to spousal abuse. According to a GBV rapid assessment, 40 per cent of health service providers indicated an increase in the number of survivors seeking help. The Office of the Presidential Advisor for Women's Equity in Colombia has reported a 150 per cent increase in calls to the national helpline for domestic violence between 25 March and 11 June 2020 compared to the same period in 2019, believed to be directly linked to isolation measures. The Colombian Ministry of Health has reported a 17 per cent increase in the number of gender-based violence cases against Venezuelans in April-May 2020, as compared to 2019.

In Lebanon, calls to domestic violence hotlines

48 https://www.unfpa.org/press/new-unfpa-projections-predict-calamitous-impact-womens-health-covid-19-pandemic-continues

increased by 110 per cent in the month of March 2020, compared to the same period a year earlier. In Bangladesh, a study by Merrill J. Fernando (MJF) Charitable Foundation in May 2020 estimated that violence against women and children has increased by 31 per cent due to COVID-19. In Zimbabwe, the number of calls received through a UNICEF-supported 24/7 helpline has tripled compared to the situation before COVID-19.

However, in other locations, requests for support have dropped, indicating increased isolation, fear and controlling behavior from abusers, preventing GBV survivors from accessing the help they need. For example, the IRC has experienced a 50 per cent decrease in GBV survivors accessing services in Bangladesh and a 30 per cent decrease in Tanzania. A surge on GBV services is expected once they reopen and some of the restrictions are lifted. This will increase the pressure on these already under resourced service.

Sexual exploitation and abuse

As seen in previous public health emergencies, when the humanitarian response scales up the risk of sexual exploitation and abuse (SEA) increases. Women and children in particular face heightened protection risks. The surge in new responders (including non-traditional humanitarian responders) combined with high demand and an unequal supply of food and health supplies increases risks.

All people should remain safe from sexual exploitation and abuse while receiving humanitarian aid, including health services and treatment, without abuse or exploitation. If sexual exploitation or abuse does occur victims should have access to safe and confidential reporting channels and services. In accordance with their responsibilities, humanitarian agencies and the HCT/UNCT have been strengthening actions to protect from sexual exploitation and abuse, including awareness-raising, safe and accessible reporting mechanisms, collective training and strengthening codes of conduct, adopted to the constraints of the current context[49] *(see also Part III, section 3.4).*

Violence against older persons *(see section 2.3 below - Older people - for additional information)*

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 discourse around COVID-19 that portray it as a disease of older people can lead to social stigma and exacerbate negative stereotypes about older persons[50]. In a number of countries, ageist stereotypes, prejudices and hate speech on social media, in the press and in statements made by politicians isolate and stigmatise older people[51].

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 countries dealing with the pandemic. Curfews and self-isolation policies are also sometimes imposed on older people on the basis of their age, disproportionately restricting their freedoms[52].

Child protection *(see section 2.3 below - Children - for additional information)*

School closures may have gender-specific immediate and long-term impacts, increase protection risks for children, while children outside of family care, such as children in street situations, children on the move, and children with disabilities in institutions or children in detention centres, are particularly vulnerable, including to discrimination within the community. Indeed, child protection risks have worsened in 17 countries included in the GHRP for which data is available, due to the pandemic, including violence against children (all countries), child marriage (12 countries) and cases of children and family separation (16 countries). In Zimbabwe for example, the child helpline has recorded a 43 per cent increase in calls since April 2020.

Children are at risk of separation from their caregivers and have expressed fear of being

49 See also IASC Interim Technical Note 'Protection from Sexual Exploitation and Abuse (PSEA) during COVID-19 Response': https://reliefweb.int/report/world/interim-technical-note-protection-sexual-exploitation-and-abuse-psea-during-covid-19

50 World Vision. "COVID-19 Aftershocks: Secondary Impacts." May 2020. https://www.wvi.org/publications/report/coronavirus-health-crisis/covid-19-aftershocks-perfect-storm

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

52 See for example: Serbia https://www.reuters.com/article/us-health-coronavirus-serbia/serbia-imposes-night-curfew-orders-elderly-indoors-idUSKBN2143XR; Sweden https://www.theguardian.com/world/2020/mar/23/swedish-pm-warned-russian-roulette-covid-19-strategy-herd-immunity; UK https://www.itv.com/news/2020-03-14/elderly-to-be-quarantined-for-four-months-in-wartime-style-mobilisation-to-combat-coronavirus/; Israel https://www.i24news.tv/en/news/israel/1584727140-bennett-isolating-the-elderly-as-nation-develops-herd-immunity-is-key-to-defeating-virus; Ireland https://www.echolive.ie/corknews/Ireland-goes-into-lockdown-Taoiseach-warns-of-difficult-days-ahead-48040614-b3b2-4cbc-897f-c2b3c0e9fe9a-ds ; Bosnia-Herzegovina https://balkaninsight.com/2020/04/02/bosnia-and-herzegovinas-coronavirus-curbs-on-children-and-older-people-are-ill-conceived/

separated from their family and subjected to exploitation if found to be positive for COVID-19. The risks of family separations can increase (sick parents, quarantine, or displacement), as well as the risks of death of parents, as well as stigmatization and exploitation of those who survive them. In addition, the possible stigmatization of certain groups and tensions between communities might increase the risk of family separations should people be forced to move

Measures taken in response to COVID-19 and their impact on family unity and coping mechanisms, may also cause children to be at heightened risk of being separated or unsupervised for longer periods, suffer neglect and increase their risk of being abused or exploited.

Other protection concerns - *(See also section 2.3 below for other population groups)*

Violence has been observed against people believed to be carriers as well as explicit denial of health services to indigenous peoples, ethnic minorities, refugees and migrants refused access to asylum or forced to undertake premature returns to their country of origin, and evictions of people believed to be infected or perceived carriers. Foreigners, including health and other humanitarian personnel, have commonly been seen as carriers of the virus. There are reports of people of countries believed to be carriers put into quarantine or evicted regardless of travel history or health status.

Stigmatized as vectors of contagion, many health care workers involved in the COVID-19 response have been physically and verbally assaulted, while others were denied transport services when commuting to work or had their entire families evicted from their homes. Despite repeated calls for ceasefires in conflict-affected settings, health care resources continue to be targeted amid the COVID-19 crisis. The WHO Surveillance System for Attacks on Health Care captured 12 attacks on health care from 6 countries experiencing complex humanitarian emergencies, while struggling to deal with COVID-19. These attacks were particularly brutal resulting in 38 deaths and 23 injuries of health care workers and patients. In addition to the recorded attacks, more than 100 incidents were also identified from secondary sources across different countries as the world struggled with COVID-19, highlighting the magnitude of the problem.

Health care workers, the majority of them women, now face a double burden of violence that takes root in pre-existing armed conflicts and heightened fear of contagion. Under constant threat of violence and infection, hundreds of health care workers in Lebanon, Nigeria, Yemen and other countries have interrupted services to denounce attacks on health care, lack of personal protective equipment or dismissals during the COVID-19 crisis.

Screening of secondary data was initiated to capture the trend and magnitude of the issue. This data is used to raise awareness among relevant parties, and advocacy efforts. In addition, WHO, together with partners, issued several social media campaigns aiming to raise awareness of the problem. As many incidents, especially those in relation to COVID-19 response stem from fear of the public and stigmatisation of health care workers and patients, the campaigns focused on raising awareness among the public and also highlighting protective measures that can be taken by health care workers and providers. In addition, active advocacy on the topic was conducted for the promotion of measures for protection of health care workers. Many governments also implemented specific legal and policy measures for the protection of health care from attacks.

Pictures of people seeking health care have been posted on social media leading to the social exclusion of those individuals. Rumors that certain military forces are deliberately spreading COVID-19 illustrates how COVID-19-related disinformation takes on context-specific political dynamics.

Examples of health care discrimination based on sexual orientation, gender identity, disabilities, refugee or migrant status have been extensively documented in many countries included in the GHRP. This discrimination can elevate the risks for LGBTIQ+[53] people from COVID-19. The pandemic has disconnected them from their networks following the closure of health and community centres that provided safe and supportive spaces. It has required many LGBTIQ+ people to stay home for extended periods of time, including non-accepting with family members, which exposes increased risk of family stigmatizing or abuse.

Given overloaded health systems, access to health services by LGBTIQ+ people, including HIV treatment and testing, hormonal treatment has been interrupted or deprioritized. Many of them have also subjected

53 Lesbian, gay, bisexual, transgender, intersex and questioning or queer.

to stigmatization, discrimination, hate speech and attacks, and may face negative mental health effects of quarantine, which may compound pre-existing health conditions.

Effects on education *(See also section 2.3 below - Children)*

Nearly 1.19 billion students in 150 countries have been affected by school closures, and vulnerable and hard to reach children, particularly girls, are in danger of dropping out of the education system altogether as many are not able to be reached with alternative learning methods. With school closures and significant inequities in access to online learning, the education gap is widening with immediate impact on children's wellbeing and medium to long-term challenges to recovery.

UNDP estimates show that 86 per cent of children in primary education are currently effectively out-of-school in countries with low human development, compared with just 20 per cent in countries with very high human development. For example, 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 more than 533,300 pupils and 8,000 youth at TVET centres.

Effects on water, hygiene and sanitation services (WASH)

WASH commodities and services play a direct and critical role in suppressing the global reach of the pandemic, along with other measures such as physical distancing and quarantines. The immediate socio-economic impacts of the pandemic pose a significant risk to WASH services, including limited access to safe WASH services, particularly for the most vulnerable populations.

Effects on supply chains and logistics

Global supply chains and logistics

Since the onset of COVID-19, supply chains globally have seen a significant slowdown due to measures put in place by governments to limit the spread of the pandemic, with reduced capacity across all transport sectors and extreme price and market fluctuations due to heavy demand for limited

School closures

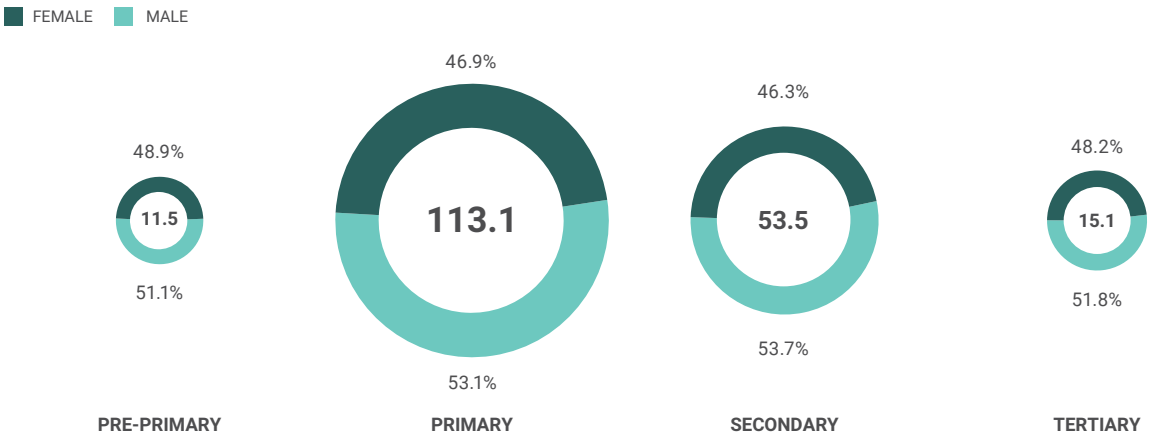
33%
OF ALL CHILDREN AFFECTED BY SCHOOL CLOSURES LIVE IN COUNTRIES WITH A HRP

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%
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



Source: UNESCO en.unesco.org/covid19/educationresponse

available capacity As of June 2020, some sectors of global transport markets have started witnessing a stabilization of prices and capacity, including the aviation industry, as restrictions in certain regions and countries have been partially lifted and air freight rates have stabilized to a range far from the extreme spikes witnessed at the onset of the pandemic. However, this sector, one of the most impacted by COVID-19, is still suffering from severe disruptions.

Cross-border movement of commercial and humanitarian cargo has for the most part continued during the pandemic. However, congestion and delays have been reported at some border crossings due to implementation of COVID-19 containment measures such as quarantine, testing or additional sanitation measures and reductions in numbers of staff. Delays were witnessed particularly at border crossings throughout East Africa (east at the Kenya/Uganda Malaba border, Uganda/South Sudan border) and West Africa (Central African Republic/Cameroon border). Measures to contain the spread of the virus have also been put in place at major ports used by WFP, such as mandatory quarantine periods for ships calling at some ports, including those in Nigeria and Yemen. A reduction in port throughput has also been seen in several locations, such as Mombasa port, due to a reduction in staff numbers, movement restrictions and delays in customs clearance.

Food supply chain

The smooth functioning of food value chains and the flow of agricultural products are key factors influencing food security and nutrition. It is vital to maintain and support the continuous functioning of local food markets, value chains and systems, focusing on vulnerable smallholder producers and food workers, as well as areas that are critical to the food supply for vulnerable urban areas.

However, government restrictions, such as import restrictions and movement limitations necessary to contain the spread of the virus, have been disrupting entire food chains – from production to processing, packaging, transporting, marketing and consumption – as well as livestock movements, which are critical for pastoralists' survival. Although food and agricultural commodities are considered in many countries to be essential and are in theory exempted from restrictions, supply chains have also been slowed and disrupted by delays at borders, checkpoints, and transport. Moreover, labour shortages have further disrupted the food chain, with many returning to their original homes in rural areas and awaiting the restrictions to be eased and the risk of infection to be minimized.

For example, in Afghanistan closed international borders have adversely impacted exports of agricultural products, resulting in cascading effects along the value chains to the farm-gate level, which may exacerbate food insecurity in rural areas, if border closures are prolonged. The closed borders/restricted trade flows have resulted in a significant reduction (for some commodities, up to 70–80 per cent) in agriculture imports and exports including cereals, vegetables, fruits, nuts, poultry, dairy, eggs, meat, cooking oil, and other essentials. This drastic fall in trade has also adversely impacted food processing units resulting in loss of perishable commodities, incomes and livelihoods for workers.

In Eritrea, movement restrictions, particularly border closures, have limited access to traditional grazing and water points for transhumant pastoralists in some areas. Livestock health is also threatened by a reduced availability of medicines in certain areas, as well as the suspension of vaccination campaigns in Djibouti and Eritrea. The dairy value chain has seen increased milk losses due to reduced consumer demand and longer transportation times.

In the Philippines, the fishing season for the Visayan Sea and North-East Palawan was closed, disrupting the food chain for nutritious seafood products. Although operations have been able to resume, the most vulnerable smallholder agri-fishery communities are likely to have adopted negative coping strategies, such as selling of assets and are consequently less equipped to continue with income generation until the end of the year. In Zimbabwe, livestock farming communities in areas affected by dry conditions, such as in the Far North, East and South of the country, are experiencing challenges to keep their animals alive. This is partly due to low quality and availability of grazing, disruption in the supply chain of animal feed and lack of veterinary support, leading to reduced income-earning opportunities for households that depend on livestock sales.

2.3

Most affected population groups

Women and girls

Women and girls' health and nutrition

Women are less likely to receive the health attention they need in the context of COVID-19, especially in conflict settings, and COVID-19 testing and cases may be underreported. The gender disparity of cases is particularly stark in Afghanistan, Central African Republic, Chad, Pakistan, Somalia and Yemen where confirmed female COVID cases are below 30 per cent[54]. In Yemen, 75 per cent of cases are male and 25 per cent female; in Chad, Central African Republic and Pakistan, 74 per cent of cases are male and 26 per cent female, and in Afghanistan and Somalia, 72 per cent of cases are male and 28 per cent female. This compares to the proportions of COVID-19 cases in richer countries which matches the global ratio of female cases equal to or very close to 50 per cent.

This may be related to norms that require the authorization of a male family member to seek health care and receive appropriate treatments, and gender-based discrimination. Women and girls who are denied the power to make their own informed decisions, are at greater risk of not being tested for the COVID-19 disease and treated. Women caring for others, and the predominant role they play as health and social welfare responders, are particularly exposed to potential contamination. Globally, 70 per cent of workers in the health and social sector are women[55], including as frontline health workers, and women perform 76 per cent of the total hours of unpaid care work, more than three times as much as men[56], thus increasing women's risk of exposure to the virus.

In addition, women, girls and other at-risk populations often have less access to information, including critical information related to COVID-19 transmission and prevention, as well as available support services. They are also more likely to receive inaccurate information, whether deliberately (to uphold existing unequal power structures and/or to create opportunities for exploitation) or inadvertently.

Women are particularly at risk of food insecurity and malnutrition due to their lower access to income and food as a result of their informal employment, low access to productive and financial resources, and social norms conditioning the distribution of intra-household food resources. This risk is increasing with COVID-19 putting a further strain on employment and agricultural production. Pregnant and lactating women, women of reproductive age and adolescent girls have increased nutritional needs that can be unmet as a result.

Breastfeeding may also be negatively impacted by misinformation about the risk associated with COVID-19 – mostly signaling that breastfeeding should be suspended – despite clear WHO guidance.

Women and girls affected by gender-based violence (GBV)

Gender-based discrimination and socio-economic inequalities exacerbated by the pandemic will place the most vulnerable groups of women and girls at an even higher risk of violence. In the aftermath of the crisis, violence against women and girls will continue to escalate, at the same time as unemployment, financial strains, and insecurity increase. A loss of income for women in abusive situations makes it even harder for them to escape. The financial impact of COVID-19 will also affect the capacity of local women's organizations to advocate for policy reforms on violence against women and girls and for service provision including sexual and reproductive health, for survivors of violence over the long-term.[57]

54 IRC - https://www.rescue.org/press-release/covid-19-testing-and-cases-among-women-conflict-settings-may-be-underreported-new-irc

55 WHO. Boniol M, McIsaac M, Xu L, Wuliji T, Diallo K, Campbell J. Gender Equity in the Health Workforce: Analysis of 104 Countries. https://apps.who.int/iris/bitstream/handle/10665/311314/WHO-HIS-HWF-Gender-WP1-2019.1-eng.pdf?ua=1.

56 International Labour Organisation (ILO). Care Work and Care Jobs for the Future of Decent Work. 2018. https://www.ilo.org/wcmsp5/ groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf.

57 UN Women 2020: https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006

As COVID-19 has spread across the world, gender-based violence has emerged as a 'shadow pandemic', The pandemic and accompanying isolation policies has led to an escalation of gender-based violence while simultaneously creating a unique set of challenges in the availability and accessibility of response services. Intimate partner violence has increased as a result of forced co-existence, coupled with economic stress and the anxiety related to the pandemic. In different countries there are reports of 60 – 770 per cent increase in calls to domestic violence helplines[58], including 775 per cent increase in calls of the national hotline in Kenya[59]. In Lebanon, out of 250 women and girls interviewed, 37 per cent reported feeling less safe since the COVID-19 lockdown.

The closure of schools has also added on the disproportionate caregiving responsibilities of women (sometimes forcing them to quit their jobs) and has put girls at greater risk of sexual exploitation and abuse, as well as harmful traditional practices such as early marriage and female genital mutilation/cutting[60]. Disrupted efforts globally to end child marriage coupled with increasing poverty (which is a known driver of child marriage, with families more likely to marry off their daughters in times of economic stress to alleviate the perceived burden of caring for them) is expected to result in a possible 13 million additional child marriages by 2030 than would have otherwise.[61]

The impact of COVID19 and the associated spike in gender-based violence are expected to be even worse in humanitarian contexts due to forced displacement, widespread poverty, weak health systems and a lack of protective community support structures. Given the living conditions of refugee and internally displaced women and girls, concerns remain on their heightened risk of contracting COVID-19 and experiencing GBV.

This is also the case in the Latin America region which has become the epicenter of the COVID-19 pandemic, due to the long-standing structural challenges such as social inequality and pre-existing humanitarian needs. The continuity of essential sexual and reproductive health and gender-based violence services during the COVID-19 pandemic is a challenge in the region, as well as in other countries with large numbers of migrants and refugees.

Recent research has shown that the social and economic costs of GBV to societies are far reaching, impacting on women's participation in the workforce, household income and on national economies[62]. This means that economic damage inflicted by COVID-19 will be exacerbated if it is accompanied by elevated levels of GBV in societies. In Kenya, for example, the annual total cost of GBV to the economy is $430 million[63]. Higher rates of GBV are also correlated with higher levels of state fragility, requiring due consideration in macroeconomic and social plans being put in place.

Women's livelihoods

Across every sphere, from health to the economy, security to social protection, women and girls are without exception the hardest hit by this pandemic. The situation is worse in countries included in the GHRP where the vast majority of women's employment (70 per cent) is in the informal economy with limited access to social protection and fiscal stimulus. From past experience and emerging data, it is estimated that the impacts of the COVID-19 global recession will result in a prolonged dip in women's incomes and labor force participation, with compounded impacts for women already living in poverty.

The economic impact of COVID-19 resulting to closure of business puts significant financial strains on communities, and particularly vulnerable populations including women and girls who disproportionately work in insecure, lower-paid, part-time and informal employment, with little or no income security and social protection, such as health insurance – and are therefore less protected from economic recession in times of crisis. In Pakistan for example, women and girls accounting to 70 per cent of informal sector workers are largely excluded from the bail-out package announced by the government for reviving businesses and industry. This situation may lead to increases in negative coping strategies such as hazardous forms of child

58 ICRC, COVID-19, Conflict and Sexual Violence: Reversing the Burden of Proof, June 2020

59 Healthcare Assistance Kenya, Weekly National GBV Cases Analytical Report, Week Four (22 – 29 May, 2020)

60 Gender-based violence (GBV) Area of Responsibility Helpdesk Research Query, GBV East and Southern Africa Regional Working Group Position Paper, May 2020

61 https://www.unfpa.org/news/millions-more-cases-violence-child-marriage-female-genital-mutilation-unintended-pregnancies

62 What Works (2020), Economic and Social Costs of VAWG, Evidence Brief. Pretoria: What Works to Prevent VAWG. https://www.whatworks.co.za/resources/policy-briefs/item/697-economic-social-costs-of-vawg

63 The economic burden on survivors: https://www.ngeckenya.org/Downloads/GBV%20Costing%20Study.pdf

labour and child marriage.

Women also comprise on average 43 per cent of the agricultural labour force in developing countries while accounting for an estimated two-thirds of the world's 600 million poor livestock keepers. They are expected to be particularly hard hit by the indirect impacts of the pandemic as they generate income predominantly through food processing, marketing of produce in local markets, petty trade and in the service industry – all industries that are hardest hit by COVID-19 prevention and control measures. As a result, female-headed households and those that heavily rely on women's income are likely to face increased levels of food insecurity, compounding the inequality in food systems already faced by women before the pandemic[64].

Migrant women and girls are particularly vulnerable to the impact of COVID-19, as they face discrimination based on both gender and migratory status. In addition, migrant women form a large share of the essential workforce across several sectors impacted by COVID-19, including the health sector, as well as the service and tourism industry.

Persons with disabilities

Persons with disabilities are disproportionately affected by health, social and economic impacts of COVID-19 due to their reliance on service providers and informal support networks for daily tasks, lack of access to remote learning options, and pre-existing health conditions isolation and marginalization. However, despite this situation, data on the situation of persons with disabilities, including data disaggregated by disability, is very limited.

