GLOBAL HUMANITARIAN RESPONSE PLAN
COVID-19

UNITED NATIONS COORDINATED APPEAL
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GHRP MAY UPDATE

Contents

This publication was produced by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) in collaboration with humanitarian partners across the world. OCHA thanks all organizations, partners and donors that contributed to the Global Humanitarian Response Plan for COVID-19 and that regularly report to the Financial Tracking Service (FTS). Last update: 7 May 2020

Front cover
A volunteer working with the Emissa organization in Idleb raises awareness of COVID-19 at the Abnaa Mhin IDP camp, home to over 1,800 internally displaced families. *OCHA/Steve Hafez*

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Foreword by the Emergency Relief Coordinator

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

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

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

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

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

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

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

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

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

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

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

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

Mark Lowcock
Emergency Relief Coordinator, United Nations

At a glance

REQUIREMENTS (US$)
$6.69 B

FUNDING RECEIVED (US$)
$923 M

COUNTRIES
63

Objectives scope, countries included

PP. 11–19

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

The total financial requirements have risen from US$2 billion to $6.69 billion. This significant increase is due to a rapid evolution of humanitarian needs, the inclusion of the additional countries, increased cost of essential health and other supplies, and air and sea transportation. To date (5 May), $923 million has been received, with another $608 million reported outside the GHRP, bringing the total received for the COVID-19 humanitarian response to about $1.5 billion. The GHRP requirements target the most vulnerable people and are a small part of the $90 billion required overall to support 10 per cent of the poorest populations affected by the pandemic worldwide.

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

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

Humanitarian situation and needs analysis

PP. 20–45

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

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

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

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

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

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

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

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

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

Progress of the response

PP. 46–67

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

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

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

Financial requirements and funding

PP. 68–78

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

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

Of the $6.69 billion required to cover the response under this plan, $1 billion will cover global support services, while $5.69 billion will cover needs in the 63 countries covered - with $3.49 billion targeting Humanitarian Response Plans countries, nearly $1 billion intended for Regional Refugee Response Plans countries, $439 million for Regional Refugee and Migrant Response Plans countries, $157 million for countries under other plans, and $606 million for the countries under new plans presented in this update.

Coherent and complementary needs analysis, and planning and funding flows between humanitarian and development actors are more important than ever. Opportunities are being seized to link the GHRP, WHO's Strategic Preparedness and Response Plan, and the UN Secretary-General's Framework for the Immediate Socioeconomic Response to COVID-19 in common response areas, noting that populations covered by the GHRP are not eligible for the UN COVID-19 Response and Recovery Multi-Partner Trust Fund, and thus will require complementary funding for socioeconomic needs.

Additional figures will be added in the next GHRP iteration.

Financial requirements (US$)