Violence, stigma and discrimination against persons with disabilities

Pre-existing negative perceptions and stigma against persons with disabilities due to their perceived associations with the pandemic, and are impacting their safety and access to health, protection, and livelihood services. The pandemic has intensified attitudinal barriers and violence against persons with disabilities, threatening their autonomy and inclusion in the community. In Haiti, 81 per cent of households led by or including persons with disabilities reported that the pandemic could result in increased stigmatisation within the communities of older persons, persons with disabilities and persons living with HIV or AIDS. Pre-existing beliefs and traditional practices are leading to more discrimination and violence against these groups.[65]

Persons with disabilities, particularly women and children with disabilities, and persons providing support, including kinship support, face heightened protection risks such as abuse or violence. Containment measures, self-isolation of households and disruption of community life, services and social support may lead to increased protection risks for persons with disabilities. In Ethiopia for example, since the COVID-19 outbreak 22 per cent of adult respondents with disabilities felt unsafe in periods of prolonged work closure and movement restrictions, and 11 per cent less safe and protected from violence and abuse, while 42 per cent of child respondents with disabilities reported experiencing fears/ anxiety/ feeling unsafe.[66]

Information and health barriers faced by persons with disabilities

In the context of the pandemic, people with disabilities are lacking accessible information and are being subject to discrimination and violence based on disability stigma. Barriers reported by persons with disabilities to implement preventive and protection measures intervention include the use of inaccessible communication channels and formats, as well the lack of access to information useful for persons with disabilities such as how to protect themselves, and where to access assistance and report violence.[67] In particular, children with disabilities have limited access to remote education due to education provision being delivered in inaccessible ways (for example, radio SSD and TV education do not have a sign language).

Methods to reach out to more isolated and remote communities have been strongly absent, impacting persons with disabilities in remote locations, those without family or community networks, and those

64 https://www.care.org/sites/default/files/documents/covid_food_security_and_gender_equality.pdf

65 Humanity & Inclusion, Rapport de l'enquête rapide sur les connaissances, attitudes et pratiques des personnes handicapées et de leurs familles en lien avec le mécanisme de réponse de la COVID-19 (21-24 April 2020, Port-au-Prince – Haiti), 37 households.

66 Humanity & Inclusion, Survey Report, Persons with disabilities and COVID-19 in Ethiopia: Knowledge and impact, May 2020. A total of 895 adults and children with disabilities participated in the survey, including 446 adults (258 women and 188 men) and 449 children from 5 to 18 years of age (286 girls and 163 boys). 40% were displaced or refugees and 60% from the host community.

67 Humanity & Inclusion, COVID-19 in humanitarian contexts: no excuses to leave persons with disabilities behind!, June 2020, https://blog.hi.org/wp-content/uploads/2020/06/Study2020_EN_Disability-in-HA-COVID-final.pdf

in institutions, such as residencies or care homes. For example, in Ethiopia, 10 per cent of adults with disabilities and 17 per cent of children with disabilities reported not having access to public information on COVID-19, 20 per cent of adults and children reported that the information provided on COVID-19 was difficult to understand as the messages included too many words, and 6-8 per cent of adults and children reported that the format was inaccessible.[68]

Persons with disabilities are challenged to access health care, in particular to maintain medical treatment, access rehabilitation care or social support services. Some 22 countries have reported a drop of more than 25 per cent coverage of disability support services since the onset of the pandemic. Health care rationing or the redirection of resources towards the COVID-19 response can also lead to poor health outcomes and reduced healthcare-seeking behavior from persons with disabilities, who are at risk of becoming subject to discrimination and denied access to services. Many are reporting unmet health needs and the aggravation of their situation, risking complications and additional permanent impairments or reduced functional ability.[69]

In Jordan, 88 per cent of persons with a physical impairment and with current medical needs reported that they could not go to the hospital either for their regular checks or for additional medical needs.[70] In Lebanon, 68 per cent of households with at least one member having a disability, reported having difficulty finding medications over the 30 days before the assessment and 59 per cent had difficulties procuring hygiene items, while 41 per cent lacked accessible information about COVID-19 and community quarantine.[71]

Livelihoods of persons with disabilities

Persons with disabilities, especially women and displaced persons, are more exposed to economic shock of the pandemic as they lack access to the informal and formal economy and to disability-inclusive social protection schemes. Many countries do not have disaggregated data of the socio-economic impact on persons with disabilities and do not implement specific measures to ensure their protection. In Manila, the Philippines, 95 per cent of youths with disabilities needed urgent financial aid, 74 per cent were worried about insufficient food supply, 69 per cent about loss of employment or income, and 64 per cent about the lack of availability of transportation.[72] In Haiti, 65 per cent of respondents with disabilities said that the economic support that they received has been greatly disrupted since the declaration of the state of health emergency, due to quarantine measures preventing other household members from working.[73]

In Lebanon, households with at least one member with a disability reported purchasing food on credit (74 per cent), reducing spending on essential non-food items including hygiene products (53 per cent), using savings (28 per cent) and selling household assets such as jewelry and phones to purchase food (23 per cent). The assessment showed greater impact of COVID-19 on refugees and displaced persons with disabilities with 69 per cent of Lebanese households compared to 78 per cent of Palestinian households and 93 per cent of Syrian households reporting not being able to meet all their food needs in April 2020.[74]

In Liberia 16 per cent of the population have a disability and Disabled people's organizations estimated that 99 per cent of persons with disabilities were living in extreme poverty already before the pandemic, mainly due to exclusion from education, skills training, work and income generation opportunities.

68 Humanity & Inclusion, Survey Report, Persons with disabilities and COVID-19 in Ethiopia: Knowledge and impact, May 2020. A total of 895 adults and children with disabilities participated in the survey, including 446 adults (258 women and 188 men) and 449 children from 5 to 18 years of age (286 girls and 163 boys). 40% were displaced or refugees and 60% from the host community.

69 Humanity & Inclusion, COVID-19 in humanitarian contexts: no excuses to leave persons with disabilities behind!, June 2020, https://blog.hi.org/wp-content/uploads/2020/06/Study2020_EN_Disability-in-HA-COVID-final.pdf

70 Humanity & Inclusion, Needs Assessment, impact of COVID-19 on People with Disabilities and their Families in Jordan, April 2020.

71 Humanity & Inclusion, Impact Assessment. Understanding the impact of the financial crisis and COVID-19 on households in Lebanon of Users accessing specialized services, April 2020. 197 members of households with at least one user with at least one impairment, including 82 females and 115 males, from 18 to 60+ years.

72 Humanity & Inclusion, Survey on the Impact of Enhanced Community Quarantine on persons with disabilities in Manila, Philippines and Jakarta, Indonesia, April 2020. Surveyed 73 youth with disabilities from Manila and Jakarta, beneficiaries of HI project 'Forward Together'. The respondents are between ages 18-39. 44% are female and 56% are male.

73 Humanity & Inclusion, Rapport de l'enquête rapide sur les connaissances, attitudes et pratiques des personnes handicapées et de leurs familles en lien avec le mécanisme de réponse de la COVID-19 (21-24 April 2020, Port-au-Prince – Haiti), 37 households

74 Humanity & Inclusion, Impact Assessment. Understanding the impact of the financial crisis and COVID-19 on households in Lebanon of Users accessing specialized services, April 2020. 197 members of households with at least one user with at least one impairment, including 82 females and 115 males, from 18 to 60+ years.

Older persons

Older persons' health and mental health and psychosocial impact of COVID-19

Older people continue to be the worst affected by the direct health effects of COVID-19. In Europe, over 95 per cent of deaths occurred in those older than 60 years. More than 50 per cent of all fatalities involved people aged 80 years or older. Reports show that 8 out of 10 deaths are occurring in individuals with at least one comorbidity, in particular those with cardiovascular disease, hypertension and diabetes, but also with a range of other chronic underlying conditions[75]. In countries included in the GHRP, as of 13 July 2020 the case fatality proportion[76] in ages 80+ and above is rising up to over 25 per cent, compared to less than 1 per cent in all age groups below 35 years. In Niger, 67 per cent of deaths due to COVID-19 have occurred among older people, many of whom have seen their treatment for chronic diseases interrupted.

According to WHO reported COVID-19 case data, in the countries included in the GHRP, an average 17 per cent of reported cases have been in adults aged 60 years and above. This proportion is lower than the global average (about 30 per cent) due to the younger demographic profile of the population in these countries. However, significant under-reporting of public health surveillance data is suspected in humanitarian contexts, combined with a lack of testing capacities and under-representation of women and vulnerable groups in both testing and treatment.

The dramatic shift toward physical distancing measures presents important challenges to maintaining health of older people living in the community and long-term care facilities, particularly those who are frail, very old, or have multiple chronic conditions. Older adults with these characteristics are at high risk of adverse effects of COVID-19. In most countries, nearly 60 per cent of non-communicable disease service users are older adults aged over 60 or over. In a recent WHO survey, 121 countries reported these services are disrupted. Being at heightened risk for COVID-19, older people face discrimination in public space as well as barriers accessing testing and treatment, and services and medication for other pathologies.

Assessments in multiple contexts reveal that older people are experiencing worsening mental health as a result of the pandemic. Having to isolate themselves from usual care givers, they have experienced great levels of neglect and coped with new measures with limited support. In addition, HelpAge's age friendly spaces in camps have been closed due to the COVID-19 risks, leaving many older people ever more isolated.

In Lebanon, 51 per cent of older people felt worried or anxious all or most of the time, and 72 per cent were dependent on external support to cope with the current situation. In Cox's Bazar, Bangladesh, 86 per cent felt worried or anxious most or some of the time, and 66 per cent were depending on external support to cope with the current situation. In Iraq, 74 per cent of older people felt worried or anxious all or most of the time, 68 per cent felt depressed about the current situation all or most of the time, and 48 per cent were depending on external support to cope. In refugee camps in Tanzania, 71 per cent of older people felt worried or anxious all or most of the time, 67 per cent felt depressed about the current situation all or most of the time, and 56 per cent were depending on external support to cope.

Several assessments[77] conducted with older people in humanitarian contexts during May and June 2020. provide a useful snapshot of the current situation of older people and how it has changed due to COVID-19. Awareness of COVID-19 and prevention methods were reasonably high overall, especially hand washing, however older people faced barriers undertaking COVID-19 prevention measures and access to testing and treatment.

Many reported difficulties following advice to reduce the risk of contracting COVID-19. For example, 27 per cent of older people in refugee camps in Tanzania reported that they were unable to follow hand washing advice, notably due to the lack of handwashing facilities. More than half (59 per cent) of older people in Lebanon and 34 per cent in Syria were unable to follow advice to avoid group gatherings and shaking hands and to stay at home as much as possible. About 27 per cent of older

75 https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/4/supporting-older-people-during-the-covid-19-pandemic-is-everyones-business

76 Out of 51 315 fatalities reported into the case-based surveillance from GHRP countries and for which age is available,

77 These assessments were short interviews conducted by telephone and covering a limited number of questions. .https://www.helpage.org/newsroom/latest-news/neglect-and-abuse-of-older-people-around-the-world-intensified-by-covid19/

people surveyed in Cox's Bazar, Bangladesh, were unable to observe 2-meter physical distancing advice and 31 per cent were unable to follow hand washing advice.

Older people's preferred methods of receiving information varies considerably between contexts, suggesting strong consultation with them is needed to ensure needs are met. In Syria, for example, 51 per cent of older people reported that TV was their preferred method for receiving information about COVID-19. Word of mouth (39 per cent) and internet (36 per cent) were the second and third preferred methods for receiving information. In Tanzanian refugee camps, radio (63 per cent), loudspeaker (51 per cent) and community meetings (47 per cent) were the preferred methods.

Many older people were unaware of the location of the nearest testing and treatment facilities for COVID-19, and unable to access facilities when they were aware of them. Despite limited barriers to messaging in Lebanon, 39 per cent of older people did not know the location of the nearest health facility which treats older people for COVID-19, with a higher proportion of older women (45 per cent) than older men (33 per cent). Over half (53 per cent) of the older people in Syria did not know where the nearest facility for testing and treatment for COVID-19 was, particularly older people with disabilities (58 per cent). Among the older people who were aware of the location of the facility for testing and treatment COVID-19, 45 per cent reported that they cannot access them. This was higher among older women (50 per cent) than among older men (39 per cent).

Older people were also often unable to afford personal protective equipment. For example, 40 per cent of older people in Lebanon stated that they could not afford to purchase materials such as masks and soaps, despite these being available at local markets. In some contexts, older persons did however benefit from humanitarian distribution of personal protective equipment. This was the case for almost all older persons interviewed in Cox's Bazar, Bangladesh.

Across multiple contexts, older people report that their access to health services has changed since the pandemic. This was the case for 62 per cent of older people in Cox's Bazar, 52 per cent of older refugees in Tanzania, 30 per cent of older Lebanese people and 45 per cent for Syrian refugees in Lebanon, and 36 per cent of older Iraqi people consider that their access to health services has changed since COVID-19. This is higher for older people.

COVID-19 has caused significant disruption to older people's access to medications for ongoing conditions, with this reported as a major source of anxiety early in the pandemic. Some 32 per cent of older people in Iraq had not been able to access their medication since the start of the COVID-19 outbreak, 29 per cent in Syria rising to 32 per cent of older persons with a disability and 43 per cent of older people in camps.

Violence against older persons

Older people are facing significant protection risks in the pandemic. COVID-19 has amplified the violence, abuse, and neglect of older people around the world. [4] Before the COVID-19 pandemic, it was estimated that 1 in 6 older people were subject to abuse. Emerging evidence is indicating that this has sharply increased in many countries as a direct result of the pandemic and imposition of lockdown measures[78]

Assessments conducted with older people in humanitarian situations during May and June identified risk of increased violence and abuse, neglect and isolation. In Bangladesh, the top risks identified for older women during this time were emotional abuse (75 per cent), physical abuse (26 per cent), neglect (15 per cent) and denial of resources, opportunities or services (15 per cent).The main risks identified for older men were emotional abuse (72 per cent), physical abuse (38 per cent), and financial abuse (14 per cent). In Syria, the top two risks for older women and men were neglect (62 and 55 per cent respectively) and isolation (54 and 52 per cent respectively). For both men and women, the risks of neglect or isolation are considered higher by people living in camps than by people living in the community.

Livelihoods of older persons

Most people in low- and middle-income countries (LMICs) rely on irregular, unreliable multiple income sources in older age including pensions, employment, small businesses, assets, savings, and financial support from family and friends. Only 20 per cent of older people in LMICs have at least basic income security through a pension, and women

78 https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/4/supporting-older-people-during-the-covid-19-pandemic-is-everyones-business

are considerably less likely to have a pension. HelpAge's rapid needs assessments in humanitarian situations[79] prior to the pandemic revealed high levels of income insecurity and borrowing among older people as well as food insecurity. Older people are often excluded – both intentionally due to misconceptions about their age and ability, or unintentionally due to a lack of targeting – from humanitarian interventions to protect wellbeing and restore livelihoods.

Many older people have reduced the quantity and quality of their food, while food is consistently identified as a top priority for older people across many contexts. In Lebanon, for example, 35 per cent of older people reported difficulty accessing food and 29 per cent had difficulty accessing humanitarian assistance, especially Syrian refugees (39 per cent). Half of older Syrian refugees also reduced the quantity of food consumed and 45 per cent had sufficient food available in the house for less than 2 days. In Syria itself, 53 per cent of older people had less than 2 days of food available in the house.

Children

Children's health and nutrition

In countries with ongoing humanitarian situations, the pandemic has added yet another layer of vulnerability. With approximately 35 million births expected in the next three months the disruption in delivery and newborn care will leave mothers and newborns at high risk.

Most countries have suspended or delayed child immunisation campaigns since the onset of the pandemic (see section 2.1 above). Recent estimates suggest that up to 6,000 children could die every day from preventable causes over the next 6 months as a direct and indirect result of COVID-19 related disruptions in essential services.

Overall, as many as 30 million children's lives could be at risk due to the stress COVID-19 has placed on existing primary health services, and interruption of or reduced capacity to provide routine child health services. Of this, an estimated 26 million children are at greater risk of being exposed to potentially fatal infectious diseases due to a 30 per cent reduction in Diphtheria-tetanus-pertussis (DTP3) immunisation coverage, while 100,000 additional children, an increase of 50% from current levels, could die from malaria[80].

In the Middle East and North Africa region, the COVID-19 pandemic has placed health systems under unprecedented pressure. An additional 51,000 children under the age of five might die in the region by the end of 2020 if the current disruption of essential health and nutrition services is protracted. If this happens, it would be an increase in under 5 child deaths of nearly 40 per cent in comparison to pre-COVID figures, reversing progress made in child survival in the region by nearly two decades.

With the closure of schools, 369 million children across 143 countries have missed out on school meals, while many of these children rely on school meals for a source of daily nutrition. This increases the risk of malnutrition among some of the most vulnerable children globally.

In countries facing food crises such as Sudan, Syria and Yemen, the quantity, frequency, and diversity of the food that the most vulnerable children and families consume have further decreased. These countries are among the top 10 countries in the world experiencing the worst food crises in 2019, with a total of 28.4 million people affected. These countries are also locations where UNICEF estimates that the prevalence of severe acute malnutrition among children will likely increase by 10 per cent by the end of this year.

More generally, recent UNICEF estimates indicate that in the absence of timely action the number of children under 5 with wasting (severe acute malnutrition) could increase globally by about 15 per cent (7 million children) over the first 12 months of the pandemic, with higher increases in Africa expected (20-25 per cent). In Niger for example, levels of severe acute malnutrition are anticipated to increase by 35 per cent (about 533,400 cases) and moderate acute malnutrition by 27 per cent (about 1,070 cases) due to deterioration of infant and child feeding practices and childcare practices. Over 250 million children globally under 5 also continue to miss out on the benefits of vitamin A supplements (vital to strengthen children's immune systems) due to the pandemic containment measures.

Violence against children

The COVID-19 context has increased the risk factors

79 https://www.helpage.org/resources/publications/?ssearch=rapid+needs+assessment&adv=0&topic=0&region=0&language=0&type=0

80 Projection from World Vision research, based on the impact the Ebola epidemic had on routine primary health care services for children under five years from 2014-2016 in west Africa. - see https://www.wvi.org/publications/covid-19-aftershocks-secondary-impacts-threaten-more-childrens-lives-disease-itself

that drive the regularity, intensity, and frequency of violence against children and women. Quarantine and restriction measures in some locations are isolating children in homes that are not safe, increasing children's risk of emotional, physical, and sexual violence at home and in their community. According to UNFPA, as many as 13 million extra child marriages will occur in the years immediately following the crises, with at least four million more girls married in the next two years.

COVID-19 lockdowns are having a significant indirect impact on children's rights and protection. World Vision research examining trends of reported incidences of violence against children and use of child helplines in the last three months, projects that up to 85 million more girls and boys worldwide may be exposed to physical, sexual and/or emotional violence over the next three months as a result of COVID-19 quarantine[81]. For example, a national assessment in Bangladesh revealed that physical abuse by parents or guardians against their children had increased by 42 per cent during the past three months, and that there was a 40 per cent increase of calls to the child helpline.

The key drivers of the increase in different forms of violence experienced by girls and boys, particularly in the home, were found to be related to frustration due to movement restrictions, school closures, loss of family livelihoods and overall manifestations of psychosocial distress in both children and their parents or caregivers.

Children's education and development

Children continue to be disproportionately impacted by the COVID-19 pandemic which has disrupted critical components of children's social, physical, and emotional development, learning, and wellbeing. Even before the pandemic, millions of children were affected by displacement, conflict, serious adversity, and loss of access to education, protection, and health support. All of this has dramatically worsened with the onset of COVID-19. Children and women at particular risk are those who were already in vulnerable situations before the onset of the pandemic, including refugees, migrants, people living with disabilities and those living in informal settlements.

As mentioned *(see section 2.2),* vulnerable and hard-to-reach children are in danger of dropping out of the education system all together as many are not able to be reached with alternative ways to learn. With school closures and significant inequities in access to online learning, the education gap is widening with immediate impact on children's wellbeing and medium to long-term challenges to recovery.

In Myanmar, World Vision surveyed 900 households in May 2020 to assess how COVID-19 had affected children, families and society. After food and hygiene items, 30 per cent of girls reported their biggest concern to be the inability to continue their education, fearing the impact the interruption to their studies due to school closures would have on their future, or never being able to return at all[82].

Infants, toddlers and very young children are at risk of being negatively affected in their development and wellbeing due to the pandemic's impact on their caregivers, and interrupted access to critical care and opportunities for play and learning. Numerous and compounding stressors and uncertainty caused by COVID-19 can exacerbate distress and further impede caregivers'/parents' ability to provide responsive care to their children[83] The need to invest in supporting caregivers' mental health and wellbeing is thus greater than ever. Evidence shows that attention to mental health and psychosocial support for caregivers/parents is essential to reduce stress and support children's early learning and development.

Child labour and poverty

Economic hardship due to the COVID-19 crisis is pushing more children into situations of child labour, which could lead to the first global rise in child labour after 20 years of progress.[84] Children are twice as likely to live in poverty; the latest projections by UNICEF[85] and Save the Children indicate that 106 million more children will live in poor households by the end of 2020. This is in addition to the 385 million children already living in extreme poverty and the 663 million children who are living in multidimensional

81 World Vision. "COVID-19 Aftershocks: A Perfect Storm." May 2020. https://www.wvi.org/publications/report/coronavirus-health-crisis/covid-19-aftershocks-perfect-storm

82 World Vision. "Asia Region Early Recovery Assessment." June 2020. https://www.wvi.org/publications/coronavirus-health-crisis/unmasking-impact-covid-19-asias-most-vulnerable-children.

83 The psychological impact of quarantine and how to reduce it: rapid review of the evidence, The Lancet

84 According to COVID-19 and child labour: A time of crisis, a time to act, child labour decreased by 94 million since 2000, but that gain is now at risk.

85 https://www.unicef.org/social-policy/child-poverty#:~:text=Children%20are%20more%20likely%20to%20live%20in%20poverty%20than%20adults.&text=Across%20the%20world%2C%20about%20one,children%20live%20in%20extreme%20poverty

poverty (i.e. monetary poverty combined with poor health, lack of education, inadequate living standards or exposure to environmental hazards, disempowerment or the threat of violence).

Children in conflict and displacement situations

Children living in situations of conflict or displacement situations have been the least able to cope with the effects of the pandemic, and the humanitarian system has been strained to respond. For example, Save the Children noted that an additional 3 million children in Afghanistan will need help to survive[86]. In the Central African Republic, family tracing and reunification services for unaccompanied and separated minors have been severely reduced due to quarantine procedures, movement restrictions and new bureaucratic impediments related to COVID-19 specifically. When children can be reunified, they experience stigma out of fear the virus may be carried along with them.

In South Sudan, over 1 million children were already experiencing psychosocial distress due to conflict and displacement. With just three practicing psychiatrists and 29 psychologists in the country, the systems in place struggled to cope even before COVID-19. This gap in qualified personnel poses a significant challenge to scaling up to meet children's increased mental health and psychosocial support needs emerging as a result of the pandemic[87].

In Venezuela, one in four (25 per cent) of 323 adolescent children affected by the crisis who were consulted reported that they had been separated from their parents during the pandemic and were unable to reunite; 34 per cent did not have access to healthcare and 28 per cent said they were facing eviction due to COVID-19. In addition, 70 per cent of children did not have access to water and soap for hand-washing[88].

Adolescents and youth

Although one of the defining messages at the start of the COVID-19 pandemic has been that older persons are more affected, health and non-health impacts on young people are proving to be also significant. 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.

As the pandemic spreads to low-income and lower-middle-income countries – which have disproportionately high numbers of young people and significantly weaker health systems – direct and indirect health impacts on adolescents and youth will likely increase. Specifically, access to essential antiretroviral medications and services for young people living with HIV remain limited and disrupted, and the health impacts on this segment of the population, who are already immunocompromised, will be important.

Adolescents, especially girls, are also a vulnerable group as economic hardship for families grows worldwide. They work disproportionately in the informal sector and are more likely to be excluded from public policies and stimulus packages addressing the economic impacts of the pandemic. Estimates show that 13 million more child marriages[89] are expected to take place over the next decade, while 2 million more cases of female genital mutilation are predicted over the next 10 years due to disruption in programmes to end female genital mutilation.

In spite of the multiple impacts of COVID-19 on young people's lives, many adolescents and youth have mobilized immediately to respond to the crisis[90]. Young people continue to play a critical role in disseminating accurate information on COVID-19, tackling myths and stigma, policing fake news, and supporting information-sharing programmes on risk reduction, national preparedness, and response efforts.

Refugees, asylum-seekers, IDPs and migrants

Overall, there are some 300 million migrants, refugees, IDPs and stateless people in the world,

86 https://www.savethechildren.net/news/covid-19-additional-three-million-children-afghanistan-need-help-survive-2020-warns-save

87 World Vision. "COVID-19 & Child Protection in Fragile Contexts." Updated June 2020. https://www.wvi.org/publications/policy-briefing/covid-19-child-protection-fragile-and-humanitarian-contexts

88 World Vision. "Venezuelan Children: Between A Rock and A Hard Place." June 2020. https://www.wvi.org/publications/venezuela-crisis/migration-and-covid-19-venezuelan-children-between-rock-and-hard

89 https://www.unfpa.org/news/millions-more-cases-violence-child-marriage-female-genital-mutilation-unintended-pregnancies

90 https://www.youthcompact.org/the-compact-response

who are among the hardest hit by the pandemic as they are not able to take the preventative measures necessary, and many do not have access to health care, WASH or decent living conditions. Of this number some 79.5 million are forcibly displaced, meaning that 1 in 97 of the world's population live in situations of displacement. More than 80 per cent are in countries or territories affected by acute food insecurity and malnutrition and not well equipped to also combat a global pandemic.

Displacement figures are on the rise, with more than 11 million newly displaced last year. The COVID-19 situation has not curbed this trend. For example, the number of IDPs in Burkina Faso, Mali and Niger has already increased by 370,000 people (33 per cent)[91].

Health situation of refugees, IDPs and migrants

While the number of confirmed cases among displaced populations remains low, this can partly be attributed to the lack of adequate testing and tracing services in many remote and rural areas where they reside. The regions where forcibly displaced populations live are among those with weaker health and social systems. As such, the true number of cases is likely to be much higher than the reported numbers. For this reason, a close watch is being kept on populations such as those in Cox's Bazar, Bangladesh, in the Americas, particularly in the North of Central America and across the Sahel and the Middle East.

Refugees, IDPs and migrants face the same health threats as host populations but they often present heightened vulnerabilities due to the circumstances of their journey and living and working conditions. They have often faced obstacles in accessing health services – including health information, prevention, testing, treatment and mental health and psychosocial support – such as language and cultural barriers, lack of inclusive health policies, requirement for documentation, fear of arrest or deportation, stigma and xenophobia. During the reporting period, access to health services for refugees were impacted in at least 36 countries, including due to lack of documentation.

Many refugees are often unable to receive reliable information in their own language and might be separated from their support networks. In addition, refugees, IDPs and migrants can face increased vulnerabilities to loss of income, increased exploitation and discrimination, and health emergencies which can exacerbate mental health and psychosocial concerns relating to uncertainty about the future, lost livelihoods opportunities, financial hardship, loss of loved ones and so forth.

The COVID-19 situation has highlighted the critical links between the adequacy of shelter and health outcomes. Overcrowded shelter, camp and camp-like conditions remain the unfortunate reality for many crisis-affected people, posing considerable challenges to attempts to reduce the transmission of COVID-19. Displaced persons face increasing health risks as COVID-19 cases continue to emerge in their cramped living quarters, which often include overcrowding, inadequate sanitation, poor nutrition and limited access to health care facilities and services such as testing, which also mean that controlling and responding to transmission is a near impossible task.

As a matter of illustration, the Colombia COVID-19 Joint Rapid Needs Assessment reported that 53 per cent of people in need highlighted shelter as the main priority after food (95 per cent) and before source of income (45 per cent). The COVID-19 response is forcing the reprioritization of shelter activities to the detriment of durable and transitional shelter solutions and it is likely to also affect funding capacity for essential life-saving winterization activities later in the year. In addition, the economic impact and limitations in transport of goods is leading to a reduction in the availability of basic non-food items as well as construction material supply and an overall increase of prices of these essential items for the sector.

Violence against refugees, IDPs and migrants

COVID-19 has intensified protection risks faced by migrants. Expulsion of migrants and asylum seekers have been observed using COVID-19 as a pretext. However, despite strict quarantine measures and closed borders, movements continue within and between countries, increasing risks of detention, refoulement, contagion and exploitation.

Stigma, xenophobia and discrimination directed towards migrants in many settings, due to perceived linkages with the origin or transmission of the pandemic increased. At the same time, migrants, including those stranded, are too often excluded from universal health coverage efforts, and face barriers to realizing their right to health and related

91 UNHCR/IOM discussion paper on COVID-19 and mixed population movements: emerging dynamics, risks and opportunities

social and economic rights – e.g. to adequate housing, water and sanitation, food and so forth – which compounds their vulnerability to the disease.

As of June 2020, at least one incident of xenophobia, stigmatization, or discrimination against refugees, IDPs or stateless persons in relation to COVID-19 was reported in 21 out of 49 countries reporting (43 per cent). Of the 21 protection clusters consulted, 18 operations report social exclusion, stigma, discrimination, racism and xenophobia as occurring, of which half indicated that they had been highly impacted by COVID-19. Cases of xenophobia have been reported, where migrants and other vulnerable populations were left destitute as they were not allowed to enter in places such as hotels, supermarkets and/or restaurants. Issues of discrimination are prevalent where migrants, refugees, and displaced populations are believed to be carrier of the virus. This has also been reported in the case of migrants who returned to their countries of origin and experienced stigma as they were viewed as bringing the virus back with them.

Although in many countries remote working adjustments are applied to continue providing critical services addressing protection needs, there are still challenges for vulnerable populations in having required access, while protection actors also have limited operations in delivering services. This creates gaps in adequate response mechanisms resulting in heightened protection risks for affected communities and vulnerable populations, including refugees, IDPs, stranded migrants, displaced populations, survivors of gender-based violence, children, older persons and persons with disabilities.

Women and girls in displaced communities have been disproportionately affected by the COVID-19 public health crisis. Restricted mobility and confinement have been widely reported to have exacerbated gender-based violence globally. Displaced women and girls are experiencing increased insecurity in the context of COVID-19, including a lack of access to shelters and organizations that provide advice, as well as increased abuse while living in lockdown with their perpetrators, increased in anxiety and depression, and additional vulnerabilities as a result of limited funds to purchase food and hygiene products.

Livelihoods of refugees, IDPs and migrants

A large proportion of the estimated 300 million of refugees, IDPs migrants and stateless people in the world are impacted by COVID-19 related restrictions, not only in terms of immediate loss of jobs but also in their capacity to engage in economic activity abroad even once these restrictions start loosening up. Strict lockdown measures have disproportionately impacted sectors with high reliance on labour for vulnerable populations, including displaced populations and migrant workers[92]. The socio-economic impact of the COVID-19 crisis on refugees, asylum-seekers, stateless persons and hosting communities remains a critical concern, affecting food security, access to basic needs, and shelter.

Many refugees, migrants and IDPs have seen the business they run or work for, often as day workers, forced to close. In Iraq, for instance, 89 per cent of the 1,500 respondents to a monitoring survey reported loss of employment or livelihoods. In South Africa, 95 per cent of calls requesting UNHCR support are from families who were previously self-sufficient.

Similarly, over the past two months, UNRWA has registered an increase in the number of vulnerable Palestine refugee households in Lebanon unable to pay rent and threatened with eviction, an increase in labour law cases relating to arbitrary dismissals and terminations without indemnities, and a significant rise in the number of child protection and gender-based violence related cases. In the West Bank, following a short period of relaxation of some COVID-19 control measures, tight movement restrictions and lockdown measures have been re-established in Hebron and Nablus areas, following a sharp increase in the number of COVID-19 cases since the middle of June. Reinforced restrictions are impacting on Palestine refugee livelihoods, as many families depend on daily labour and do not have the capacity to live through extended periods of home quarantine.

The socio-economic consequences of the pandemic are affecting displaced persons disproportionally with implications for their assistance and protection. Using the Displacement Tracking Matrix (DTM), IOM conducted an express survey of micro enterprises in Eastern Ukraine, where the majority of IDPs reside, revealing that micro- and small enterprises in government-controlled areas of Donetsk and Luhansk regions had to dismiss one in three employees due to the COVID-19 pandemic and

92 Remittances and Beyond: COVID-19 Impacts All Forms of Migrant Contributions to Development, IOM, Available at: https://weblog.iom.int/remittances-and-beyond-covid-19-impacts-all-forms-migrant-contributions-development

quarantine, making IDPs appear more at risk of being unable to recover from the economic shock of COVID-19 control measures.

Stranded migrants

The extraordinary mobility and travel restrictions are exacerbating the precarious situations and vulnerabilities of migrant populations and, in particular, leading to a large number of migrants being stranded. Loss of jobs and income, lack of employment, loss of residence permits and lack of resources to return home have all impacted vulnerable migrants and, as visas and permits expire, migrants are now also facing deportation. This increases the possibility of more limited or no access to health care and social support, stigmatization and xenophobia, the risk of detention in already overcrowded detention facilities, and homelessness. Those stranded may also be more vulnerable to exploitation, including trafficking in persons and - out of desperation - take up employment in conditions with increased exposure to COVID-19.Tens of thousands of refugees and migrants – men, women and children – in South-East Asia, East and Horn of Africa, Latin America and elsewhere have become stranded as a result of COVID-19 mobility restrictions, often in precarious situations and lacking access to basic services, including shelter, food and health care. As of 9 July, out of 195 countries, 90 countries denied access to territory while an additional 78 countries at least provided exemptions for asylum-seekers.

In West and Central Africa, it is estimated that over 25,000 persons hosted in transit centers are left with no option but to wait for borders to reopen. In Djibouti, more than 1,200 young migrants are stranded due to border closures and movement restrictions. Hundreds of migrants are also stranded in the Chilean-Bolivian border, as well as over 2,000 migrants stranded in the southern and northern borders of Panama. Over 50,000 Venezuelan nationals have returned to Venezuela in recent weeks, due to the increased precarity of their situation and lack of access to healthcare. Many are crossing illegally or being quarantined on arrival (with limited facilities in place). This also raises concerns about a potential spike in COVID-19 prevalence rates in the countries of origin.

Food-insecure people and people at risk of food insecurity and malnutrition

Population groups most vulnerable to food insecurity to the adverse effects of the pandemic include:

- households already in acute food insecurity before the COVID-19 outbreak (149 million people in Integrated Phase Classification of Food Security Phases 3 and 4),
- nutritionally vulnerable groups and people with chronic illness at risk of inadequate nutrition;
- groups facing difficulties to access food due to their reliance for their income on the informal sector (including many in urban areas), on remittances, on seasonal migration, or on small-scale farming (particularly women);
- groups excluded from national social protection systems;
- people in lockdown or quarantine who cannot access sources of food and income.

Concerns are particularly high for populations already in IPC Phases 3 and 4 in rural and urban areas who are not receiving assistance due to access or resource constraints, as well as refugee and migrant populations who largely rely on the informal sector for income and are (often) excluded under national social protection schemes.

Food insecurity is a significant contributor to acute malnutrition. Besides nutrition rehabilitation programmes, prevention measures are essential particularly for the most vulnerable to malnutrition, including children, pregnant and lactating women, adolescent girls, and people affected by HIV/AIDS and tuberculosis.

In the East and Horn of Africa and the Great Lakes, as of 12 May, over 2.9 million refugees (63 per cent) have been affected by food ration cuts. In Colombia, a Joint Rapid Needs Assessment conducted by the Interagency Group on Mixed Migration Flows on the situation of refugee and migrant households in the context of the pandemic found that only 20 per cent of households reported receiving any source of income and 48 per cent received none. The main needs were food (95 per cent), shelter support (53 per cent) and employment (45 per cent). In Syria, 32 per cent of respondents did not have enough to eat due to lack of money, food stocks and travel restrictions limiting their access to markets. IOM's latest Displacement Tracking Matrix round in the Philippines found that food remained a top priority

in evacuation sites, as the delivery frequency of food assistance has decreased due to limitations in movements of Government and humanitarian actors.

Nomadic herders, who rely on migration patterns, are also at-risk as border restrictions and internal movements in countries have been imposed. For example, in Afghanistan, such measures have disrupted the Kuchis (nomadic herders) traditional migration to summer grazing areas. If restrictions continue, they will also be blocked from moving herds to winter pastures in September. This could hinder access to veterinary inputs and animal feed/fodder, particularly with conflict and market closures compounding the situation. Similar herding groups are also found in Iran and throughout the Sahel and East Africa, and at risk of losing their animals and livelihoods due to not being able to access feed and key watering points. These populations are reporting limited access to pasture and market, increase in price of fodder/feed and increasing intercommunity tensions.

Population groups vulnerable to food insecurity and malnutrition could further be impacted by seasonal climate factors over the coming months. The cyclone seasons have recently started for Southeast Asia, the Northern Pacific Islands and Caribbean regions. The Caribbean region in particular has a forecast of an above-average season. In addition, the outlook period coincides with monsoon season in southwest Asia, which increases the risk of flooding, while in Sudan an above-average wet season also increases their flooding risk. Families living in these areas are at risk of losing their livelihoods and slipping further into food insecurity.

Informal urban settlement dwellers

UN-Habitat work in urban areas in Mozambique showed that people living in informal settlements including older persons and children assisting their families with chores such as water fetching and market purchases, continue to be unable to fight the pandemic since their housing and basic water and sanitation conditions have not improved and their precarious financial conditions oblige them to move daily and to be in contact with other people.

In Syria, the urban populations most at risk because of the socio-economic impact of COVID-19 are those who depend heavily on the informal economy and on employment in the public sector, women-headed households and female health workers, those relying on the informal economy, older people who have lost caregivers who immigrated outside the country because of the war, children out of school, and those who have limited capacities and opportunities to cope and adapt with the new situation.

COVID-19 Socio-economic situation and needs monitoring indicators

The lack of disaggregated data by sex, age, and disability – and other vulnerability factors - makes it difficult to understand the needs of vulnerable populations more at risk of discrimination in the context of COVID-19. Such disaggregated data are also key to monitor how the response is operationalized and contribute to ensuring accountability to the most vulnerable populations.

Several guidelines exist to collect disaggregated data[93]. All efforts should be made in future progress reports to disaggregate and analyse indicator data 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.

Please note that the below monitoring findings are initial and rely on best estimates. They reflect the COVID-19 situation and needs as tracked by the indicated responsible agency. IASC partners are exploring ways to improve monitoring information by better capturing the full breadth of collective efforts.

93 For example, for persons with disabilities: IASC Guidelines on Persons with Disabilities in Humanitarian Access. Washington Group Short Set of Disability Questions. Recent Humanity & Inclusion study on collection of disability data in humanitarian contexts: https://humanity-inclusion.org.uk/en/projects/disability-data-in-humanitarian-action.

OHCHR, Human rights-based approach to data, https://www.ohchr.org/Documents/Issues/HRIndicators/GuidanceNoteonApproachtoData.pdf

Mobility, travel and import/export restrictions in priority countries

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number of priority countries with international travel restrictions in place	Monthly	**IOM, WHO**	62[1]
		WFP	WFP's overview is available here: https://data.humdata.org/dataset/covid-19-global-travel-restrictions-and-airline-information
Number of priority countries with partial or full border closures in place	Monthly	**IOM, WHO**	62[2]

Food security

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Market functionality index	Monthly	**WFP**	Available data cannot be aggregated at global level
Number and proportion of people with unacceptable food consumption score	Daily	**WFP**	169.4 million in 18 countries including 4 outside the GHRP[3]
Number of people adopting crisis level coping strategies (Reduced Coping Strategy Index)	Daily	**WFP**	165.7 million in 18 countries including 4 outside the GHRP[4]
Food and crop production estimates in GHRP countries	Seasonal	**FAO**	Data not available at time of reporting. Seasonal data will be provided when available for the countries included in FAO's component of the GHRP
Food Insecurity Experience Scale (FIES) in GHRP countries	Bi-monthly	**FAO**	Data not available at time of reporting. This data will be included in later reporting cycles for a sample of rural populations in the countries included in FAO's component of the GHRP.

1 As of 29 June, IOM data for 62 countries out of 63 GHRP countries with international travel restrictions in place. Fourteen 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.

2 As of 26 June 2020, 62 priority countries have full or partial border closures in place. (oPt is not included when looking at status of border).

3 Mozambique, Somalia, Niger, Burkina Faso, Mali, Chad, Central African Republic, Democratic Republic of the Congo, Colombia, Yemen, Syrian Arab Republic, Iraq, Cameroon, Nigeria, as well as Malawi, Guatemala, El Salvador and Honduras which are not included in the GHRP.

4 Ibid.

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number of priority countries with reduced availability of agricultural inputs[5]	Bi-monthly	**FAO**	17
Number of people in IPC Phase 3+ in priority countries (in countries where new analyses are available)[6]	Bi-monthly	**FAO/IPC**	42,369,601

Education

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number of children and youth out of school due to mandatory school closures in GHRP countries	—	**UNHCR, UNESCO**	1,068,197,694 affected learners, 61% of total enrolled learners.[7]

Vaccination

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Proportion of countries where at least one vaccine-preventable diseases mass immunization campaign was affected (suspended or postponed, fully or partially) due to COVID-19	—	**WHO**	As of 1 June, 27 countries have postponed measles/ measles rubella / measles mumps rubella immunization campaigns due to COVID–19; Bivalent Oral Poliovirus Vaccine (bOPV) campaigns postponed in 26 countries; Monovalent Oral Poliovirus Vaccine Type 2 (mOPV2) in 13; Inactivated Polio Vaccine (IPV) in 8. 7 countries postponed Yellow Fever and Tetanus campaigns.

5 This figure takes into account the data available as of 29 June 2020 and covers the 34 countries included in FAO's component of the GHRP. The data for this round of reporting is a combination of FAO primary data and secondary data from partner organizations. It is largely based on qualitative observations and respondent perceptions in the following countries: Afghanistan, Bangladesh, Colombia, Ethiopia, Haiti, Iraq (livestock inputs only, no change in crop inputs), Liberia, Myanmar, Nigeria, Pakistan (crop only, no data on livestock inputs), Palestine (livestock inputs, no data on crop inputs), Sierra Leone, South Sudan, Syrian Arab Republic, Togo (crop inputs, no data on livestock inputs), Venezuela and Zimbabwe (livestock inputs, no data on crop inputs). The degree of reduced availability ranges from moderate to significant and considers both crop and livestock inputs except where indicated. In all 17 countries covered by FAO's where data was available at time of reporting, challenges in accessing agricultural inputs were noted. Data is not available on the other 18 countries covered by FAO's component of the GHRP at time of reporting.

6 This figure takes into account all IPC numbers (current and projected) that are valid as of June 2020, and provides the current status in the countries referenced. A trend analysis will be undertaken to ascertain pre/post COVID status in subsequent reporting rounds where possible. This figure covers the following countries: Afghanistan* (10,313,185), Burundi* (858,960), Central African Republic* (2,362,737), Ethiopia** (8,473,790), Haiti** (4,101,280), Kenya** (984,534), Pakistan** (1,265,034), Somalia* (2,700,000), South Sudan** (6,480,000), Tanzania** (488,661), Zimbabwe**(4,341,420). *indicates an analysis taken between March and June 2020; ** indicates an analysis undertaken prior to March 2020, the results of which do not take into account the impact of COVID 19 and other unforeseen shocks/changes.

7 Available at: https://en.unesco.org/covid19/educationresponse.

Gender Based Violence

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number and proportion of countries where GBV services have been interrupted	—	**UNFPA**	16/40

Child protection

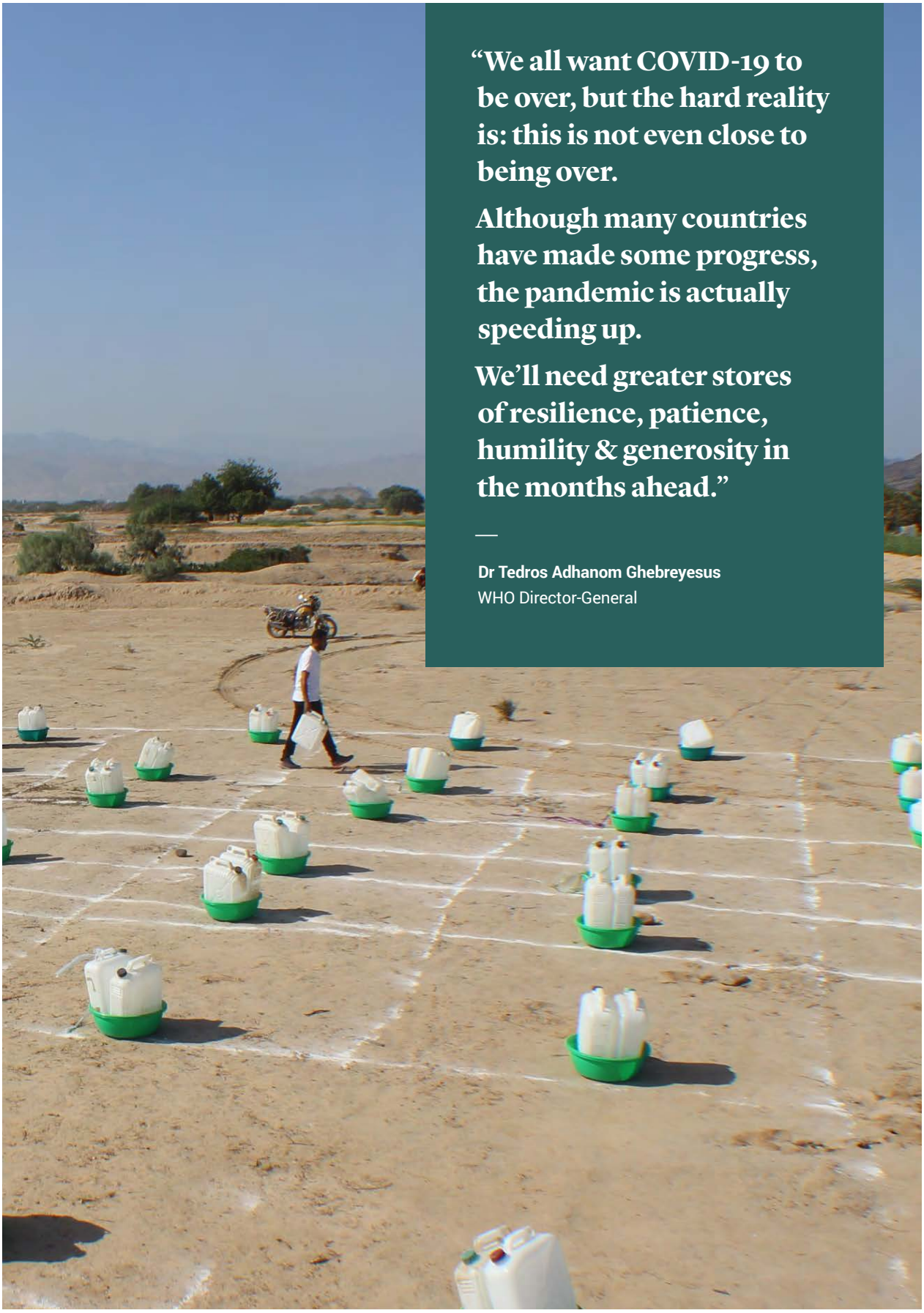
INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number and percentage of countries integrating a monitoring system able to measure changes and to identify child protection needs	Quarterly	**CP-AoR**	29 (76%)

Nutrition

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number of countries that have activated the Nutrition Coordination mechanism in response to COVID-19 and/or its impacts	Quarterly	**UNICEF (Global Nutrition Cluster)**	28

Protection

INDICATOR	FREQUENCY	RESPONSIBLE ENTITY	CURRENT SITUATION
Number of countries reporting incidents of COVID-19 pandemic-related xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons.	Bi-weekly	UNHCR	21 out of 49 countries (43%)



“We all want COVID-19 to be over, but the hard reality is: this is not even close to being over.