COVID-19 REQUIREMENTS

REQUIREMENTS
$6.69B

OF WHICH:
HEALTH: $2.00 B
NON-HEALTH: $3.67 B

TOTAL ADJUSTED HUMANITARIAN REQUIREMENTS

REQUIREMENTS
$36.69B

OF WHICH:
COVID-19: $6.69 B
NON-COVID-19: $30.06 B

INTER-AGENCY APPEAL		COVID-19 TOTAL	OF WHICH: HEALTH	NON-HEALTH	ADJUSTED NON-COVID-19	TOTAL HUMANITARIAN COVID + NON-COVID
Afghanistan	HRP	**108.1 M**	21.7 M	86.4 M	695.7 M	**803.8 M**
Burkina Faso	HRP	**60.0 M**	15.0 M	45.0 M	276.4 M	**336.4 M**
Burundi	HRP	**36.7 M**	-	36.7 M	131.7 M	**168.4 M**
Cameroon	HRP	**99.6 M**	23.0 M	76.6 M	292.7 M	**392.4 M**
CAR	HRP	**152.8 M**	7.7 M	145.2 M	400.8 M	**553.6 M**
Chad	HRP	**99.5 M**	6.0 M	93.5 M	610.7 M	**710.2 M**
Colombia	HRP	**197.0 M**	152.7 M	44.4 M	209.7 M	**406.7 M**
DRC	HRP	**287.8 M**	119.4 M	168.4 M	1.82 B	**2.11 B**
Ethiopia	HRP	**322.6 M**	100.0 M	222.6 M	1.00 B	**1.32 B**
Haiti	HRP	**105.0 M**	105.0 M	-	319.3 M	**424.3 M**
Iraq	HRP	**263.3 M**	65.4 M	197.9 M	397.4 M	**660.7 M**
Libya	HRP	**38.8 M**	14.9 M	23.9 M	90.9 M	**129.8 M**
Mali	HRP	**42.3 M**	10.1 M	32.2 M	350.7 M	**393.2 M**
Myanmar	HRP	**46.0 M**	18.1 M	27.9 M	216.3 M	**262.3 M**
Niger	HRP	**76.6 M**	9.9 M	66.7 M	433.3 M	**509.8 M**
Nigeria	HRP	**259.8 M**	85.2 M	174.6 M	839.0 M	**1.10 B**
oPt	HRP	**42.4 M**	19.1 M	23.3 M	348.0 M	**390.4 M**
Somalia	HRP	**176.4 M**	72.1 M	104.4 M	1.08 B	**1.25 B**
South Sudan	HRP	**217.2 M**	21.0 M	196.2 M	1.55 B	**1.77 B**
Sudan	HRP	**87.5 M**	87.5 M	-	1.35 B	**1.44 B**
Syria	HRP	**384.2 M**	157.5 M	226.7 M	3.42 B	**3.81 B**
Ukraine	HRP	**47.3 M**	16.6 M	30.7 M	157.8 M	**205.1 M**
Venezuela	HRP	**72.1 M**	44.1 M	28.0 M	677.0 M	**750.0 M**
Yemen	HRP	**179.1 M**	101.6 M	77.6 M	3.20 B	**3.38 B**
Zimbabwe	HRP	**84.9 M**	35.0 M	49.9 M	715.8 M	**800.7 M**
Burundi *Regional*	RRP	**65.4 M**	36.5 M	29.0 M	209.9 M	**275.4 M**
DRC *Regional*	RRP	**155.7 M**	94.7 M	61.0 M	483.0 M	**638.7 M**
Nigeria *Regional* [1]	RRP	**-**	-	-	-	**-**
South Sudan *Regional*	RRP	**128.8 M**	51.4 M	77.4 M	1.21 B	**1.34 B**
Syria *Regional* [2]	3RP	**643.8 M**	82.6 M	561.1 M	5.56 B	**6.21 B**
Venezuela *Regional*	RMRP	**438.8 M**	132.4 M	306.4 M	968.8 M	**1.41 B**
Rohingya Crisis [3]	JRP	**117.2 M**	71.8 M	45.3 M	-	**-**
DPR Korea	Other	**39.7 M**	19.7 M	20.0 M	107.0 M	**146.7 M**
Benin	New	**17.2 M**	10.9 M	6.3 M	-	**17.2 M**
Iran	New	**89.5 M**	64.4 M	25.1 M	-	**89.5 M**
Lebanon	New	**70.7 M**	30.5 M	40.2 M	-	**70.7 M**
Liberia	New	**57.0 M**	17.5 M	39.5 M	-	**57.0 M**
Mozambique	New	**68.2 M**	16.0 M	52.2 M	-	**68.2 M**
Pakistan	New	**126.8 M**	29.2 M	97.6 M	-	**126.8 M**
Philippines	New	**96.2 M**	23.2 M	73.0 M	-	**96.2 M**
Sierra Leone	New	**60.5 M**	16.8 M	43.7 M	-	**60.5 M**
Togo	New	**19.4 M**	3.3 M	16.0 M	-	**19.4 M**
Global Support Services		**1.01 B**	-	-	-	**1.01B**
TOTAL		**6.69 B**	**2.00 B**	**3.67 B**	**30.06 B**	**36.69 B**

[1] The requirements for the Nigeria RRP are included in the Cameroon, Chad and Niger HRPs.
[2] The existing 3RP 2020 budget is 5.56 billion. A full prioritization exercise is ongoing in and an adjusted non-COVID-19 figure is pending
[3] Revised new COVID-19 related requirements, plus total 2020 JRP requirement adjusted to COVID response, will be presented in the June GHRP update

Key achievements

HEALTH

- Information and prevention campaigns
- Health staff training
- Distribution of medical supplies
- Reproductive and maternal healthcare