Although many countries have made some progress, the pandemic is actually speeding up.

We’ll need greater stores of resilience, patience, humility & generosity in the months ahead.”

—

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

ABYAN, YEMEN

In Abyan, Yemen, families displaced by insecurity collect basic hygiene kits. Following global guidelines on social distancing in the face of COVID-19, the distribution is now organised to allow families to maintain physical distance. The hygiene kits contain soap, laundry detergent, jerry cans, buckets and sanitary pads. They provide dignity to families and allow them to practice effective hand-washing techniques and hygiene. *UNICEF*

3.0

Progress of the response against the strategic priorities and specific objectives

A summary of the main response achievements and challenges is provided for each of the GHRP Strategic Priorities and specific objectives. While the results reflect programmes carried out by UN agencies and their implementing partners, it must be noted that a large number of NGOs in addition are also undertaking their own intervention. **Annex II** includes additional details by agencies.

JUBA, SOUTH SUDAN

Community mobilisers are raising awareness on the Coronavirus disease in the Mangateen camp for internally displaced people in South Sudan's capital Juba.
UNICEF/Chol

3.1

Progress on Strategic priority 1

Strategic priority 1

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

Progress by specific objective

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 continue to be 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.

GHRP partners made progress in preparing populations and decreasing risks through multi-sectoral interventions, risk communication and community engagement, preparedness and public health measures at prioritised points of entry, capacity enhancement of health workers and authorities, roll out of tools, and development of water, sanitation and hygiene (WASH) plans.

Innovative artificial intelligence methods were used to gather insights on behaviors, respond to COVID-19 questions and refer individuals to national hotlines and educational materials. Population movements and their health and socio-economic situation have continued to be tracked, together with government mobility restrictions.

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

To address the challenges of underreported COVID-19 confirmed cases and deaths, WHO surveillance guidance, case definitions and reporting requirements were modified and simplified to improve data collection and reporting to better understand the epidemic and guide response efforts. This includes some conflict areas where no information is made available and insecurity jeopardizes access and investigations while in some instances release of information can put health workers and international aid at risk.

Support to national disease surveillance systems has also been provided at points of entry, for example in Bangladesh, Democratic Republic of the Congo, Libya, Somalia and South Sudan, among other countries.

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 social distancing, and the suspension of mass gatherings and international travel.

Technical guidance on preparedness, readiness and response has been updated to support governments' capacities and guide their actions,

including to strengthen epidemiological surveillance, clinical management and laboratory testing, and to maintain essential health services. This also covers immunisation, in view of the delayed or suspended campaigns in numerous countries. A dedicated IASC guidance was prepared to adapt public health and social measures to reduce the risk of COVID-19 spread and impact in low capacity and humanitarian settings[94].

In displacement sites, existing health facilities have been repurposed to become isolation and treatment facilities in displacement sites, for example in Cox's Bazar, Bangladesh and Iraq, and purpose-built shelters have been constructed such as in Nigeria. Partners continued to reach communities with life-saving information and activities to halt the spread of the pandemic and promote healthy and safe lifestyles. As of 23 June, 85 per cent of countries included in the GHRP have Risk Communication and Community Engagement (RCCE) plans for COVID-19; a five-fold increase since 1 March where only 37 countries had such plans.

Partners distributed risk communication messages through locally and culturally mediums such as announcements through megaphones and mosques, where relevant. RCCE activities also include efforts to ensure that life-saving information reaches children with disabilities, including by making all information available in accessible formats.

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.

Partners continued to scale up case management capacity at health facility and community levels across all countries to provide safe and effective clinical care. This includes remote and on-site support in architectural design and Infection Prevention and Control support, mobilizing critical supplies, guidance and secondment of staff. Remote counselling and referral services relating to COVID-19 were also provided, including by telephone or online, for example in Bangladesh, Ecuador, Sudan, Syria, Turkey, Ukraine, and Uruguay.

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.

WHO continues to share knowledge and innovation around diagnostic and vaccine development. As of 24 June 2020, 16 candidate vaccines are in clinical evaluation including one in Phase 3 trials. There are also 125 candidate vaccines in preclinical evaluation. This is compared to 5 candidate vaccines in clinical evaluation and 71 in preclinical evaluation as of 20 April 2020.

To assess disease dynamics and risk factors through standardized tools enabling better design and targeting of public health interventions and a contribution to the global body of knowledge about the disease and its epidemiology, ten GHRP countries have started implementing at least one sero-epidemiological investigation using WHO Unity Study master protocol. These include Central African Republic, Colombia, Ethiopia, Jordan, Lebanon, Liberia, Niger, Pakistan, South Sudan and Togo.

A policy paper on Cross-border Mobility Amid and Post COVID-19 was developed to provide further knowledge on the short and medium-term challenges and selected solutions for human mobility, possible and preferred scenarios for promoting coordinated and healthy reopening of borders and lifting of travel restrictions, and longer-term recommendations for migration and health policies in this regard.

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[95].

Common services benefitted 375 organisations (55 per cent NGOs, 11 per cent UN, 14 per cent donor and government representatives, 5 per cent other international organisations and 15 per cent others). As of 29 June, the passenger transport service was used by about 5,300 passengers reaching 43

94 https://interagencystandingcommittee.org/health/interim-guidance-public-health-and-social-measures-covid-19-preparedness-and-response

95 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. It is fine to report against 1.6 only.

destinations. Eight humanitarian response hubs were established to facilitate cargo movement to transport essential assistance including test kits.

Essential health services and secure systems have continued to be provided in countries included in the GHRP, including primary, maternal and sexual and reproductive health services. Training of health workers in infection prevention and control has also expanded, as well as the provision of personal protective equipment. Through a WHO-coordinated COVID-19 Supply Chain, three purchasing consortia were established to help secure diagnostics, personal protective equipment and biomedical equipment for oxygen provision[96].

In Yemen for instance, the provision of a Minimum Service package has been safeguarded at more than 4,300 non-COVID health care facilities, providing essential medicines and vaccines, and malnutrition treatment to pregnant women and malnourished children. In Burundi, vaccine and immunization campaigns continue, focusing on door-to-door, instead of mass campaigns. Sierra Leone has put in place standard operating procedures for tuberculosis and HIV programmes that reduce clinic attendance. A number of countries have also been able to successfully implement triage and screening measures to ensure the continuity of essential health services, such as in Burundi, Haiti and Sierra Leone.

Health partners in many countries are reinforcing the health sector response to gender-based violence by regularly assessing and updating GBV referral pathways to reflect changes to formal or informal services or access points as a result of the COVID-19 pandemic. Virtual platforms have been used to offer trainings on the provision of first-line support for sexual violence and intimate partner violence and introducing telemedicine approaches. In north-eastern Syria for example, over 2,000 health service providers have been trained. While innovations in telemedicine have also been introduced, reports suggest that use of such technologies may place survivors experiencing violence in the home at further risk. Safety and confidentiality considerations should inform new approaches to health service provision in humanitarian settings.

Safe and accessible reporting channels have been scaled up and a field support function to Humanitarian Coordinators and Humanitarian Country Teams has been established. Under the framework of the UN System-Wide Medevac Task Force in response to COVID-19, a UN Medevac Cell has been set up to approve, manage and coordinate all COVID-19 Medevac requests for UN and INGO personnel.

Response gaps and challenges to achieve Strategic priority 1

Despite access and operational challenges, GHRP partners have committed to stay and deliver and continue to sustain humanitarian interventions and find innovative ways to adapt programming in order to scale up operations.

In several contexts persisting **access challenges and violence** continue to hamper the movement of humanitarian personnel and endanger their safety. In other countries, restrictions imposed on domestic travel are impacting the movement of humanitarian actors, limiting the ability to implement and monitor programmes. The movement of humanitarian supplies has been constrained in many operations with increased restrictions on international and domestic travel, curfews, checkpoints and bureaucratic impediments impacting the delivery of assistance and the prepositioning of core supplies. In several countries, vaccination campaigns have been put on hold, rapid response missions have been cancelled, and some locations have become largely inaccessible to staff.

On-site needs assessments in direct communication with beneficiaries and stakeholders have been difficult, limiting evidence-based programming and effective preparedness and response efforts. Mobility restrictions have also affected cross-border coordination for contact tracing and other components of the health response.

With already weak health systems overburdened or at risk of becoming overburdened, it remains difficult to ensure the continuity of essential health services to vulnerable populations by providing life-saving primary health services, referral, procurement of essential medicines and medical supplies, and the improvement of infrastructure, particularly in countries with **compounding pre-COVID-19**

96 So far, the consortia have delivered 123,436 tests to 18 HRP countries, with 428,476 being shipped and an additional 1,06 million being planned for all 23 HRP countries; 32,880 tests have been delivered to an additional 4 RRP countries with 55,000 under shipping and a remaining 578,842 tests to 8 RRP countries (not part of HRP); 4.7 million pieces of PPE have been delivered to 16 HRP countries, 1.2 million pieces to 11 RRP countries; 87 million pieces planned for 23 HRP countries; 7.4 million pieces for 8 additional RRP countries and 45 million pieces for Venezuela RMRP in 13 additional countries. 4,845 oxygen concentrators, accessories and consumables are in planning for delivery across all HRP countries with 264 delivered or shipped to 10 countries; 582 units are planned for an additional 5 countries (not HRP) with 100 shipped or delivered.

humanitarian needs. Preparedness efforts are also constrained by ongoing humanitarian crises in some countries.

Although some positive achievements have been made for more **gender inclusive responses**, accelerated efforts are still required for a more predominant role of women as frontline health-care and social workers in the design of delivery mechanisms and better inclusion in all decision-making and policy spaces to improve health security surveillance, detection, information and prevention mechanisms. Increased attention and scale up are also required to address the specific risks and barriers facing **older people** and **people with disabilities.**

In many countries, **gender, gender-based violence and sexual and reproductive health considerations** are still not prioritized at key entry points. Health partners may further reinforce the health sector response to gender-based violence by assessing and updating GBV referral pathways to reflect changes to formal or informal services or access points as a result of the COVID-19 pandemic.

Access to critical legal institutions is also affected, leading to a culture of impunity. GBV prevention activities are also limited due to remote service provision, including lack of connectivity, internet access, phones and electricity. Unpredictability of the crisis, and the ongoing restrictions in mobility has also left the service providers without required training on adapting the services to remote support. Even in countries with awareness raising plans, messaging on preventing/reporting may not reach all refugees and internally displaced persons, as access to messaging may vary.

Recognizing GBV as an essential service in the COVID-19 national response plans is required to facilitate the movement of GBV service providers, including civil society organizations and their networks at the community level. GBV messaging and sensitivity needs to be mainstreamed in key entry points, including hospitals and drug stores - especially during lockdown situations) and risk mitigation needs to be integrated in other sectors.

Efforts are also required to increase **reporting of public health surveillance data** (and the overall situation) of COVID-19 should be improved, as it affects the effectiveness of the humanitarian response.

There is a need to identify innovative solutions to better identify, refer, and provide mental health and psychosocial support, protection and assistance services for **migrants exposed to violence, exploitation and abuse** and at increased risk, particularly children. Efforts are also required to confront xenophobia, violence and discrimination against migrants and other mobility population groups in relation to the spread of COVID-19, particularly for groups of migrants and displaced populations who may be at increased risk such as victims of gender-based violence and LGBTIQ persons, which can significantly limit those vulnerable groups' access to life-saving services including health care, especially during a pandemic.

Strategic Priority 1 response monitoring indicators

Please note that the below response monitoring results are initial and rely on best estimates. They reflect progress as tracked per the indicated responsible agency. Some target figures may not be available as country operations adjust and respond to emerging and changing needs. IASC partners are exploring ways to improve reporting against strategic priorities by better capturing the full breadth of collective efforts.

All efforts should be made in future progress reports to disaggregate and analyse indicator data 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
Ensure essential health service and systems *Continuity of health and humanitarian supply chain is crucial for life-saving response and any interruptions will increase risks*	Number of passenger movement requests fulfilled	**WFP**	90%	94%
	Number of GHRP countries with multisectoral mental health and psychosocial support technical working groups [1]	**WHO**	100%	46% (29 countries)
	Number of cargo movement requests fulfilled	**WFP**	90%	86%
	Number of hubs established for consolidation and onward dispatch of essential health and humanitarian supplies	**WFP**	8	8
	Number of caregivers of children less than 2 years old reached with messages on breastfeeding, young child feeding or healthy diets in the context of COVID through national communication campaigns	**UNICEF**	14,393,176	6,773,237
	Number of 3 plies/medical masks distributed against need (or request)	**UNFPA**	25,000,000	1,012,489 in 18 countries
		UNHCR	100%	2,797,500 / 4,669,730 60% [2]
		WHO	100%	1,658,250 [3]

1 There is 11% progress in the indicator in one month as seven additional GHRP countries activated their MHPSS Technical Working Groups. WHO's Department of Mental Health and Substance Use is currently conducting a survey to all 194 member states which includes a question on this specific indicator. The questionnaire also asks line Ministries, UN agencies and INGOs who are members of these platforms, and whether a plan for MHPSS COVID response was developed and budgeted. Almost half of the countries (29 out of 63) have established a working group on mental health and psychological support. This ranges from 11.8% in AMRO, 41,7% in AFRO, 79% in EMRO to 100% in EURO and WPRO.

2 UNHCR reporting against this indicator includes 27 countries reporting covering the period from 1 March to May 31 cumulative.

3 WHO reporting against this indicator is based on the number of masks shipped.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
Ensure essential health service and systems *Continuity of health and humanitarian supply chain is crucial for life-saving response and any interruptions will increase risks*	Number and percentage of children and adults that have access to a safe and accessible channel to report sexual exploitation and abuse	**UNFPA**	-	Information will be available in future reporting
		UNICEF	10,127,158	3,627,018
	Number of health workers provided with PPE	**UNICEF**	1,405,349	463,929
		UNRWA	3 months supply of PPE for 4,000 UNRWA front line health workers.	All UNRWA health staff have received PPE during the period March-June.
		WVI	-	162,641 people
Learn, innovate and improve *Indicates efforts to improve knowledge and response effectiveness*	Percentage of countries implementing sero-epidemiological investigations or studies	**WHO**	20%	15.9%
Prepare and be Ready	Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	**UNICEF**	60	58
	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**	100%	38%

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
Prevent, suppress and interrupt transmission	Proportion of GHRP countries with a functional, multi-sectoral,multi-partner coordination mechanism for COVID-19 preparedness and response	**WHO**	100%	95%
	Number and proportion of countries with COVID-19 Risk Communication and Community Engagement Programming	**UNICEF**	60	57 GHRP countries (95%)
	Proportion of GHRP countries with COVID-19 national preparedness and response plan	**WHO**	100%	97%

3.2

Progress on Strategic priority 2

Strategic priority 2

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

Progress by specific objective

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.

Partners have continued to monitor risk factors to local food production and consumption. Livelihoods assistance has been provided to sustain food production while also supporting access to food through protecting incomes and purchasing power of the most vulnerable affected or at high risk of COVID-19.

In addition to providing bigger food rations at less frequent intervals to reduce exposure to the virus and physical distance at food distributions, innovative solutions were implemented such as swapping of drivers at regional boundaries in Ethiopia to comply with movement restrictions and quarantine requirements, aa countrywide home delivery e-shop that allows people to order food from local retailers in Somalia, and an agreement with the Ministry of Finance of Sudan to import wheat to ensure a continuous supply of flour to local bakeries while enabling the Central Bank to retain hard currency.

Cash and voucher-based assistance has been scaled up and the value of unconditional cash transfers has been adjusted, for example benefitting vulnerable groups such as migrants, IDPs and refugees in Iraq, Myanmar, and Somalia. In several countries, social assistance programmes implemented by governments were used to help families cope and respond to the impacts of COVID-19.

Agricultural inputs (seeds, tools, livestock feed) have been distributed and animal health support provided to ensure uninterrupted food production and income generation. Food security and agriculture partners have advocated for exemption of seeds from restrictions given planting season criticality in Haiti, South Sudan and elsewhere. In the complex and fragile contexts of Central African Republic, Democratic Republic of Congo, Haiti, northeast Nigeria, Somalia and South Sudan, coverage is being extended to ensure people already in IPC Phases 3 and 4 benefit from assistance and do not fall into hunger risk due to COVID-19.

Measures have also been taken to preposition food rations and adequate food and other supplies for nutrition programmes including for therapeutic treatment of severe acute malnutrition in refugee sites.

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.

Several actions have been taken to avoid risks of infection while providing essential services. The guidance on implementation of **vaccination campaigns** in the COVID-19 context was updated, and essential services provided while respecting physical distancing and confinement measures in place, including health, WASH, nutrition, education, and protection services for children

and other vulnerable population groups. Guidance was provided to support the social services workforce to safely deliver in-person and remote case management and protection services to children. The guidance covers violence in the home, online, in conflict settings, alternative care, detention, child marriage, child labor, and other key protection concerns.

WHO recently published a framework for decision-making for implementing vaccination campaigns[97]. It recommends that a risk assessment should be done, including a detailed review of the epidemiological data as well as consideration of the short- and medium-term public health consequences of immediately implementing or delaying a mass vaccination campaign, weighed against the potential aggravation of COVID-19 transmission resulting from a vaccination campaign. Adaptations and transition towards resumption of immunization services and campaigns are being considered by building capacity of countries and partners to deliver immunization services using appropriate Infection Prevention and Control measures and ensure the continuity of health services including vaccine supply.

A large range of **mental health and psychosocial support materials** have been developed, disseminated, translated and used widely[98]. This includes a book to support children aged 6 to 11 years to cope with COVID-19 stressors (in 110 languages) and an illustrated basic psychosocial skills guide for COVID-19 responders. An operation guide for multisectoral MHPSS programmes in context of COVID-19 was endorsed by the IASC[99] and an MHPSS rapid deployment programme was also launched[100].As of end June, more than nine million parents and primary caregivers were reached with community-based mental health and psychosocial support and messages.

Partners have provided critical **WASH supplies** including personal hygiene items and services to over 31 million people while more than 93 million children and youth were supported with distance/home-based learning in 55 countries. Infection Prevention and Control actions have been enhanced by establishing handwashing stations and trailers, and providing hygiene kits in camp and camp-like settings. In addition, minimum child protection services were maintained. Some 750,000 children aged 6-59 months also received treatment for severe acute malnutrition. UNICEF and WHO have launched a new global initiative to scale up hand hygiene and call for countries to lay out comprehensive roadmaps that bridge the national COVID-19 response plans with mid- and long-term development plans to ensure than hand hygiene is a mainstay in government programmes throughout and beyond the pandemic.

GBV services provision have continued to be adapted to remote support, including (i) scaling up capacity of hotlines/helplines as entry point for referrals and case management (for example in Kenya, South Sudan and Zambia); (ii) expanding availability of shelters for survivors and those at risk of violence; and (iii) testing cash/voucher systems to replace dignity kits and reduce contact (e.g. Mozambique). Referral pathways for GBV have been updated and GBV risk mitigation measures have been integrated throughout programming in key sectors such as WASH.

Partners have scaled up efforts to decongest and reduce human density in **shelters and settlements**, identifying and establishing places of treatment, isolation and quarantine as well as non-food item distribution and shelter upgrades. Housing units and tents have been distributed and a guidance disseminated on planning of high-density settlement infrastructure to facilitate essential health services. Country level Shelter clusters have engaged with Health clusters and local authorities to collaborate on quarantine, isolation and expansion of medical facilities for triage and testing. Vulnerable households have also received material to expand their shelters to reduce overcrowding and upgrade inadequate shelter conditions including hygiene facilities.

Action was taken to protect **food availability and access** by supporting local market actors to ensure that up to three months of requirements are available in stock. Partners have also worked with national authorities and stakeholders to ensure that food production, marketing and distribution services are sources of COVID-19 transmission, and that

97 WHO, Framework for decision making: implementation of mass vaccination campaigns in the context of COVID-19, May 20, 2020, https://www.who.int/publications/i/item/framework-for-decision-making-implementation-of-mass-vaccination-campaigns-in-the-context-of-covid-19

98 All MHPSS COVID-19 related guidance is available at: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-resources-covid-19

99 https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance

100 Additional details are available at: https://www.drrteam-dsswater.nl/mhpss/

agriculture and food supply chain workers are protected. Corresponding Risk Communication and Community Engagement activities have been undertaken in 18 priority countries with high levels of food insecurity to reduce the risk of transmission in the agriculture sector and across the food value 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.[101]

Please see Specific objective 1.6 for progress on supply chains that also contributes to Specific objective 2.3.

In addition to what was reported under Specific Objective 1.6 above, partners have produced or acquired key items such as reproductive health kits, mobile storage units, housing units and multipurpose tents. Innovative ways to secure and maintain the food supply chain are also being explored by combining local traditions and technology to conserve, store, dry and process grains, fruits and vegetables, for example in Afghanistan. In several West African countries, local producers were connected to e-commerce and safe shipping options were identified.

Response gaps and challenges to achieve Strategic priority 2

Most of the **access and mobility challenges** mentioned for Strategic priority 1 also apply to Strategic priority 2. Airline carriers appear to have slowly restarted – both humanitarian and commercial providers. However, many staff are still stranded inside or outside of countries, and bureaucratic barriers have increased to access to visa services.

Improving the **WASH** sector resilience to absorb the shock of the primary and immediate socio-economic impacts caused by COVID-19 is key. Restrictions on the entry and movement of materials and equipment coupled with price increases for WASH services and commodities, which play a direct and critical role in suppressing the global reach of the pandemic, will have a grave impact on maintaining good hygiene practice.

It is indispensable to step up efforts to prevent a deterioration of acute food insecurity and famine. Timely funding is critical given the coming lean season and hurricane season in many countries.

Resources will enable humanitarian actors to scale up adapted responses such as take-away food rations in lieu of school meals and expanding social safety nets in support of governments. **Social protection systems** across crisis contexts should continue to be explored to consider linkages with humanitarian assistance and potential expansion.[102]

Cash and voucher assistance, particularly multi-purpose cash, should be implemented whenever it is feasible, as it is an efficient, flexible and often preferred mechanism to help people meet their basic needs and decrease the adoption of negative coping mechanisms[103]. Some country operations such as Afghanistan, Ethiopia, Iraq, Yemen and many others are already using multipurpose cash grants to cover purchase of basic needs and public health items, including masks, soap and hand sanitizers.

Resources to **local women's organisations** for service provision and flexibility in their use are essential but lacking for them to be able to adapt service delivery, for example to procure personal protective equipment kits, ensuring spaces can guarantee physical distancing, phone credit, etc. These major barriers should be removed.

More must be done in **prepositioning food and cash** to ensure timely delivery including in hard-to-reach areas and in anticipation of mobility restrictions and lockdowns.

This also requires **protecting the supply chain** is critical. Restrictions on movement of goods and people have resulted in supply chain disruptions for essential supplies related not only to COVID-19, such as testing kits and supplies, but also to other essential supplies and commodities. Lockdowns and restricted access to camps in places such as Iraq and Uganda have also meant that provisions of

101 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.

102 The Common Cash Delivery Network (CCD) which is made up of 15 INGOs has developed an advocacy paper on the use of social protection systems in COVID-19 contexts: https://a32c7e8e-1b5e-4cca-a913-6e85a831e8f3.filesusr.com/ugd/79d5cf_

103 For a comprehensive overview of issues to consider at each stage of the humanitarian programme cycle, the Cash and Learning Partnership - CaLP has crowdsourced and consolidated information on issues to consider. https://www.calpnetwork.org/publication/cva-in-covid-19-contexts-guidance-from-the-calp-network/.

goods and services to IDP populations have been reduced. For many countries, movement restriction also prohibits IDPs capacity to access livelihood opportunities, putting further pressures on their ability to supplement limited aid. Resources are needed to address COVID-19 limitations on transport, logistics and functioning of local markets, and to link farmers to consumers in order to avoid food losses and ensure food availability in local markets.

The social and economic secondary negative effects of the pandemic will take many years to reverse and significant international assistance to fragile, violence and conflict affected contexts will be required at a time when donor countries are expected to be inward looking to address the needs of their own population. In Lebanon for example, where the population is at 90 per cent urban, there needs to be a scaled-up and focused response in dense urban areas with a focus on WASH facilities and targeted livelihood support.

Stronger community engagement is required in a number of field operations so that design and implementation take better into account the specificity of the context and population in the unique circumstances of the pandemic. In particular, greater efforts and support (including funding) is needed to ensure the meaningful participation of women and girls – and grassroots organizations led by them - in COVID-19 policy making, and that the response measures reflect and address their situation, views and needs.

Strategic Priority 2 response monitoring indicators

Please note that the below response monitoring results are initial and rely on best estimates. They reflect progress as tracked per the indicated responsible agency. Some target figures may not be available as country operations adjust and respond to emerging and changing needs. IASC partners are exploring ways to improve reporting against strategic priorities by better capturing the full breadth of collective efforts.

All efforts should be made in future progress reports to disaggregate and analyse indicator data 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
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 protection and humanitarian assistance	Number of people/ households most vulnerable to/affected by COVID-19 who have received livelihood support, e.g. cash transfers, inputs and technical assistance.	**FAO**	-	-
		WVI [4]	-	59,457 peope [5]
		NRC	-	744,694 people
		CARE	-	247,000 people[6]
		UNHCR	-	719,390 households[7]
		UNICEF	1.3 million households	14,107 households
		UNDP	-	-
		IOM[8]	1,157,008 people	309,146 people
	Number of people/ households most vulnerable to/affected by COVID-19 who benefit from increased or expanded social protection	**FAO**	-	-
		UNICEF	15.4 million households	5.7 million households
		UNDP	-	-
		UNRWA	850,000 Palestine refugees	687,369 Palestine refugees
		UNHCR	-	Progress data will be available in future updates.

4 World Vision International, Norwegian Refugee Council and CARE were the only three NGOs able to report on certain indicators in this July update of the GHRP. More NGOs are implementing similar activities. Work is underway to capture their achievements

5 World Vision programme; not a duplication of beneficiaries reported by a UN agency

6 As this indicator is a compound indicator, only the cash and voucher assistance is being reported against it.

7 This indicator includes all populations of concern for 1 March – 30 June 2020 from 48 countries reporting. UNHCR livelihoods indicator does not include cash assistance. UNHCR reports all cash delivered under the GHRP assistance indicator in Annex 2, Priority 3 rather than under livelihoods. UNHCR uses cash for a wide range of purposes, including protection, basic needs, education, shelter, health, livelihoods and protection against winter conditions.

8 Although IOM has been in contact with all its missions in targeted countries, the targets and reporting numbers provided do not represent the full picture of IOM's operations in those countries as part of the COVID-19 response. Due to the short timeframe, not all population groups have been included under the numbers provided, and some of the countries were not able to provide data for all indicators.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
Ensure the continuity of and safety from infection of essential services including health, water and sanitation, nutrition, shelter protection and education for the population groups most exposed and vulnerable to the pandemic.	Number of people (girls, boys, women, men) who are receiving essential healthcare services	**IOM**	4,495,335	1,302,144
		UNHCR	5,400,000	271,544 [9]
		UNICEF	43,450,524	18,482,477
		UNRWA	-	1.03 million
	Number of people reached with critical WASH supplies (including hygiene items) and services	**UNICEF**	61,816,915	31,902,120
		WVI	-	4,133,513 [10]
		NRC	-	1,949,794 [11]
		IOM	7,335,657	4,238,310
	Number of children and youth supported with distance/home-based learning	**UNICEF**	178,336,631	93,610,033
		UNHCR	-	Progress data will be available in future updates.
	Number of children and youth in humanitarian and situations of protracted displacement enrolled in pre-primary, primary and secondary education levels	**UNHCR**	-	Progress data will be available in future updates.
		UNRWA	533,000	479,700 [12]
	Number of people (including children, parents and primary caregivers) provided with mental health and psychosocial support services	**UNICEF**	17,658,974	9,446,290
		UNHCR	115,000	16,178 [13]
		IOM	719,674	133,921

9 Covers refugees, asylum seekers and immediate host community. Data reported in this reporting cycle does not include large referral programmes in Lebanon and Jordan. Figure excludes reproductive health, nutrition and mental health services reported through other GHRP indicators. Reporting period is 1 March to May 31 2020 cumulative with reporting from 12 countries.

10 World Vision programme; not a duplication of beneficiaries reported by a UN agency

11 As by end June 2020.

12 533,000 students were enrolled in UNRWA schools for the academic year 2019/20. Of them, more than 90% accessed at least one type of UNRWA remote learning support during the suspension of in-person learning due to COVID-19

13 Indicator includes services for mental health only. Covers refugees, asylum seekers and immediate host community. Reporting period is 1 March to May 31 2020 cumulative with reporting from 12 countries.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
Ensure the continuity of and safety from infection of essential services including health, water and sanitation, nutrition, shelter protection and education for the population groups most exposed and vulnerable to the pandemic.	Number and proportion of countries in which minimum child protection services are operational during the COVID-19 crisis	**UNICEF**	60	57
	Number of children 6-59 months admitted for treatment of severe acute malnutrition (SAM)	**UNICEF**	3,616,340	748,957
		UNHCR	34,117	2,488 [14]
	Number of children 6-59 months admitted for treatment of moderate acute malnutrition (MAM)	**UNHCR**	63,083	354
	Number of women and girls who have accessed Sexual and Reproductive Services	**UNFPA**	Women 3,394,070	4,956,821 Women reached with SRH services in 25 GHRP countries
			Youth 629,294	780,269 Adolescents and youths 10-24 reached with SRH services and information in 24 GHRP countries
		UNHCR	375,000	20,635 [15]
	Number and proportion of countries where messages on gender-based violence risk mitigation and available gender-based violence services were disseminated in all targeted areas	**UNFPA**	100 %	17/40 537 out of 820 target areas in 40 GHRP countries

14 Covers refugees, asylum seekers and immediate host community. Reporting period is 1 March to May 31 2020 cumulative with reporting from 12 countries.

15 Includes ANC, PNC, delivery, contraceptive services, SGBV clinical services. Covers refugees, asylum seekers and immediate host community. Reporting period is 1 March to May 31 2020 cumulative with data coming from 12 countries.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE ENTITY	TARGET	PROGRESS
Ensure the continuity of and safety from infection of essential services including health, water and sanitation, nutrition, shelter protection and education for the population groups most exposed and vulnerable to the pandemic.	Number and proportion of countries where GBV services are maintained or expanded in response to COVID-19[16]	**UNFPA**	63 GHRP countries/100%	25 out of 40 countries
		UNHCR	63 GHRP countries (100%)	33 out of 48 countries (69%)[17]
		CARE	-	18 countries
	Number of people who have accessed protection services	**UNHCR**	-	2.8 million [18]
		IOM	1,261,111	219,557
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 cargo movement requests fulfilled	**WFP**	90%	86%
	Number of passenger movement requests fulfilled	**WFP**	90%	94%
	Number and percentage of countries that have had requested consignments of reproductive health kits and other pharmaceuticals, medical devices and supplies to implement life-saving sexual reproduction and health services shipped since 1 March 2020	**UNFPA**	100%	82% of countries had their core commodities shipped and 72 per cent of those that arrived were distributed

16 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.

17 UNHCR's persons of concern have access to expanded/maintained GBV services in 33 GHRP countries (69% of the 48 GHRP countries where data was available).

18 51 of 63 countries reporting.

3.3

Progress on Strategic priority 3

Strategic priority 3

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

Progress by specific objective

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.

Partners have continued to advocate and ensure that the rights of vulnerable people on the move and host communities are safeguarded. Essential protection services have been provided, including protection monitoring; registration and documentation; status determination interviews; individual case management; legal aid; psychosocial counselling; response to gender-based violence and child protection; risk communication; engagement with diverse communities and strengthening of accountability to affected people mechanisms. Services have also been delivered to ensure access to education, nutrition, health and child protection services, social protection mechanisms, access to clean water, hygiene items, sanitation facilities, and essential supplies, among others.

Advocacy efforts to governments were successful to avoid that public health measures and protection be seen as mutually exclusive, and to ensure that people seeking international protection are afforded their fundamental rights and receive essential protection and other basic services. Nevertheless, at least 99 States have made no exception for people seeking international protection while at least 19 countries are still not providing adequate reception for arriving asylum-seekers.

UNHCR and IOM announced the resumption of resettlement departures for refugees on 18 June. The temporary hold on resettlement travel caused by the disruptions to international air travel delayed the departures of some 10,000 refugees to resettlement countries. Throughout this period, partners processed and counselled refugees and resettled scores of emergency and urgent cases. In addition, numerous resettlement countries established or expanded capacities to apply flexible processing modalities, and to adapt and ensure the continuity of their resettlement programs in unpredictable circumstances. More refugee departures can be anticipated as travel restrictions are gradually being lifted.

IDPs, refugees and host populations as well as public health facilities benefited from oxygen concentrators, ambulance transport, medicine and medical supplies including personal protective equipment, refurbishment, expanding clinical capacity through infrastructure improvements and human resource support, such as in Bangladesh, Cameroon, Chad, Colombia, Lebanon, Egypt, Ethiopia, Kenya and Uganda.

Partners have also continued to provide health and WASH services for refugees, IDPs, asylum seekers, migrants and other vulnerable population groups including those in camps and camp-like settlements. Access to water was enhanced for personal basic preventive hygiene measures such as handwashing, home-based health care, and testing capacity. For instance, a testing facility was set up in Cox's Bazar with a capacity of up to 500 tests per day.

Community health workers have been extensively trained in camps to support the COVID-19 response. Infection prevention and control measures have been put in place across points of entry, IDP and refugee camps, while water production, treatment

and distribution, as well as soap distribution and access to sanitation facilities have increased. Risk Communication and Community Engagement messages are being delivered using a variety of media platforms together with community and religious leaders.

Individual case management, referral pathways and community-based protection in operations with IDPs, refugees, asylum-seekers and migrants have been adapted and bolstered so that they can be carried out remotely and respond to increasing reports of incidents of gender-based violence. Several operations created or expanded 24/7 emergency hotlines and other communication channels for survivors. Others broadened their network of community outreach volunteers, who serve as a safe and trusted means to refer cases to partner organizations for care. Online support was also provided to persons with disabilities and older people given reports of gender-based violence towards these population groups.

Mental health and psychosocial support has been integrated into existing health, protection and education response and best practices have been captured[104].

Efforts have been made together with governments to ensure children and youth continue receiving education and access online and distance learning channels. For example, online courses and platforms have been developed, tablets have been distributed to refugee students, and power supply increased in refugee camps in Jordan and Uganda. Where online /distance learning is less available such as in Niger and South Sudan, partners have provided self-learning packs and produced radio broadcasts. Cash transfers have also been used to help refugee families to maintain access to national educational resources to continue learning, and to retain teachers in refugee institutions during school closures

Teachers and parents have also received incentive payments while schools remain closed. As many countries lift confinement restrictions, schools are being prepared to re-open by cleaning infrastructure, enhancing health training for teachers, raising awareness on COVID-19 preventive measures and accelerating education programmes to make up for the time spent out of school. Building back better opportunities are also being considered for the long term by improving WASH infrastructure in schools, for example.

Partners have advocated with Member States and development actors for the inclusion of refugees, IDPs, migrants and other populations of concern in social protection responses. Cash and voucher-based assistance has also been used to respond to the needs of these population groups. Hygiene and physical distancing measures have been applied during cash distribution to avoid risks of COVID-19 transmission. Some partners deliver up to 80 per cent of their cash assistance digitally, and new technology such as contactless biometrics, verification and monitoring of cash assistance through digital means are tested[105].

The situation of IDPs, refugees, migrants, asylum seekers and other population groups seeking protection is closely monitored by UNHCR, IOM and partners. IOM's Displacement Tracking Matrix mechanism continues to produce regular updates on the impact of COVID-19 on migrants and IDPs to provide better public health responses and address specific needs of these population 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.

As of June 2020, at least one incident of xenophobia, stigmatization, or discrimination against migrants, refugees, IDPs or stateless persons in relation to COVID-19 was noted in 41 country contexts. These were addressed by establishing 24/7 hotlines and email communication facilities, and undertaking follow-up interventions.

Risk Communication and Community Engagement activities have ensured that mobility is taken into account in public health messaging, and that information is contextualized and communicated effectively to migrants and mobile populations, while aiming at preventing panic, xenophobia and/or discrimination. Such campaigns were delivered in a variety of contexts including Afghanistan, Bangladesh, Burkina Faso, Djibouti, Egypt, Ethiopia, Iraq, Malaysia, Mozambique, Nigeria, Somalia,

104 Emerging Practices: mental health and psychosocial support in refugee operations during the COVID-19 pandemic, Available at: http://reporting.unhcr.org/sites/default/files/UNHCR%20Mental%20Health%20and%20Psychological%20support%20during%20COVID-19%20-%20June%202020.pdf

105 UNHCR Cash Assistance and COVID 19: Emerging Field Practices, Available at:https://www.unhcr.org/5eb55d427.pdf

South Sudan, Sudan, Yemen, and Zimbabwe, with awareness-raising public sessions, door-to-door visits, and peer discussions.

In South Sudan and Somalia, community consultations were held with organizations of persons with disabilities to understand levels of exclusion in the COVID-19 response. These include lack of adapted education for children with disabilities, lack of accessible information on COVID treatment and prevention, increased xenophobia and stigma. The findings will be used to programme more inclusive responses for persons with disabilities.

In Syria, awareness raising campaigns to face the pandemic were designed to be inclusive and accessible to all groups. The messages conveyed by these campaigns focus on removing potential prejudices based on gender, ethnicity, culture, faith and economic and displacement conditions.

Response gaps and challenges to achieve Strategic priority 3

Additional challenges to ensure access to services for migrants, displaced persons and other vulnerable populations are faced in contexts with **weak health system capacities and health financing constraints**. Maintenance of supply chains and continuity of care for migrants and vulnerable groups in need of essential health services are more difficult in **hard-to-reach areas and due to mobility restrictions**. The market for medicines and personal protection equipment is not stabilizing and joint and collaborative solutions are needed to support Ministries of Health and humanitarian actors.

COVID-19 has also brought the unmet **mental health and psychosocial support** needs of refugees, IDPs, stateless persons, migrants and other people of concern to the fore; it is crucial to ensure adequate mechanisms are in place to address these needs.

Migrants have also largely been overlooked in the **preparedness and response planning for COVID-19**, in particular in crisis settings where social protection is fragile or nonexistent. A number of countries have seen resurgences in COVID-19 cases where migrants and mobile populations were not included in planning. Additional efforts are required to safeguard the human rights of vulnerable populations and counter stigma and discrimination, including advocacy at global, regional and national levels, and further scaling up and wider reach of technical guidance and tools to ensure risk communication and community engagement messages are culturally and linguistically tailored and that migrants, displaced populations and other vulnerable groups are included in outreach campaigns to increase awareness and avoid stigmatization.

Gender-based violence services must be urgently resourced and funded to address the upscale of GBV notably in displacement and migration contexts.

Due to border closures, **durable solutions** such as resettlement and voluntary repatriation are still severely limited. Persons in need of international protection continue facing challenges in terms of access to territory and safety, as a result of growing political and security consequences of the pandemic worldwide. This exacerbates existing tensions as the impact of COVID is felt by communities and groups already excluded from development gains and/or discriminated against, including female heads of households, unaccompanied and separated children, older persons and LGBTI people.

Increased efforts are required to address humanitarian needs in **poor dense urban neighbourhoods** and **informal settlements** where large numbers of IDPs, refugees and migrants tend to reside, with a focus on WASH services and targeted livelihood support.

Strategic Priority 3 response monitoring indicators

Please note that the below response monitoring results are initial and rely on best estimates. They reflect progress as tracked per the indicated responsible agency. Some target figures may not be available as partners adjust and respond to emerging and changing needs. IASC partners are exploring ways to improve reporting against strategic priorities by better capturing the full breadth of collective efforts.

All efforts should be made in future progress reports to disaggregate and analyse indicator data 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
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 and migrants particularly vulnerable to the pandemic that receive COVID-19 assistance	**IOM**	8,797,016	4,474,039
		UNHCR	67 million people	22.6 million people[19]
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 and proportion of countries where areas inhabited by refugees, IDPs, migrants and host communities are reached by information campaigns about COVID-19 pandemic risks	**IOM**	60	40
		UNFPA	-	27 of 45 countries/60 %[20]
		UNHCR	100%	Progress data will be available in future updates.
		UNICEF	-	Progress data will be available in future updates.
	Proportion of countries inhabited by IDPs, refugees and migrants with feedback and complaints mechanisms functioning	**UNHCR**	100%	87%[21]
		UNRWA	Palestine refugees in all 5 fields of operation	All 5 fields of UNRWA operations have functioning feedback and complaint mechanism

19 Approximately 22.6 million persons are receiving or have received of COVID-19 assistance, including access to protection services, shelter, health, nutrition, education and livelihood support, or benefitted from rights-based advocacy, information campaigns, etc. This figure includes 996,704 individuals who received COVID-19 specific cash assistance. Different assistance modalities are being used, including in-kind and multipurpose cash assistance.

20 The list of countries include: Afghanistan; Bangladesh; Brazil; Burkina Faso; Cameroon; Central African Republic; Chad; Chile; Colombia; Djibouti; Dominican Republic; Democratic Republic of the Congo; Ecuador; Ethiopia; Guyana; Haiti; Kenya; Liberia; Mali; Myanmar; Mexico; Mozambique; Niger; Nigeria; Pakistan; Panama; Peru; Philippines; Rwanda; Sierra Leone; Somalia; Sudan; Syria; Trinidad and Tobago; Turkey; Ukraine; Tanzania; Venezuela; Yemen; Zimbabwe

21 63 countries reporting

3.4

Adherence to the guiding principles and key considerations for the response

Application of the guiding principles for the response

Respect for humanitarian principles.

Principles of humanity, impartiality, neutrality and independence are applied throughout the response. This is indispensable to address notably issues of access and of violence targeting health care workers and facilities *(see Section 2.2 above).*

People-centered 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.

GHRP partners are assessing and responding to needs taking into account the diversity of vulnerabilities and threats faced by the persons affected, and a human rights and "do-no-harm" approach. Efforts are made, and should continue, to ensure participatory, inclusive and people-centred analysis and implementation modalities.

For example, in Mozambique, UN-Habitat's COVID-19 response initiatives are based on a human rights approach, putting people at the center of the activities and leaving no one behind. Priority is given to the most vulnerable populations in informal settlements, especially older persons, widows, youths and people with disability. These people are involved as direct beneficiaries and in the implementation through participatory processes in coordination with the Municipality and local civil society organisations.

Existing programme standards (Sphere, Common Humanitarian Standards, Child Protection Minimum Standards, International Network for Education in Emergencies Minimum Standards) are references that should continue to guide programme design and implementation.

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.

All actors recognise and put emphasis in their response, on the increased risk of exacerbation of inequality, gender discrimination and gender-based violence due to the pandemic. FAO for example set up a monitoring system using remote data collection modalities in the most food insecure countries included in the GHRP with questionnaires designed to understand the impact of COVID on small holder and pastoralist supply chains and livelihoods, with specific emphasis on most vulnerable groups. Each questionnaire is designed to capture and differentiate the views of both men and women as respondents. Through the analysis, the impact of the COVID – 19 crisis on female traders, female respondents at household level and female headed households will be further understood and fed into programme and project design both for FAO and partners.

Cultural norms, gender relations, disabilities, languages, literacy rates, phone coverage, internet access etc. are analysed through community mapping and needs assessment exercises with local stakeholders and groups, in order to tailor an evidence-based response according to the social relations, communication infrastructure and information needs of the affected population.

UNICEF's COVID-19 response is guided by UNICEF's Core Commitments for Children in Humanitarian Action, is a global framework for humanitarian action for children undertaken by UNICEF and its partners. Interventions are culturally sensitive and tailored to the specific needs of different age groups (children, youth, adults), and they take into consideration issues of local customs, gender equality, women's and girls' specific needs and risks and disability, among others. UNICEF has specific interventions targeting women and girls as well as specific interventions targeting different aged children. The needs of persons with disabilities are addressed by supporting accessible online education; making risk communication and community engagement accessible; delivery of accessible WASH services, and inclusive child protection and mental health and psychosocial support initiatives.

UNFPA's response lies in its unique approach to preventing and responding to gender-based violence, which bridges protection, gender equality and sexual and reproductive health and rights in humanitarian action. The responses are tailored to cultural contexts, addressing specific needs of women and girls and most at risk groups (people with disabilities, LGBTI, etc.). UNFPA is also prioritizing the protection of adolescents and young people, and support for their active engagement in COVID-19 related risk communication.

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 social distancing.

Humanitarian actors addressing gender-based violence have adopted key community messages on GBV and COVID 19 which are being contextualized and translated to local languages by frontline GBV actors locally.

For example, in Libya key messages to support the prevention and risk mitigation of GBV were prepared and shared with the Libya National Centre for Disease Control for endorsement and dissemination. GBV key messages have also been developed targeting the entire community and different groups, such as men, children and people with disability, to be shared on TV and social media. In Uganda, a helpline is operated by a call centre with agents speaking 15 different languages. GBV survivors who call the helpline are provided with counselling by protection staff.

Complementarity and synergies between agency plans and responses.

GHRP partners are coordinating their action notably through the GHRP and using cluster and other coordination mechanisms at field level (see also below inter-agency collaboration).

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

Preparedness is essential in the unpredictable context of the pandemic. In April 2020 the IASC updated the guidance on emergency response preparedness[106] to reflect the circumstances of COVID-19 in an effort to encourage and support a coordinated risk analysis, prioritisation of humanitarian response and review of delivery capacities.