LOGISTICS

- Air bridges for medical cargo and staff
- Shipment of personal protective equipment (PPE) and laboratory supplies

WATER SANITATION AND HYGIENE

- Distribution of hygiene kits
- Set up of handwashing stations
- Distribution of water supplies
- Installation of toilets

EDUCATION

- Temporary learning spaces
- Educational radio programmes

FOOD AND AGRICULTURE

- Food distribution respecting social distancing
- Vouchers distribution
- Containment of desert locust upsurge
- Cash assistance

PROTECTION

- Psychosocial support
- Child friendly spaces
- Training for caregivers
- Support for survivors of gender-based violence

COVID-19 RESPONSE

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

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

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

Introduction

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

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

The GHRP is articulated around three interrelated strategic priorities:

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

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

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

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

1.0 Objectives, scope and countries included

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

1.1
Objectives and scope

Objectives of the GHRP May update

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

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

Specifically, the update of the GHRP aims to:

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

Scope of the GHRP May update

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

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

1.2

Countries included in the GHRP May update

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

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

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

Countries included in the GHRP March

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

- **Countries with HRPs:** Afghanistan, Burkina Faso, Burundi, Cameroon, Central African Republic (CAR), Chad, Colombia, Democratic Republic of the Congo (DRC), Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, occupied Palestinian territory (oPt),Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela and Yemen.
- **Countries with RRPs:** Angola, Burundi, Cameroon, Chad, DRC, Egypt, Iraq, Jordan, Kenya, Niger, Nigeria, Lebanon, Republic of Congo, Rwanda, South Sudan, Uganda, Tanzania, Turkey and Zambia.
- **Venezuela RMRP:** Argentina, Aruba,* Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao,* Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay.
- **Others:** Bangladesh, Democratic People's Republic of Korea (DPR Korea), and Iran.

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

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

* Aruba (Netherlands), Curaçao (Netherlands)

Countries added to the GHRP May update

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

- COVID-19 risk analysis based on vulnerability (transmission and epidemic risk factors) and response capacity (institutional capacities; access to water, sanitation and hygiene services; and access to health care) to the pandemic.
- Existing humanitarian concerns[2] despite the absence of an ongoing humanitarian plan.
- Countries part of the Regional Migrant Response Plan (RMRP) for the Horn of Africa and Yemen.
- Existing shocks or stresses, such as food insecurity, displacement, a high number of migrants in-country or in transit.
- Low-income country status.