Several partners have prepositioned key supplies and equipment to ensure the delivery of health, nutrition, food and other assistance to the most vulnerable population groups. For example, to mitigate the upcoming peak of impacts in Kinshasa (epicenter of the pandemic in the DRC), FAO is implementing rapid support of local peri-urban food production and supply chains through vegetable seeds distribution as well as the distribution of rice processing and conservation machinery for the May-June rice harvest. This will help overcome restrictions on movement within the city and from the city to the neighboring provinces which are expected to severely affect food supply chains, food availability and accessibility, and the livelihoods of the most vulnerable people in the coming months.

In Haiti, a context of economic fragility and socio-political tensions, the preventive measures taken to contain the spread of COVID-19 are also likely to cause a reduction in food availability and accessibility due to the disruption of agricultural activities and markets. FAO is launching an anticipatory action project to mitigate the expected negative effects on the availability of inputs, as well as the impact of the foreseen economic slowdown on the purchasing power of vulnerable households. The project provides vegetable seeds, agricultural

106 https://interagencystandingcommittee.org/system/files/2020-04/IASC%20Interim%20Guidance%20on%20COVID-19%20-%20ERP%20Approach%20-%20April%202020.pdf

tools and cash for nearly 1,000 vulnerable households living in urban or peri-urban areas while at the same time raising community awareness on measures to prevent the spread of COVID-19. In response to the forecast above-normal 2020 Atlantic hurricane season, this anticipatory action project also includes a component on anticipating and mitigating the potential impact of hurricanes on vulnerable households.

In Afghanistan, a shift was made to more mobile based approaches and prepositioning of supplies in the country, while in Myanmar preparations are made to avoid problems with the use of cyclone shelters for quarantine purposes during the monsoon season when large-scale evacuation and temporary displacement are typical.

Building on existing coordination mechanisms.

Several coordination mechanisms are leveraged in the collective response to the pandemic. As one example, the WHO Health Emergency Operations Centre (PHEOC) Framework offers a best practice guide for developing and managing PHEOCs. Many countries have used the guide and built and improved their PHEOCs and operational capacities to coordinate and collaborate across response agencies and other partners, before and during the COVID-19 crisis. As various health and other entities converge to support response to COVID-19, the PHEOC is the most practical and best positioned to support the required coordination and collaboration for effective and efficient response and recovery.

Duty of care for agency staff and volunteers.

In line with existing business continuity practices, UN entities have been adhering to the principle of "Stay and Deliver" to provide necessary services to partners at the country level. UN agencies and NGOs alike are ensuring duty of care of their staff and volunteers through surge, mental health and psychosocial support, equipment and medical evacuation (medevac) services. An agency working group has also been set up around the growing issue of intimate and domestic partner violence as it pertains to personnel. ICVA developed a paper of duty of care for humanitarian workers[107] focusing on prevention by strengthening labour rights, occupational safety measures and health for all, including national staff.

A UN System-Wide Task Force on Medical Evacuations in response to COVID-19 was established under the leadership of the Department of Operational Support[108]. As part of this system eligible personnel will have access to regional treatment facilities supported by the appropriate medical personnel, appropriate medical personnel, air assets (aircraft and air ambulances), as well as a dedicated operations center that will coordinate the joint resources of the UN system.

At a global level, COVID-19 MEDEVACs are organized and arranged by a dedicated 24/7 UN MEDEVAC Cell. Led by WHO the coordination cell comprises medical experts and aviation experts. At field level, the implementation of the medical evacuations rests heavily on WFP which has contracted medical evacuation services, procured road ambulances and established field hospital infrastructure where no alternative is available; in coordination with health partners and governments. As large numbers of UN staff and dependents continue to work in locations where there is little or no access to any UN medical facility, IOM is supporting UN outpatient clinics and provides staff through its global network of qualified health workers, including physicians, nurses and laboratory staff, across locations where IOM already has medical presence.

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

Integration, complementarity and synergies with other agency and global response plans for COVID-19 and inter agency collaboration

Existing coordination mechanisms through the Resident/Humanitarian Coordinator system, global and field clusters are used to plan and implement complementary responses amongst UN agencies, NGOs and the Red Cross and Red Crescent Movement. Humanitarian organisations are also aligning as appropriate their response plans to the GHRP. The refugee response is led by host governments and supported by UNHCR in line with the Global Compact on Refugees and relying on existing coordination structures. Particular attention is paid to coordination and interagency collaboration on gender-based violence and sexual and

107 https://www.icvanetwork.org/system/files/versions/Protecting%20humanitarian%20workers%20against%20COVID-19.pdf

108 The Task Force reports to the UN Executive Committee led by the Secretary-General, and is comprised of FAO, IOM, UNDP, UNFPA, UNHCR, UNICEF, UNOPS, WFP, WHO, the UN Medical Directors Network (UNMD) and the offices and departments of the United Nations Secretariat.

reproductive health, food security, and data analysis.

All agencies are highlighting concerns with significant GBV in the COVID-19 context and are integrating GBV in their response. UNICEF is leading the interagency coordination on GBV risk mitigation across all sectors[109]. UNICEF, UNFPA and OCHA will also leverage this crisis to advance the GBV Accountability Framework within COVID-19 responses at field level. In complement, UN Women also launched a global appeal for COVID-19 on 14 July 2020 to support women's leadership and participation in the response, support women and girls' livelihoods, resilience and coping and risk reduction capacities, and prevent and mitigate gender-based violence.

At the regional and country level, UNFPA participates in the WHO regional crisis management group and various coordination mechanisms, including the UN Country Team and Humanitarian Coordination Team, and supports the respective national COVID-19 Preparedness and Response Plans ensuring integration of sexual and reproductive health and GBV concerns, and mitigation of social and economic impacts, including protection from GBV and prevention of sexual exploitation and abuse. UNFPA is leveraging these partners to support risk communication, community engagement in primary prevention and stigma reduction, and reinforcing women and girls' agency, decision-making, and voice with a constant focus on their safety, dignity and rights. A multisectoral approach will safeguard and support families and communities, and build their knowledge and capacities to protect themselves and prevent further spread of the virus.

In all countries WFP is leveraging its food assistance platform to disseminate COVID-19 prevention messaging through community behavioral change communication at distribution sites and retail shops or WFP-supported call centers (Afghanistan), extending WFP's cash-based transfer platform to partners, or leveraging WFP's food distribution network to deliver hygiene items (Namibia). Recognizing how the COVID-19 crisis is contributing to increased incidence of GBV, partnerships were reinforced with protection partners to scale up GBV awareness and referral systems using WFP's retail network and its complaints and feedback mechanisms, for example in Ethiopia, Republic of Congo, and Somalia.

WFP is a member of the Supply Chain Interagency Coordination Cell (SCICC). The Cell, established by the UN Crisis Management Team, is responsible for information management and operational activities related to the COVID-19 Supply Chain System providing a 'line of sight' to supply chain requirements, ensuring COVID-19 needs are prioritized within the wider humanitarian response. Within this framework, WHO leads the prioritization and destination for health items, while WFP serves as logistics lead to deliver the items on behalf of the humanitarian community.

In addition, WFP and WHO co-chair the Task Force on Supply Chain Coordination, which also includes other UN agencies, NGOs, and civil society organizations. The Task Force provides strategic direction to the SCICC, ensuring that supply chains are driven by strategic and tactical priorities and that the most critical gaps in supplies are identified and met in a timely fashion.

Considering the dire food security and nutrition situation and prospects in the COVID-19 context, the Global Network' Against Food Crisis[110] partners carried out the campaign on "Food Crises and COVID-19" and delivered key messages on priority actions to respond to multiplying food crises, which are now being compounded by the COVID-19, the ongoing locust plague and other risk factors, and to protect and strengthen food systems in the post-pandemic word. As a result, the Global Network's partners are strengthening their analytical capacities to monitor and assess the situation providing data, analyses and intelligence on COVID-19 related risk and potential impact on livelihoods and value chains in order to inform anticipatory actions to avert food crises. In particular, within the framework of the Global Network Against Food Crises, FAO and WFP have established a coordinated monitoring system of risks for food security and livelihoods from COVID-19 in order to identify and initiate critical anticipatory actions.

FAO works with various partners, including WHO and the World Organisation for Animal Health (OIE), to deploy a One Health approach. It is raising awareness of actors along the food supply chain about health regulations, including rights, roles

109 See www.gbvguidelines.org

110 The Global Network Against Food Crises is an alliance of humanitarian and development actors united by the commitment to tackle the root causes of food crises and promote sustainable solutions through shared analysis and knowledge, strengthened coordination in evidence-based responses and collective efforts across the Humanitarian, Development

and responsibilities of workers along the food supply chain. Based on the guidance material on the technical standards and messaging of WHO, guidelines are being adapted to the specific needs of the agriculture sector to reduce risk of transmission within the food value chain and ensure business continuity in compliance with national safety protocols. Through such mechanisms, collaboration with community radios, posters, SMS campaigns, etc. are contextualized for farmers, herders, and other people who work along the food value chain. Social messages on health and safety are being developed and disseminated in collaboration with the WHO, UN risk communication teams, government and local communities.

On the health side, the COVID-19 Supply Portal launched by the Supply Chain Coordination Cell in May offers a common platform for UN agencies, partners and Member States to submit requests for essential supplies. Supply Coordinators appointed by WHO, PAHO, and partner agencies, including UNICEF, WFP, the Office of the Resident Coordinators, UNDP and UNOPS coordinate the COVID-19 Supply Portal.

OCHA has set up a Global Information Management, Assessment and Analysis Cell for COVID-19 (GIMAC) to enhance data sharing and collaboration across humanitarian actors on analysing the needs caused by the pandemic on the most vulnerable population groups. IOM, OCHA, UNHCR and WHO are coleading the GIMAC, and a variety of UN agencies and NGOs are members. Discussions are ongoing with the Development Coordination Office (UN Development System Group) to also support joint needs analysis with development actors.

WFP is working closely with FAO, IOM, the World Bank and other global and regional institutions on food security needs analysis. It has rapidly adapted and significantly expanded its various real-time remote assessment and monitoring tools to assess and track impacts, reaching even displaced and migrant populations on the move.

Humanitarian and development collaboration

Beyond the immediate humanitarian consequences caused or exacerbated by COVID-19, a deeper and longer-lasting socio-economic impact is emerging. The Report of the Secretary-General *Responding to the socio-economic impacts of COVID-19*[111] provided a preliminary analysis of the longer-term socio-economic impact and the priorities governments need to consider in order to mitigate its impact. On this basis, UN Resident Coordinators and Country Teams have been at the forefront of this effort, working with governments, NGOs, faith-based organisations and international financing institutions.

As of 29 June, 28 UN Country Teams have finalised socio-economic response plans, eight of which have been developed in countries covered by the GHRP. Resident Coordinators and UN Country Teams ensure that country-level COVID-19 humanitarian response plans and socio-economic plans complement each other. As such, emergency response activities included in the GHRP are complementary to socio-economic response priorities, based on impact analyses coordinated by country Resident Coordinators and UN Country Teams. Complementarity of the response is particularly important at a time when discussions begin on revising/renewing UN Sustainable Development Frameworks.

UNHCR worked closely with the World Bank Group which has decided to provide up to $1 billion from the IDA-19 allocation through the sub-window for host and refugee communities during the next fiscal year starting 1 July 2020. This will make financing more attractive for refugee-hosting states ensuring refugees and host communities will continue to be considered in efforts to mitigate the health, economic and fiscal impact of the pandemic.

In line with the 19th IDA replenishment the World Bank Group also pledged to significantly increase the resources for fragile and conflict-affected situations. This includes an important commitment to conduct a systematic review of refugee policy and institutional environments in countries eligible for the sub-window on host and refugee communities so as to inform the creation of socio-economic development opportunities. In addition, the World Bank, the InterAmerican Development Bank and the European Investment Bank have pledged additional resources to countries hosting Venezuelan refugees and migrants to cope with the economic impact of COVID-19.

The African Development Bank is supporting the G5 Sahel countries' (Chad, Burkina Faso, Mali, Mauritania and Niger) COVID-19 response with a particular focus on areas affected by forced displacement. UNHCR is supporting the

111 https://unsdg.un.org/resources/shared-responsibility-global-solidarity-responding-socio-economic-impacts-covid-19

implementation of the health and community resilience components of this project in all five countries.

Social protection is an area conducive to collaboration between humanitarian and development actors, given its capacity to address urgent and longer-term survival and livelihoods needs[112]. Several GHRP partners are actively engaged in this programme area. For example, WFP is cooperating with several governments to provide technical assistance, service provision, and complementary support to develop or adapt their existing social protection measures in response to COVID-19. This support spans from digitization and expansion of the National Aid Fund in Jordan (395,000 households monthly), to helping the government of Ethiopia to introduce a cash top-up under the Urban Productive Safety Nets Programme. in Colombia, WFP and the government are partnering to extend for the first time support to Venezuelan migrants in Arauca border region not previously covered under the national programme.

Basic service delivery and supply chain systems for nutrition, food, health (including mental health and psychosocial support and sexual and reproductive health), gender-based violence, WASH, education and school feeding are other areas where collaboration between humanitarian and development actors is being concretised. For example, in the Philippines, WFP is supporting the government with digital solutions for their national-led COVID-19 basic service delivery response.

UNICEF's programming is designed to be risk-informed and forward-looking to 'build back better' to create more robust and resilient health, education, WASH and protection systems and permanent expanded social protection systems to preserve and contribute to peaceful and inclusive societies. UNICEF for instance is supporting ministries of education and other education actors to provide remote learning during the pandemic, which is a system that can be used and adapted in the future to support better learning outcomes. With relevant line ministries, UNICEF and UNFPA are training government staff (including social workers) in case management and are working closely with local structures, including women and girls' groups to strengthen and/or establish response and referral mechanisms for gender-based violence and mental health and psychosocial support services.in Ilusion of GBV guidance in national COVID-19 response plans is also used to strengthen the general GBV response in the health system moving forward.

In Somalia, UNFPA's Geographic Information Systems provides data maps with geo-referenced information at dwelling structure level on hotspots and areas that present vulnerability to COVID-19 by various risk factors. The data supports key government actors as well as local and international development partners to better target the country's COVID-19 response.

Preparedness planning supports a quick adaptation to the COVID-context also in case of a second wave of COVID-19 infections, but it also serves as a longer-term resilience mechanism. For example, in Palestine, UNFPA is investing in preparedness plans for GBV service providers, factoring in availability of supply, PPE and strengthened capacities for alternative modes of service provision.

Conflict sensitive and risk informed programming

Conflict and high levels of mistrust have posed a barrier to effective responses across multiple countries. In places that already experience or are at risk of experiencing significant social tensions, political unrest and instability, especially in conflict-affected and fragile settings, GHRP partners are identifying existing or potential conflict dynamics or strains to social cohesion to minimize the potential negative impacts of misinformation for children and their communities ('do no harm'). Risk Communication and Community Engagement initiatives are critical to preserve and contribute to peaceful and inclusive societies.

The evolution of the COVID 19 pandemic is also characterized by a high degree of uncertainty. Investment in understanding the likely evolution of the crisis in the coming weeks and months is essential for the design of anticipatory actions and to reduce the risk of the health crisis becoming also a global food crisis in particular. FAO is embedding scenario planning in the design of its response programme to support the design and implementation of appropriate anticipatory and response action coherently and allow timely adjustments to the country specific crisis timeline.

112 Linking Humanitarian Cash and Social Protection for an Effective Cash Response to the COVID-19 Pandemic, https://www.calpnetwork.org/wp-content/uploads/2020/07/Grand-Bargain-Sub-Group-Humanitarian-Cash-and-Social-Protection-and-COVID-19-response.pdf

Community engagement

Humanitarian operations are capitalizing on the common risk communication and community engagement strategy developed by WHO, UNICEF and IFRC, target messages in relevant languages (including sign language and for displaced populations), and the on-going work on community engagement in the field. Community-based structures are used intensively to maintain in-person two-way communication and feedback and reporting mechanisms in the physical distancing context of COVID-19 and for hard-to-reach population groups. These involve community and religious leaders, outreach volunteers, members of women's and youth groups, agricultural and animal extension workers and others to disseminate relevant risk and assistance information, including on protection risks related to the pandemic such as evictions, gender-based violence, child protection and protection from sexual exploitation and abuse.

Significant inroads are being made on community engagement in preventing and responding to gender-based violence. Specific attention is being given to vulnerable groups such as people with disabilities, women in poor households, older persons, IDPs, migrants and refugees. For example, humanitarian actors involved in GBV in Cox's Bazaar are strengthening capacities to recognize red flags of gender-based violence among older persons, as concerns have been raised of their increased vulnerability to GBV during isolation measures. In DRC, women-led organizations have developed an advocacy initiative in partnership with UNFPA to address the increase of intimate partner violence during COVID-19 by conducting community sensitisation in markets, campaigns on social media, radio programs.

In Jordan, selected messages were included in the nationwide "Elak o Feed" campaign together with key partners in the Government and UN agencies. The messages were further adapted by national actors and covered risks of increased family tensions and domestic violence, and hotlines available to seek help. Those messages developed during the emergency will be adapted and used in all primary health care facilities for a GBV campaign. Key messages were also developed in Nigeria for the Women's Committees on handling GBV disclosures. The Women's Committees had been engaged and trained as part of the Women's pacification programme.

Digitally enabled platforms, radio, television and social media are largely employed to provide and receive messages. A number of partners have developed helpline mechanisms in multiple languages, including sign, such as UNHCR. UNICEF's *internet of good things* (IOFGT) platform, for example, is providing access to online learning modules to District Social Welfare Officers in Tanzania that train officers to support families and patients through the COVID-19 pandemic. In Zimbabwe, IOGT is delivering storybooks to out-of-school pupils and is equipped to provide online learning modules. These books include audio and video recordings of book reading to address the needs of students with disabilities.

Efforts are also made to engage with the youth. UNFPA and Prezi have spearheaded a youth campaign on COVID-19, focused on what they can do to keep their friends, families and communities safe. The campaign reached more than 500,000 users in 20 languages and was adapted for platforms like Whatsapp, that require relatively little data, as well as for afro-descendant young people, indigenous youth and young people living with disabilities.

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

The essential role of local and national organisations and groups, including faith-based, have been acknowledged before and further reinforced in the COVID-19 pandemic. The size of humanitarian needs, complexity of the response, criticality of community engagement and inclusion of diverse vulnerable groups, and travel restrictions for international staff, make local and national actors an indispensable and major component of the collective response. As acknowledged in previous occasions, they must be fully included on an equal footing with international partners in response planning, programme implementation and coordination mechanisms.

As an illustration of efforts made in this regard, World Vision has equipped about 80,000 faith leaders across Latin America, Asia, Africa, Middle East and Eastern Europe to share accurate information about preventing COVID-19 with their communities, as well as spiritual-based psychosocial support. In Afghanistan, World Vision partnered with the WHO and Ministry of Hajj and Religious Affairs to conduct training with 60 faith leaders, who passed

on prevention messaging to 1,300 people. In South Sudan, over 1.4 million people were reached with a COVID-19 awareness campaign, including 420 faith leaders.

UNICEF and UNFPA's global partnership with Religions for Peace (the world's largest inter-faith network) led to the launch of a global multi-Religious Faith-in-Action COVID-19 initiative to mobilize religious leaders, Women in Faith and interfaith networks to support COVID preparedness and response. The partnership has developed 6 guides to support Religious Leaders and Faith communities' response. UNHCR currently works with 1,033 different implementing partner organizations, including 165 international non-governmental organizations, 658 national non-governmental organizations and civil society actors, 195 local and government authorities and 15 UN agencies. Some 83 per cent of UNHCR's implementing partner organizations are local/national actors.

In Mozambique, UN-Habitat relies on local associations and municipalities to monitor the handwashing facilities and raise awareness in informal settlements. These civil society organizations are identified by the partner municipalities among the ones most active in the vulnerable informal settlements and are usually already engaged in awareness raising activities. In Iraq, UN-Habitat's engagement with local private-sector organizations (contractors) and local authorities (municipalities, directorates and mayoralties) has been critical due to movement restrictions between towns, cities and governorates. In Palestine, UNRWA is mobilising youth to disseminate positive messages in their communities and to become actors of positive change.

Partnership with NGOs *(See also, section 4 on funding)*

Under the GHRP, all UN agencies are partnering with international and national NGOs. NGOs are also implementing COVID-19 response programmes funded by their own resources.

UNICEF's COVID-19 response is realized through partnerships with governments, humanitarian organizations, civil society groups, including NGOs and others. While governments have primary responsibility for administration of national development and humanitarian processes and programmes, NGOs and civil society play an essential role. NGOs are often responsible for providing basic services to children and raising awareness among the population and wider humanitarian community about gaps in response policy, enforcement and practice on child rights issues, among many others. NGO partnerships strengthen advocacy efforts for children's rights and create opportunities to strengthen innovative approaches and programming for children. They also enable a greater exchange of knowledge across organizations in different fields of expertise.

In many operations UNHCR is realigning and reallocating resources to find flexible, pragmatic solutions that allow UNHCR and NGO partners to stay and deliver together. Since the outset of the pandemic, UNHCR has organized weekly NGO consultations, with an average of 100-200 participants each week, to discuss critical issues and ensure a smooth flow of communication. Efforts are made to give NGOs the flexibility needed to make adjustments in their activities given physical distancing measures and travel restrictions, and to jointly address shared challenges such as the need for humanitarian exemptions, supply chain and other logistical issues, and duty of care for humanitarian workers.

Several localization activities have been scaled up, including capacity sharing and partnerships with local actors and NGOS. For example, in Yemen, the gender-based violence sub-cluster has Yemen Women Union as its co-lead, which is one of the local organizations with branches in all geographic locations. Dissemination of awareness messages on COVID-19 to grass root level is channeled through their member organizations on the frontline. In Iraq, UN-Habitat's partnerships with local NGOs are critical to response implementation due to movement restrictions between towns, cities and governorates.

As part of IOM's localization efforts in the context of the COVID-19 pandemic, IOM has received a multi-country allocation of USD 25M from CERF that will be channeled to NGOs at a country level and will help NGOs in Bangladesh, the Central African Republic, Haiti, Libya, South Sudan and Sudan to effectively respond to the COVID-19 pandemic (see Section 4.4.below). This is a critical step to the delivery of effective humanitarian assistance, marking the way to support grass roots and direct implementation efforts to get closer to the needs of those affected.

Protection from sexual exploitation and abuse (PSEA)

COVID-19 has been a time of heightened risk of sexual exploitation and abuse (SEA) due to disruptions to livelihoods, social isolation and surge in new responders. At the same time, COVID-19 has brought challenges to community-based complaints and reporting channels and weakened referral pathways and services for victims of SEA.

The IASC developed interim guidance on Protection from Sexual Exploitation and Abuse (PSEA) in the COVID-19 response. The guidance has been translated and adapted to several contexts. in June, IASC[113] released a Checklist to Protect from SEA during COVID-19 and IASC members have started a series of consultations with high-risk duty stations to better understand needs and possibilities for tailored support to PSEA field networks in the context of COVID-19.

UNFPA developed a five-point checklist for its PSEA Focal Points and Managers in the field to implement and in coordination with other agencies has supported the development of communications materials on topics related to PSEA adapted to the COVID-19 context, to ensure that access to information continues.

UNHCR recently launched the PSEA Community Outreach and Communications Fund in partnership with ICVA to support the community engagement efforts of local NGOs. The Fund aims to reinforce sexual exploitation and abuse (SEA) prevention measures as the pandemic brings increased risks of SEA and also makes community outreach and engagement more challenging. Over 1,600 proposals have been submitted to the Fund, many of which specifically address new risks arising out of the pandemic. Many also seek to strengthen engagement with groups at heightened risk such as women and girls with disabilities, LGBTQI people and members of geographically isolated communities.

113 The Checklist was developed by CHS Alliance, InterAction, IOM, Oxfam, UNFPA, OCHA, WFP, WHO and UN Victims' Rights Advocate under the IASC umbrella.

“Just like our world, our global food systems are connected – and COVID-19 is forcing us to rethink how we can transform them to deliver for all. ”

—

David Beasley
Executive Director of the United Nations World Food Programme

SANA’A, YEMEN

21 April 2020. WFP has a network of warehouses across Yemen so we can deliver food assistance to food insecure families.
Here are 6 ways we are making sure our warehouses stay safe during the COVID19 pandemic: 1. all staff have their shoes washed before entry to the warehouse; 2. workers have their temperature checked as they arrive at the warehouse; 3. everyone must wash their hands regularly; 4. all workers wear masks to protect themselves and others; 5. all workers must observe social distancing measure at all times; 6. the warehouses are regularly cleaned and sanitised. *WFP/Mohammed Awadh*

4.0

Financial requirements and funding status

VENEZUELA

June 19, 2020. A plane carrying 90 tons of medical and water, sanitation and hygiene supplies arrived in-country today to continue supporting the UN response against COVID-19. The supplies will help strengthen the health system, improve access to safe water for thousands of families and ensure continued assistance in other critical areas, including sexual and reproductive health. *UNICEF/Pocaterra*

4.1

Overview of global appeals for COVID-19

At the beginning of 2020, global humanitarian requirements were already close to $30 billion, with 168 million people in need of humanitarian assistance. These global requirements have risen to a record $40 billion including requirements to respond to COVID-19.

Funding for the GHRP addresses the most urgent humanitarian health and socio-economic needs caused by the pandemic. Other sources of funding are complementing this response, including from the UN Secretary General COVID-19 Multi Partner Response and Recovery Fund[114], International Financing Institutions (IFIs), the Red Cross Red Crescent Movement, the Vaccine Alliance (GAVI) and the Global Fund. The targeted focus of these other responses, for example the provision of debt relief from the International Monetary Fund and the work by the Global Fund to adapt HIV, tuberculosis and malaria programmes to mitigate the impact of COVID-19, complements the urgent, live-saving assistance provided by the GHRP.

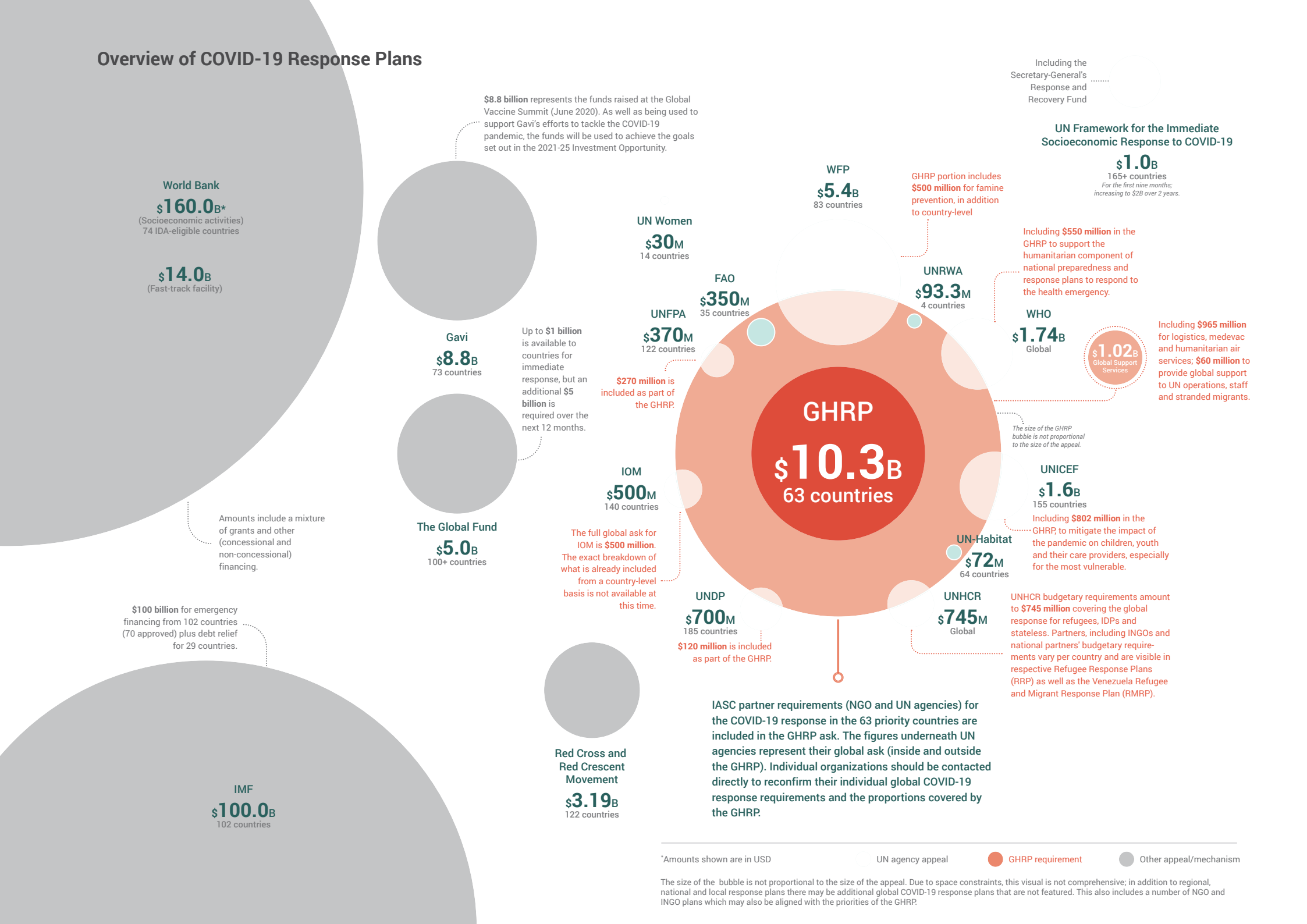
A number of countries included in the GHRP have successfully leveraged IFIs' financing to maintain liquidity and fiscal space to respond to the health and socio-economic impact of the crisis. For example, for Sierra Leone the International Monetary Fund has approved suspension of loan payment, deferring $17.8 million, in addition to the provision to $143 million to meet balance of payments and fiscal needs stemming from the COVID-19 pandemic, and to $107.5 million from the World Bank to address health and socio-economic needs. As of 19 May, the World Bank emergency COVID-19 operations had reached 100 countries, with nearly one-third of the total projects in fragile and conflict-affected situations, such as Afghanistan, Chad, Haiti, and Niger.

The visual on the following page illustrates global collective efforts to respond to COVID-19 across three different – yet connected – areas of response (humanitarian, health socio-economic/development). It includes a selection of COVID-19 appeals, recognizing that many countries have comprehensive national response plans and that there are a myriad of response efforts and plans being enacted by community-based organizations and local and national NGOs. Individual organisational appeals may also in some cases include requirements outside of the scope of the GHRP[115]. Agencies should be contacted directly to reconfirm their individual global COVID-19 response requirements.

114 As of 3 July, $46 million had been received against the MPTF.

115 This includes, in particular, UN Women global appeal for COVID-19 launched on 14 July 2020 requesting $30.4 million for support to women's leadership and participation to the response, support to livelihoods, resilience, coping and risk reduction capacities of women and girls, and prevention and mitigation of gender-based violence.

Overview of COVID-19 Response Plans



The size of the bubble is not proportional to the size of the appeal. Due to space constraints, this visual is not comprehensive; in addition to regional, national and local response plans there may be additional global COVID-19 response plans that are not featured. This also includes a number of NGO and INGO plans which may also be aligned with the priorities of the GHRP.

4.2

Funding requirements at country level

Updated COVID-19 response requirements in the countries included in the GHRP amount to over $8.4 billion. Details by country are shown in the table below[116].

Compared to early May, most countries have increased their funding requirements to scale up their support to health systems and to address increasing food insecurity, impact on livelihoods and protection concerns including GBV[117]. Significant increases were made in Afghanistan, Colombia, Ethiopia, Nigeria, Somalia and Syria 3RP. The sectors where most of the funding requirements rose were food security, health, WASH, protection, shelter and education (see table below).

At the same time, countries are also reviewing their non-COVID requirements as and when appropriate, with some of these changed downwards (e.g. Somalia, Libya), others increased, and others yet to be reviewed or the decision has been not to review.

116 Funding requirements updated on 6 July 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.

117 UNHCR budgetary requirements amount to $745 million covering the global response for refugees, IDPs and stateless. Partners, including INGOs and national partners' budgetary requirements vary per country and are listed in respective Refugee Response Plans (RRP) as well as the Venezuela Refugee and Migrant Response Plan (RMRP).

Financial requirements (US$)

COVID-19 REQUIREMENTS

REQUIREMENTS
$10.3B

OF WHICH:
HEALTH: $2.86 B
NON-HEALTH: $7.44 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS
$40B*

OF WHICH:
COVID-19: $10.3 B
NON-COVID-19: $29.4 B

INTER-AGENCY APPEAL		ADJUSTED NON-COVID-19	COVID-19 REQUIREMENTS: HEALTH	COVID-19 REQUIREMENTS: NON-HEALTH	COVID-19 TOTAL	TOTAL HUMANITARIAN COVID + NON-COVID
Afghanistan	HRP	**735.4 M**	107.6 M	288.1 M	395.7 M	**1.1 B**
Burkina Faso	HRP	**318.4 M**	17.1 M	88.8 M	105.9 M	**424.3 M**
Burundi	HRP	**159.8 M**		38.0 M	38.0 M	**197.9 M**
Cameroon	HRP	**309.1 M**	18.2 M	63.5 M	81.7 M	**390.9 M**
CAR	HRP	**400.8 M**	7.7 M	145.2 M	152.8 M	**553.6 M**
Chad	HRP	**540.5 M**	38.1 M	86.1 M	124.2 M	**664.6 M**
Colombia	HRP	**209.7 M**	140.0 M	189.4 M	329.4 M	**539.1 M**
DRC	HRP	**1.79 B**	122.1 M	152.4 M	274.5 M	**2.1 B**
Ethiopia	HRP	**1.14 B**	100.0 M	406.0 M	506.0 M	**1.7 B**
Haiti	HRP	**327.6 M**	105.0 M	39.3 M	144.4 M	**472.0 M**
Iraq	HRP	**397.4 M**	65.4 M	199.4 M	264.8 M	**662.2 M**
Libya	HRP	**83.2 M**	16.7 M	29.9 M	46.7 M	**129.8 M**
Mali	HRP	**398.9 M**	2.1 M	73.3 M	75.4 M	**474.3 M**
Myanmar	HRP	**216.5 M**	21.6 M	37.2 M	58.8 M	**275.3 M**
Niger	HRP	**433.8 M**	15.7 M	66.7 M	82.3 M	**516.1 M**
Nigeria	HRP	**838.0 M**	85.3 M	157.1 M	242.4 M	**1.1 B**
oPt	HRP	**348.0 M**	19.1 M	23.3 M	42.4 M	**390.4 M**
Somalia	HRP	**784.3 M**	81.0 M	144.6 M	225.6 M	**1.0 B**
South Sudan	HRP	**1.5 B**	91.4 M	296.0 M	387.3 M	**1.9 B**
Sudan	HRP	**1.3 B**	128.0 M	155.6 M	283.5 M	**1.6 B**
Syria	HRP	**3.4 B**	157.5 M	226.7 M	384.2 M	**3.8 B**
Ukraine	HRP	**157.8 M**	27.6 M	19.3 M	46.9 M	**204.7 M**
Venezuela	HRP	**674.6 M**	50.4 M	37.5 M	87.9 M	**762.5 M**
Yemen	HRP	**3.0 B**	304.6 M	81.1 M	385.7 M	**3.4 B**
Zimbabwe	HRP	**715.8 M**	24.8 M	60.1 M	85.0 M	**800.8 M**
Burundi *Regional*	RRP	**209.9 M**	36.5 M	29.0 M	65.4 M	**275.4 M**
DRC *Regional*	RRP	**483.0 M**	94.7 M	61.0 M	155.7 M	**638.7 M**
Nigeria *Regional*	RRP					
South Sudan *Regional*	RRP	**1.2 B**	51.4 M	77.4 M	128.8 M	**1.3 B**
Syria *Regional*	RRP	**5.2 B**	87.4 M	670.9 M	758.3 M	**6.0 B**
Venezuela *Regional*	RMRP	**968.8 M**	132.4 M	306.4 M	438.8 M	**1.4 B**
Horn of Africa and Yemen	MRP	**45.0 M**	20.9 M	10.6 M	31.5 M	**76.5 M**
Rohingya	JRP	**876.7 M**	86.5 M	95.0 M	181.4 M	**1.1 B**
Benin	Other		10.9 M	7.0 M	17.9 M	**17.9 M**
DPRK	Other	**107.0 M**	20.0 M	19.7 M	39.7 M	**146.7 M**
Iran	Other		99.6 M	17.7 M	117.3 M	**117.3 M**
Lebanon	Other		96.3 M	40.2 M	136.5 M	**136.5 M**
Liberia	Other		17.5 M	39.5 M	57.0 M	**57.0 M**
Mozambique	Other		16.0 M	52.1 M	68.1 M	**68.1 M**
Pakistan	Other		37.4 M	108.4 M	145.8 M	**145.8 M**
Philippines	Other		28.9 M	92.9 M	121.8 M	**121.8 M**
Sierra Leone	Other		18.3 M	44.6 M	62.9 M	**62.9 M**
Togo	Other		2.3 M	17.43 M	19.8 M	**19.8 M**

Percentage of funding received

Financial requirements (US$) continued

COVID-19 REQUIREMENTS

REQUIREMENTS
$10.3B

OF WHICH:

HEALTH: $2.86 B
NON-HEALTH: $7.44 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS
$40B*

OF WHICH:

COVID-19: $10.3 B
NON-COVID-19: $29.4 B

INTER-AGENCY APPEAL		ADJUSTED NON-COVID-19	COVID-19 REQUIREMENTS: HEALTH	NON-HEALTH	COVID-19 TOTAL	TOTAL HUMANITARIAN COVID + NON-COVID
Bangladesh	Intersectoral		103.8 M	102.1 M	205.9 M	**205.9 M**
Djibouti	Intersectoral		11.1 M	18.9 M	30.0 M	**30.0 M**
Ecuador	Intersectoral		10.3 M	36.2 M	46.4 M	**46.4 M**
Jordan	Intersectoral					
Kenya	Intersectoral		56.5 M	198.4 M	254.9 M	**254.9 M**
Republic of Congo	Intersectoral		0.6 M	11.3 M	12.0 M	**12.0 M**
Tanzania	Intersectoral		46.1 M	112.8 M	158.9 M	**158.9 M**
Uganda	Intersectoral		71.2 M	129.0 M	200.2 M	**200.2 M**
Zambia	Intersectoral		20.1 M	105.5 M	125.6 M	**125.6 M**
Global Support Services	Global				1.0 B	**1.0 B**
Famine prevention	Global				500.0 M	**500.0 M**
NGOs - supplemental envelope	Global				300.0 M	**300.0 M**
Total		29.4 B	2.9 B	5.5 B	10.3 B	40 B

Percentage of funding received

*The total for GHRP countries (including COVID-19 plus non-COVID-19) is $39.7 billion. Total humanitarian requirements, including flash appeals covered under the Global Humanitarian Overview, is $40 billion. Refer to FTS for latest figures.

Funding requirement updated on 12 July 2020. The figures may change as the situation evolves and country offices review their projects and ongoing activities. For the most up-to-date figures, please refer to hpc.tools or fts.unocha.org.

The requirements for the Nigeria RRP are included in the Cameroon, Chad and Niger HRPs. Please refer to country and regional pages for more details.

The requirements for the Horn of Africa and Yemen MRP amount do not show amounts included in the Somalia and Ethiopia country plans. Please refer to the Horn of Africa and Yemen MRP plan page for further information.

The requirements for the Kenya and Uganda intersectoral plans do not include refugee multi-sector responses to avoid overlap with regional plans. Please see country page for full requirements and more information

The requirements for Jordan are under development and will be uploaded directly to FTS in mid-July, once consultations conclude.

Amount required for COVID-19 Response, by Plan and Global Sector

US$
m= million

	CCCM	Coordination	Early Recovery	Education	Food Security	Health*	Logistics
GLOBAL							
Global Support Services							
Famine Prevention							
NGO - supplementary envelope							
HRPS	**55.7m**	**18.7m**	**127.5m**	**250.0m**	**1,339.0m**	**1,465.8m**	**48.1m**
Afghanistan				20.8m	60.7m	107.6m	
Burkina Faso		0.3m		4.1m	52.8m	17.1m	
Burundi				5.8m	8.1m		12.8m
Cameroon		2.0m	2.1m	4.9m	11.5m	18.2m	
CAR				10.1m	66.1m	4.0m	2.0m
Chad	1.5m			2.0m	71.3m	12.2m	
Colombia		0.3m	75.5m	11.6m	73.1m	140.0m	
DRC				6.1m	85.6m	62.5m	6.0m
Ethiopia				15.1m	313.2m	100.0m	
Haiti				9.8m		2.0m	0.6m
Iraq	24.2m		10.2m	2.6m	21.2m	65.4m	
Libya		13.5m			6.0m	16.7m	1.0m
Mali				8.9m	38.4m	2.1m	
Myanmar				4.8m	6.2m	21.6m	2.8m
Niger				4.9m	39.4m	5.2m	
Nigeria	6.5m	0.3m	12.7m	14.6m	102.5m	53.8m	
oPt				1.2m	11.8m	19.1m	
Somalia	8.1m		6.3m	36.8m	64.1m	47.6m	
South Sudan	0.2m	2.4m		13.4m	179.0m	91.4m	8.4m
Sudan				29.1m	56.1m	128.0m	14.2m
Syria	8.1m		20.7m	27.4m	37.8m	158.0m	0.4m
Ukraine				1.2m	9.2m	16.6m	
Venezuela					10.0m	47.2m	
Yemen	7.2m			4.7m		304.6m	
Zimbabwe				10.3m	15.1m	24.8m	
OTHER PLANS	**3.3m**	**24.6m**	**14.8m**	**26.1m**	**218.9m**	**335.1m**	**28.2m**
Horn of Africa and Yemen (MRP)							
Rohingya JRP	0.5m	17.2m		1.3m	49.7m	86.5m	1.4m
Benin				0.5m	3.2m	10.9m	1.5m
DPRK		4.6m			5.8m	23.9m	
Iran				0.8m	6.2m	99.6m	
Lebanon							
Liberia				3.0m	20.0m	17.5m	4.5m
Mozambique	0.9m	0.5m		5.0m	15.0m	16.0m	3.0m
Pakistan				4.0m	54.0m	37.4m	8.5m
Philippines	1.9m	2.3m	8.9m	5.9m	39.7m	28.9m	0.6m
Sierra Leone			5.8m	4.5m	19.6m	12.2m	6.2m
Togo				1.1m	5.7m	2.3m	2.5m
INTERSECTORAL PLANS		**17.3m**	**6.7m**	**47.6m**	**305.1m**	**319.6m**	**17.5m**
Bangladesh		0.5m			6.7m	103.8m	
Djibouti				1.0m	10.4m	11.1m	1.2m
Ecuador			6.0m	6.0m	14.2m	10.3m	0.1m
Jordan							
Kenya		6.9m		23.7m	94.8m	56.5m	
Republic of the Congo		0.1m	0.7m		10.2m	0.6m	
Tanzania		2.2m		2.5m	57.7m	46.1m	12.7m
Uganda		1.3m		2.3m	62.3m	71.2m	3.5m
Zambia		6.3m		12.1m	48.8m	20.1m	
RRPs			**85.3m**	**69.5m**	**407.1m**	**296.0m**	
Burundi Regional						36.5m	
DRC Regional						94.7m	
Nigeria Regional							
South Sudan Regional						77.4m	
Syria RRP			85.3m	69.5m	407.1m	87.4m	
RMRP			**23.3m**	**9.7m**	**188.7m**	**132.4m**	**10.5m**
Venezuela Regional			23.3m	9.7m	188.7m	132.4m	10.5m
GRAND TOTAL	**59.0m**	**60.5m**	**257.6m**	**403m**	**2,458.8m**	**2,548.9m**	**104.3m**

	Nutrition	Protection	Shelter/NFI	WASH	Refugee Response	Multi-sector	Grand Total
GLOBAL						**1,825.0m**	**1,825.m**
Global Support Services						1,025.0m	1,025.0m
Famine Prevention						500.0M	500.0M
NGO - supplementary envelope						300.0M	300.0M
HRPS	**171.1m**	**314.7m**	**269.1m**	**513.0m**	**113.1m**	**165.9m**	**4,851.7m**
Afghanistan	42.1m	29.5m	67.5m	67.4m			395.7m
Burkina Faso	2.0m	7.8m	4.0m	17.8m			105.9m
Burundi	4.7m	0.8m				5.9m	38.0m
Cameroon	2.2m	17.0m	1.6m	11.4m	9.4m	1.5m	81.7m
CAR	6.1m	3.1m	31.5m	30.0m			152.8m
Chad	14.8m	2.3m	5.2m	4.6m	10.4m		124.2m
Colombia		7.2m	12.9m	8.8m			329.4m
DRC	17.4m	39.1m	11.9m	27.0m	19.0m		274.5m
Ethiopia	25.8m	14.0m	24.3m	13.7m			506.0m
Haiti	1.1m	5.2m	2.5m	18.1m		105.0m	144.4m
Iraq		71.2m	7.6m	19.4m		43.0m	264.8m
Libya		3.5m	2.3m	3.7m			46.7m
Mali	3.6m	6.2m	2.5m	13.8m			75.4m
Myanmar	1.6m	6.6m	6.9m	8.3m			58.8m
Niger	5.4m	12.9m	2.1m	6.8m	5.6m		82.3m
Nigeria	10.0m	13.7m	10.7m	17.7m			242.4m
oPt		1.0m	3.3m	6.1m			42.4m
Somalia	1.8m	16.8m	6.3m	32.3m	4.0m	1.4m	225.6m
South Sudan	6.2m	12.2m	7.5m	43.4m	23.2m		387.3m
Sudan	1.1m	15.6m	1.6m	23.0m	14.9m		283.5m
Syria	10.9m	12.8m	33.2m	69.9m		5.1m	384.2m
Ukraine		4.9m		11.0m		4.0m	46.9m
Venezuela		0.6m	6.5m	23.5m			87.9m
Yemen	9.6m	5.3m	16.0m	28.2m	10.2m		385.7m
Zimbabwe	4.5m	5.5m	1.1m	7.2m	16.5m		85.0m
OTHER PLANS	**32.4m**	**44.2m**	**11.6m**	**92.4m**		**168.0m**	**999.7m**
Horn of Africa and Yemen (MRP)						31.5m	31.5m
Rohingya JRP			1.6m	23.2m			181.4m
Benin	1.0m	0.3m		0.5m			17.9m
DPRK	4.0m			1.4m			39.7m
Iran	0.5m	7.8m		2.3m			117.3m
Lebanon						136.5m	136.5m
Liberia	2.0m	6.0m		4.0m			57.0m
Mozambique	3.0m	2.1m	8.6m	14.0m			68.1m
Pakistan	11.5m	14.9m		15.4m			145.8m
Philippines	6.5m	6.5m	1.4m	19.2m			121.8m
Sierra Leone	3.7m	4.8m		6.1m			62.9m
Togo	0.2m	1.7m		6.1m			19.8m
INTERSECTORAL PLANS	**44.3m**	**34.3m**	**11.5m**	**59.8m**	**2.3m**	**168.0m**	**1,033.8m**
Bangladesh	1.3m	5.7m	5.5m	5.0m		77.5m	205.9m
Djibouti		3.7m		2.5m			30.0m
Ecuador		1.8m	6.0m	2.1m			46.4m
Jordan							
Kenya	22.6m	4.2m		11.6m		34.5m	254.9m
Republic of the Congo		0.4m		0.1m			12.0m
Tanzania	8.3m	11.8m		12.2m		5.4m	158.9m
Uganda	9.1m	4.8m		13.5m	2.3m	29.9m	200.2m
Zambia	2.9M	1.9m		12.8m		20.6m	125.6M
RRPs		**24.2m**	**13.2m**	**210.1m**		**2.8m**	**1,108.2m**
Burundi Regional				29.m			65.4m
DRC Regional				61.m			155.7m
Nigeria Regional							
South Sudan Regional				51.4m			128.8m
Syria RRP		24.2m	13.2m	68.8m		2.8m	758.3m
RMRP		**30.3m**	**29.3m**	**14.5m**			**438.8m**
Venezuela Regional		30.3m	29.3m	14.5m			438.8m
GRAND TOTAL	**247.8m**	**447.7m**	**334.7m**	**889.8m**	**115.4m**	**2,329.7m**	**10,257.2m**

This table is indicative of sector requirements, please refer to FTS or hpc.tools for the most up-to-date figures. The global sector 'Coordination' includes the field cluster 'risk communication'; 'Early Recovery' includes 'livelihoods' and 'Food Security' includes 'agriculture'.