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

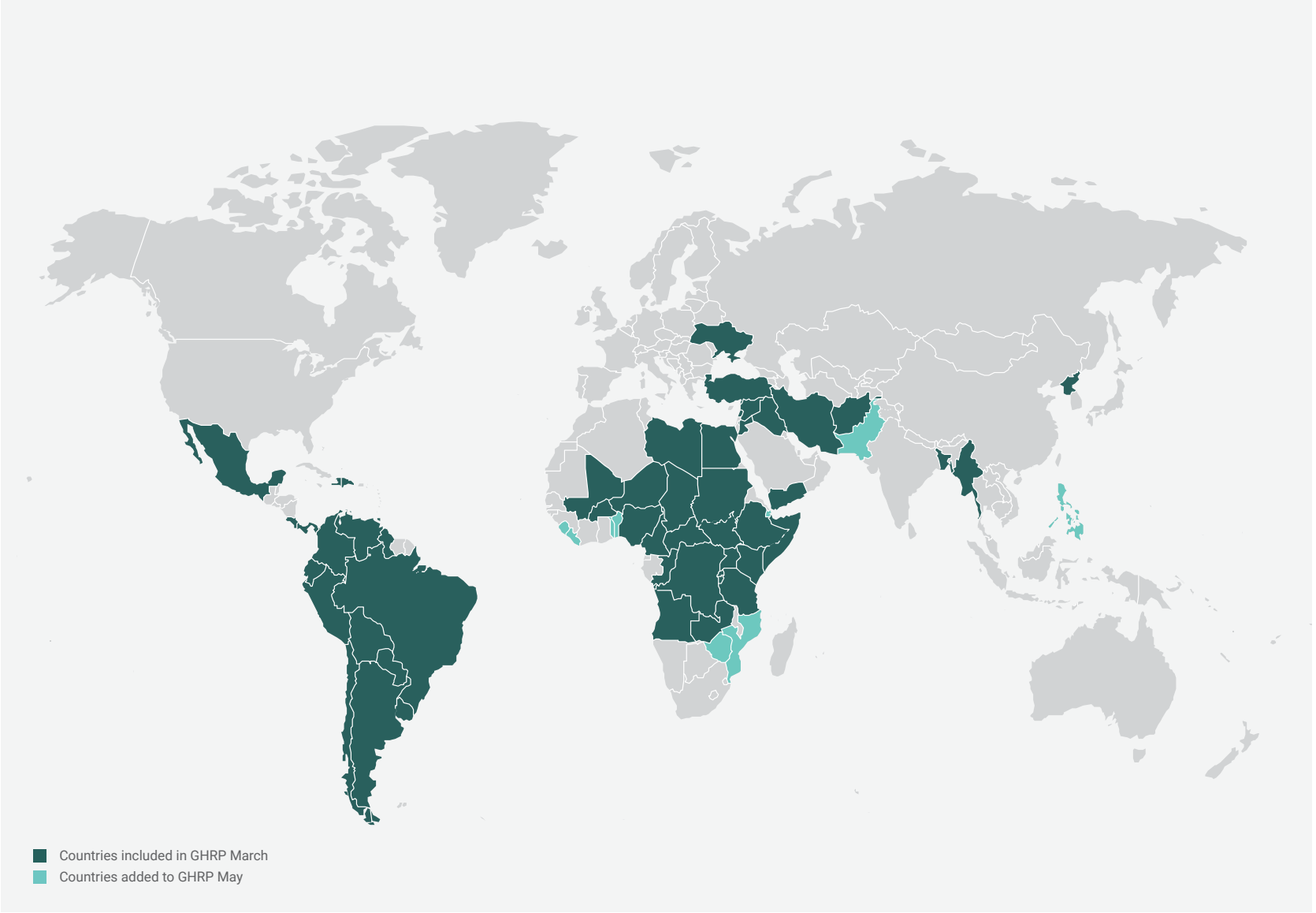
Based on this process, the following nine countries plus one included in the RMRP are considered as a priority in the GHRP: Benin, Djibouti (part of the RMRP)[3], Liberia, Lebanon (now counted on top of being part of the 3RP for Syria), Mozambique, Pakistan, the Philippines, Sierra Leone, Togo and Zimbabwe.

Countries to watch

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

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

GHRP countries: May update



NUMBER COUNTRIES
GHRP MAY

63

OF WHICH:
NUMBER COUNTRIES
GHRP MARCH

54

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

NUMBER COUNTRIES
ADDED TO GHRP MAY

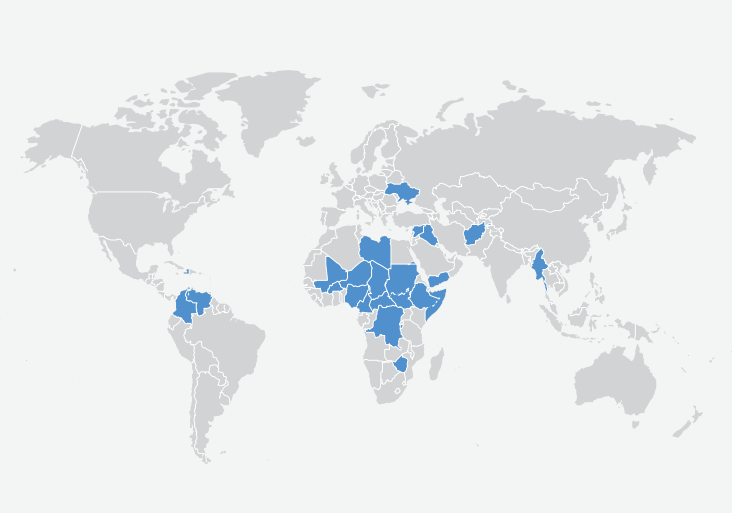
9

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

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

* Aruba (Netherlands), Curaçao (Netherlands)