The "health" financial requirements listed in the financial requirements tables in section 4.3 include COVID-19 health activities that may draw funding from one or more sectors. The "health" column in this table on sectoral funding requirements only includes funding requested in the "health" sector.

4.3

Funding required for the GHRP

The original $2.01 billion requirements for the GHRP issued on 25 March rose to $6.71 billion in the update released on 7 May, and stand now at **$10.26 billion** as a result of the adjustments made to the response at country level based on the evolution of the pandemic, and the addition of a supplementary NGO envelope and a famine prevention envelope. As was the case with the May update, the July update captures the collective requirements of both NGOs and UN agencies which have been identified at country level as vital to address urgent needs resulting from deteriorating humanitarian situation.

Supplemental NGO response to COVID-19, envelope of $300 million

In addition to the country-level requirements of over $8 billion, an unallocated supplementary amount of $300m has been added to the plan to bolster NGO rapid response actions and allow NGOs to redirect their response as quickly as the pandemic evolves. There are four key avenues that would facilitate the rapid, flexible disbursement of funds for this envelope: (i) augmenting the resources under CERF (specifically for NGOs through the Rapid Response Window); (ii) making use of NGO-managed pooled funds, such as the Start Fund; (iii) increasing the amount of funding channeled through Country-Based Pooled Funds as a key mechanism to secure NGO funding in-country (see section 4.5), and (iv) most importantly, by giving directly to NGOs. The latter is especially important to ensure the most effective use of funds in meeting the priority needs of affected people. This may also help to realize Grand Bargain commitments to prioritize funding to local and national NGOs as directly as possible.

Famine prevention envelope of $500 million

The global economic recession resulting from the pandemic has caused food security needs to soar in many countries already in a state of humanitarian crisis. According to the Global Report on Food Crises 2020, almost 30 million people in about three dozen countries were in emergency food security situations (IPC Phase 4) at the end of 2019.

Prolonged conflicts, climatic shocks, economic volatility and desert locust were the main factors. These recurrent factors create chronic poverty and hunger which fuels migration out of destitution. According to UNHCR already at least 79.5 million people have been forced to flee their homes. About 80 per cent of the displaced people live in countries affected by acute hunger and malnutrition. At the same time, one-third of the world's 45.7 million internally displaced people live in 10 countries most at-risk from COVID-19.

The evolution of COVID-19 is unpredictable, yet a sharp increase in acute food insecurity and risks of famine amongst the most vulnerable population groups is a realistic possibility. They will face deepening economic insecurity, food systems disruptions and collapsing health systems. Funding deficits will have severe impacts on countries presenting high levels of food insecurity, including those affected by poor rainfall, locust infestation, natural disasters and conflicts. Lack of funds will further exacerbate the socio-economic effects of the crisis, putting additional lives at risk.

It is critical to avoid famines as responding to famines is too late to save lives. Famines represent a collective failure because by the time a famine is officially declared, the damage is already done—at least 20 per cent of the population has starved; 30 per cent of the children have become acutely malnourished; and the death rate has doubled to two adults or four children per 10,000 people per day.

Adequate funding for famine prevention is thus urgently required to avoid a major catastrophe. Acute food insecurity and famine can and must be prevented. This requires scaling up interventions reaching the most vulnerable already severely food insecure populations. Crucially, it also requires supply chains to function across borders, including humanitarian aid. Prepositioning of food and cash ready for delivery despite mobility constraints is also essential.

The humanitarian community can act now to establish a buffer that gives confidence that the

most severe effects can be mitigated. For this purpose, $500 million are requested for urgent food security actions to ensure that measures are taken and stocks are put in place to limit the possibility of famine in the most vulnerable communities.

[1] Other plans include all non-HRP countries: Horn of Africa and Yemen MRP, Joint Response Plan for the Rohingya Humanitarian Crisis, Benin, DPRK, Iran, Lebanon, Liberia, Mozambique, Pakistan, Philippines, Sierra Leone and Togo.

[2] Intersectoral plans include the humanitarian component of existing intersectoral COVID-19 response plans in countries already included in the GHRP through a regional refugee response plan, a regional migrant plan or a joint response plan. This covers stand-alone plans for Bangladesh, Djibouti, Ecuador, Jordan, Kenya, Republic of the Congo, Tanzania, Uganda and Zambia.

[3] Supplemental NGO response to COVID-19, in addition to funding already channeled to NGOs through country level plans.

[4] Data current as of 12 July. The GHRP is a live document and requirements may change over time as the situation evolves. For the latest figures, please consult hpc.tools and FTS.

Overview of GHRP cost components

REQUIREMENTS (US$)

$10.3B

	COVID-19 TOTAL	OF WHICH: HEALTH	NON-HEALTH	NUMBER OF PLANS
Humanitarian Response Plans (HRPs)	**4.9 B**	1.7 B	3.1 B	**25**
Other plans	**999.7 M**	454.3 M	545.4 M	**12**
Regional Refugee Response Plans (RRPs)	**1.1 B**	269.9 M	838.3 M	**5**
Regional Refugee and Migrant Response Plan (RMRP)	**438.8 M**	132.4 M	306.4 M	**1**
Intersectoral Plans	**1.0 B**	319.6 M	714.2 M	**9**
Global support services	**1.0 B**			**-**
Famine prevention	**500.0 M**			**-**
NGOs - supplementary envelope	**300.0 M**			**-**
TOTAL	**$10.3 B**	**$2.9 B**	**$5.5 B**	**52**

4.4

Funding received against the GHRP requirements and impact of gaps

As of 12 July, funding received for the GHRP – including financial needs for 63 countries and the $1.01 billion required for global operational logistics support (cargo transport, passenger services and medical evacuation) – is $1.64[118] billion or 22 per cent of the May requirement, and 16 per cent of the July updated requirement. An additional $1.45[119] billion has been reported for bilateral support directly to Governments, funding to the Red Cross / Red Crescent Movement, and funding to UN agencies and NGOs not towards GHRP countries, including funding to WHO's Strategic Preparedness Response Plan and Contingency Fund for Emergencies which covers countries beyond those identified in the GHRP. Some of this funding may eventually be recorded against the GHRP requirements as more details are received from donors and recipient organisations.

While funding received is far below what is required, there is concern that funding for COVID19 humanitarian response may start to divert funding from ongoing humanitarian operations at a time when other crises such as in the Horn of Africa, Nigeria, Syria or Yemen are further spiraling out of control. At the beginning of 2020, global humanitarian requirements were already close to $30 billion, with 168 million people in need of humanitarian assistance. These global requirements have risen to a record $40 billion to assist 249.6 million people of the 405.9 million in need[120], including requirements to respond to COVID-19. As of 12 July, funding received against these global requirements amounted to $8.49 billion, representing 23 per cent of the requirements (a level similar to June 2019 despite the increased requirements).,

Impact of funding gaps

The cost of inaction against the public health, GBV, poverty, food security, education, economy, stability and conflict impacts of the pandemic will grow exponentially if the right combination of relief and recovery assistance, guided by the Sustainable Development Goals, is not implemented quickly and at scale. It is better, less costly and more dignified to frontload responses to the pandemic and the secondary impacts. Waiting until the full impacts are visible is a more expensive proposition as delaying action not only shifts the burden of payment to the future, but the price of the response will also exponentially increase. Acting now to mitigate the impact saves money in the long term.

Health response

Any financial shortfall preventing the procurement and delivery of essential laboratory and personal protection equipment, deployment of experts, training of national staff and coordination in countries lacking the capacity to handle the pandemic, will inevitably weaken the public health response when the outbreak is escalating. Similarly, funding gaps will prevent the implementation of water, hygiene and sanitation programmes notably in camp and camp-like settings and other densely populated areas, awareness and risk communication activities, and direct response to disease outbreaks.

Food security

The evolution of COVID-19 is unpredictable, yet a sharp increase in acute food insecurity and risks of famine amongst the most vulnerable population groups is expected. Already vulnerable populations will face deepening economic insecurity, food systems disruptions and collapsing health systems.

118 The funding received does not include $72.8 million for the intersectoral plans newly included in this July update of the GHRP.

119 This amount includes $72.8 million for the intersectoral plans newly included in this July update of the GHRP.

120 The revised numbers for people in need and people targeted were calculated using country inputs and the same methodology as for the GHO to avoid double-counting with regional plans.The Burundi RRP, DRC RRP and South Sudan RRP were partially included in the calculation. Nigeria RRP was not included due to overlap with HRPs. All other regional plans (Syria 3RP, Venezuela RMRP, Rohingya JRP, Horn of Africa and Yemen MRP) were included.

Funding deficits will have severe impacts on countries presenting high levels of food insecurity, including those affected by poor rainfall, locust infestation, natural disasters and conflicts. Lack of funds will further exacerbate the socio-economic effects of the crisis, putting additional lives at risk. Up to 12,000 people could die each day from hunger linked to the social and economic effects of the pandemic)[121].

Lack of funding will also affect directly the assistance to small-scale farmers and herders who cannot access markets to sell their products and purchase agricultural and livestock inputs. Damage will ensue on their livelihoods as well as on food production. Unless resources enable a large-scale coordinated action to address the impacts of COVID-19 both on the food supply and demand sides, the disruption of food systems could result in a global food emergency.

Concretely, time-critical interventions such as the provision of food and cash assistance, pre-positioning of supplies, maintenance of the food supply chain will not be implemented, preventing millions of poor and already food-insecure people to meet their basic food consumption needs and avoid malnutrition and worse effects on their lives and survival.

Basic needs and gender-based violence

A lack of funding will leave millions of vulnerable children at considerable risk of losing out on their education, falling deeper into poverty, being at higher risk to violence, including gender-based violence, missing out on life-saving vaccinations, not receiving adequate nutrition and becoming ill, among many others. Other vulnerable groups facing similar risks if humanitarian assistance is not provided include women and girls, older persons, persons with disabilities, and people on the move.

Funding gaps for GBV and for other basic needs will have dramatic consequences. Should funding be insufficient in the next 6 months:

- 47 million women in 114 low- and middle-income countries, including GHRP countries may not be able to access modern contraceptives and 7 million unintended pregnancies are expected to occur if lockdowns carry on for 6 months and there are major disruptions to health services.
- 31 million additional cases of gender-based violence can be expected to occur if lockdowns continue for at least 6 months. Experts also predict that for every 3 months 'lockdown' conditions are imposed, an additional 15 million cases of GBV are expected. With the re-allocation of services to respond to COVID-19 and the reduced capacity of women and girls' safe spaces and the restriction in mobility, the survivors' needs are exacerbated.
- Due to the disruption of programmes to prevent female genital mutilation in response to COVID-19, 2 million female genital mutilation cases may occur over the next decade that could have been averted.

Global support services

WFP's logistics support to the humanitarian community requires an immediate injection of funds to avoid vital services grinding to a halt in mid-July. These common services allow frontline health workers and aid workers to stay and deliver in fragile settings where vulnerable people are at risk of infection or the socio-economic impact of the pandemic.

WFP has achieved cost-efficiencies in the global passenger and cargo transport services it provides. Demand for the transport of medical and life-saving cargo is expected to increase as the availability of supplies increases. An increase in passengers is also expected as new routes throughout Latin America are opened and additional destinations throughout Asia, Africa and the Middle East become available.

Without sufficient funding, the number of cargo flights transporting critical health and humanitarian cargo will be immediately impacted, hampering the effective and efficient delivery of 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. All organisations will be affected by the suspension of global services, UN agencies and NGOs alike.

121 https://oxfamilibrary.openrepository.com/bitstream/handle/10546/621023/mb-the-hunger-virus-090720-en.pdf

4.5

Funding flows and partnership

Central Emergency Response Fund (CERF) and Country-Based Pooled Funds (CBPFs)

Since the beginning of the COVID-19 crisis, donors have responded positively to the call for quality, flexible funding in support of pandemic preparedness and response, allowing recipient organisations to use the funds where they are needed most.

In total, OCHA's pooled funds have released around $294 million to fight the COVID outbreak in 46 countries/contexts since February, including $120 million through CERF block-grant allocations (20 per cent of CERF's total allocations in 2020) and $155.9 million through Country Based Pooled Funds (CBPFs) allocations (34 per cent of CBPFs total allocations in 2020 to date). This includes $18 million was provided through the reprogramming of already allocated resources ($12.2 million from CERF and $5.8 million from CBPFs).

OCHA's **Country Based Pooled Funds** provided a quick and early response to humanitarian needs, with over 60 per cent of already allocated funds going to NGOs. To date, some $90.5 million have been channeled to international, national and local NGOs as well as to Red Cross/ Red Crescent national societies. By 7 July, CBPFs had effectively disbursed $125.6 million to partners - 82 per cent of allocated CBPF funds – with another $36.1 million currently under strategic and technical reviews. Project vetting and disbursements have been made in record time, using fast-track approaches ("reserve allocations") that support the speedy delivery of resources.

Options for establishing regionally-hosted pooled funds covering countries without CBPFs are also being explored for the medium and longer-term, as mechanisms to increase direct funding to NGOs. In addition, in line with agreed guidance for all HRPs, OCHA aims to have 15 per cent of HRP funding channeled through CBPFs in the 18 countries where they are present, representing a target of $2.49 billion. Maximizing use of the CBPFs helps to ensure funding is accessible by local and international NGO partners without the need for additional levels of pass-through

In response to NGO calls for greater direct funding for the COVID response, the Emergency Relief Coordinator made the first-ever CERF rapid response allocation of $25 million to support NGOs' life-saving responses to COVID-19. The allocation focused on two key sectors critical to the COVID response: health, and water, sanitation and hygiene. It places special emphasis on mental health and psychosocial support and gives due consideration to people with disabilities and gender issues, including gender-based violence. Six priority countries, chosen on the basis of their COVID risk and underfunding levels, received funding: Bangladesh, Central African Republic, Haiti, Libya, Sudan and South Sudan. IOM serves as grant manager, facilitating contracting of NGOs at country level, with a light-touch approach that reflects the flexible funding measures promoted by the IASC. Resident Coordinators/ Humanitarian Coordinators in each of the six countries are leading the selection of NGOs and the identification of priority operational areas through expedited modalities, as speed is of the essence.

The $24 million provided by CERF for procurement of supplies will support all humanitarian partners. The CERF has also worked with the recipient agency to ensure that the conditions offered to NGOs in the sub-granting process, largely replicate the conditions CERF offers to UN recipient agencies. IOM has offered a flexible and light contracting approach for NGOs, taking on the fiduciary responsibilities of being a CERF recipient agency while acting very much as a "pass through" for financial resources.

The selection of NGOs and the identification of priority operational areas will remain under the leadership and decision-making power of the

Resident Coordinator/ Humanitarian Coordinator, with IOM contracting selected NGOs without programmatic engagement. Both international and national NGOs are eligible for the resources, and NGO sub-granting and partnership arrangements are also possible. As speed is of the essence. RC/HCs are being called on to expedite the NGO selection, and IOM has agreed to fast track contracting, in order to ensure the timely implementation of funding – which is set to take place from July to March 2021.

This allocation complements the $95 million provided by CERF to UN agencies, much of which will have an onwards positive impact on NGO partners. This includes $40 million provided by CERF to WFP for logistics and the establishment of medical centers, which will also support NGO operations.

Agency funding flows to NGOs and direct NGO funding

Current funding levels are far below the level needed for NGOs and local organisations to support both ongoing humanitarian responses and the new operational challenges presented by COVID-19. Despite inadequate financial resources, NGOs and local organisations have continued to deliver aid and life-saving information to communities to prevent the spread of the virus.

Although NGO access to funding has improved, more can be done. This includes more transparency and regular reporting on the transfers, the use of funding, and amounts allocated directly to NGO partners; cascading the benefits of funding flexibility measures to all NGO partners of UN agencies; and greater speed of pass-through funding to non-UN actors. According to NGO consortiums, as of 11 July approximately 15 per cent of GHRP funding has gone to NGOs[122] [123][124].

This is a significant shortfall for NGOs who typically receive 30-40 per cent of the funding stream of Humanitarian Response Plans. Current funding levels are far below the level needed for NGOs to support both ongoing humanitarian responses and the new operational challenges presented by COVID-19. NGOs are essential to the collective efforts to respond to the COVID-19 pandemic. In many cases NGOs are front line responders and serve as a vital link with local actors and the community. More direct funding to NGOs can reduce administrative and oversight burdens and increase the scale of the response. At present, a large amount of NGO proposals have been submitted to donors but not yet funded.

Increased advocacy for funding to reach frontline responders as fast as possible with minimum impediments has taken place since the beginning of the pandemic. Several concrete measures have been taken, including strengthening national NGO involvement in planning and coordination processes, and increasing funding to NGOs via UN agencies. Steps have also been taken to ensure more transparency and regular reporting on the transfers, the use of funding and amounts allocated directly to NGO partners, and the cascading of the benefits of funding flexibility measures to all NGO partners of UN agencies. IASC guidance outlining nine specific flexibility provisions was agreed in June[125].

The need to regularly report on funding pass through from UN agencies to NGO partners has been highlighted as an important step to ensure that there is appropriate visibility into how and when GHRP funding is transferred to partners for implementation of field activities. Going forward, it is critical for all partners to support this timely reporting to ensure that stakeholders remain accountable for use of GHRP funding and are able to make appropriate management decisions based on current funding data.

While NGOs have mobilised independent funding via different response funds to implement COVID-19 interventions, these resources need to be replenished to preserve the capacity of NGOs to address other potential crises. Reduced independent income is affecting NGOs' ability to respond rapidly while less flexible institutional funding is secured, allowing rapid funding of local partners, front-loading of spending, and subsidizing of core administrative costs that enable programs to be delivered safely and with a minimum of fraud. This has also limited the capacity of NGO partners to step up needs assessment, analysis and advocacy on the needs of affected people, and is likely to have longer

122 See latest figures here.

123 Internal monitoring suggests that the funding pipeline of SCHR members at the end of June 2020 was about $600m, however less than $100m of this had been received.

124 Note that this proportion is higher than the proportion of funding going to NGOs reported in FTS, due to additional amounts not reported in FTS.

125 https://interagencystandingcommittee.org/humanitarian-financing/iasc-proposal-harmonized-approach-funding-flexibility-context-covid-19

term impacts.

WHO received $227 million flexible funding, which represents 26 per cent of the total amount of COVID funding received during the period 1 February – 31 May 2020. Of this amount, 30 per cent has been allocated to country programmes in the GHRP or for transport/procurement of supplies for GHRP countries. To date, 2 per cent is expected to be implemented by NGOs or Red Cross /Red Crescent National Societies – 2/3 of this ratio through international NGOs and the Red Cross and 1/3 of by national partners. The ratio is still low but will increase as WHO concludes more agreements with implementing partners.

UNFPA has issued from the outset of the crisis internal guidance on providing flexibility to local partners during the COVID-19 pandemic. The guidance includes budget flexibility, allowable Implementing Partner costs, frequency of cash transfers and flexibility surrounding assurance activities. UNFPA allows indirect support costs (6.9 per cent) being charged by partners, with much of the focus directed towards training partners in institutional capacity strengthening. UNFPA has reported that approximately 20 per cent of COVID-19 funding received before 15 June has been made available to partners.

Since the outset of the pandemic, UNHCR has introduced measures to increase the flexibility and ensure faster disbursement of funding to NGO partners. While the first funding received covered the procurement of PPE, medicines and cash-based assistance - interventions which are more cost effective through direct implementation - the per centage of funds allocated to partners continues to grow. As of the end of June, UNHCR had disbursed 77 per cent of the COVID-19 funding amounts allocated to partners. In line with the localization agenda, 65 per cent of the COVID19 funds to partners have gone to local NGOs and to Government partners and national or regional authorities, while 32 per cent has gone to INGOs[126].

As of 25 June, UNICEF spent $330 million for the COVID-19 response, of which close to $92 million was transferred and committed to implementing partners. Of the funding received against the UNICEF COVID-19 global appeal, 37 per cent of the disbursements were made to national NGOs, community-based organization and academic institutions, and 12 per cent to international NGOs.

While funding flows to NGOs have progressed with adaptation of funding streams and conditionalities, many NGOs, including frontline NGOs well placed to respond, are still to receive significant COVID-19 funding. NGOs are also struggling to raise unrestricted funds to launch operations as lockdowns and economic hardships have slowed individual giving to such organizations.

Besides CBPFs and CERF ‘block’ allocation as described above, expanded use of existing NGO consortia and NGO-managed pooled funds such as such as Start Fund COVID-19, which funds local and international NGOs in low income countries to implement anticipation and response action, could be instrumental in expediting the direct disbursement of funding to NGOs and improve national and local NGOs access to funding.

126 Generally, UNHCR allocates approximately one third of its total budget to NGO partners. As of mid-July, UNHCR has disbursed approximately $700 million to partners (including for specific COVID-19 related as well as regular programmes).

MÉMÉ, FAR NORTH REGION, CAMEROON

05 May 2020. 40-year-old Tati Ali collects food items for her 10 school-aged siblings from their primary school in Mémé, Far North region, Cameroon. With schools closed as a preventive measure taken by the govern to curb the spread of COVID-19 in-country, WFP is providing Take-Home Rations (THR) to ensure that pupils continue to study at home on a full stomach. *WFP/Glory Ndaka*

“COVID-19 is reversing decades of progress on poverty and hunger.

We must accelerate coordinated global action to ensure that we recover better from this crisis and deliver together on the Global Goals for a better world for all.”

António Guterres,
Secretary-General, United Nations