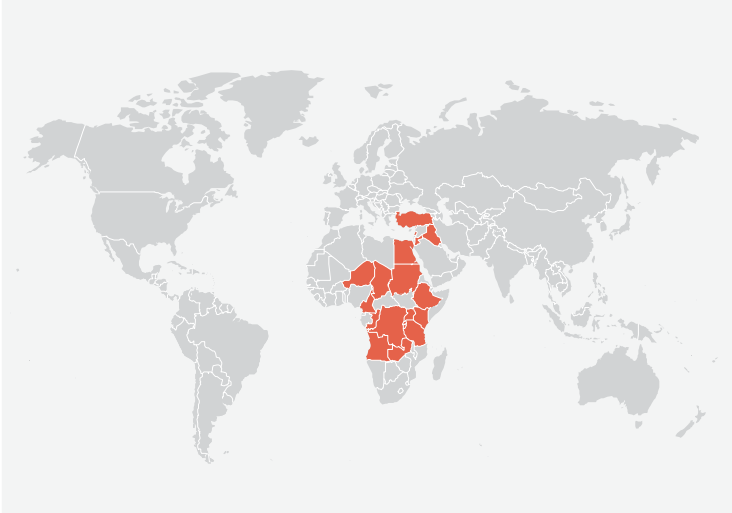
GHRP countries: per type of humanitarian appeal



HUMANITARIAN RESPONSE PLANS (HRP)

25

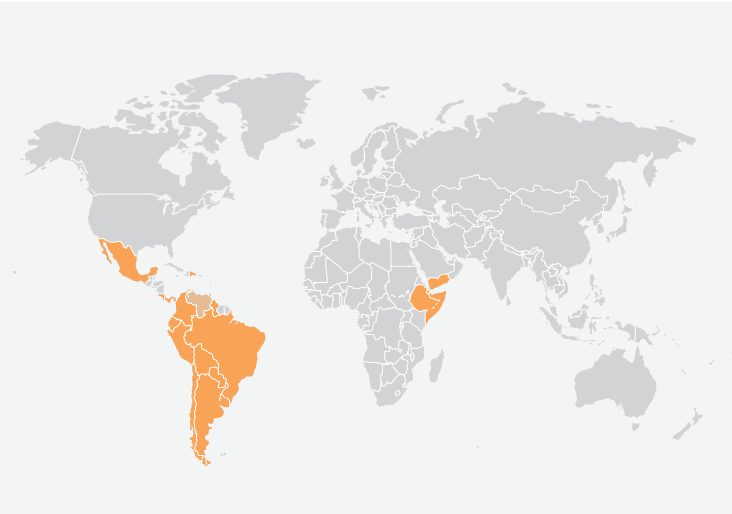
Afghanistan, Burkina Faso, Burundi, Cameroon, CAR, Chad, Colombia NEW DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, oPt, Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela, Yemen, Zimbabwe NEW



REGIONAL REFUGEE RESPONSE PLANS (RRP)

19

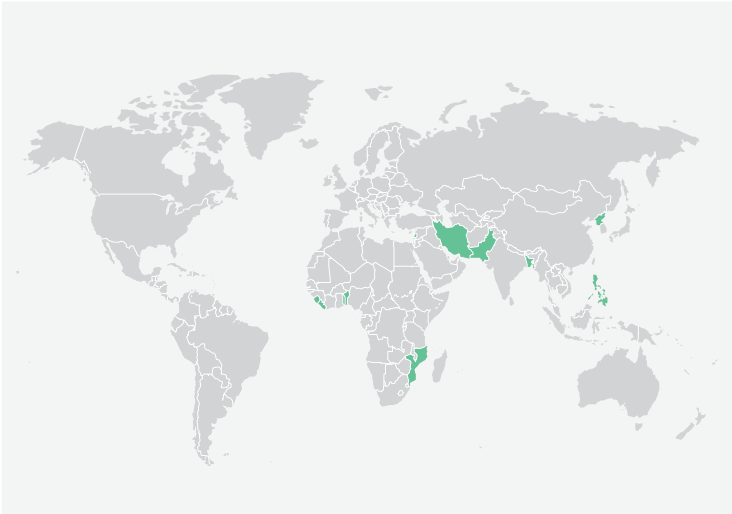
Angola, Burundi, Cameroon, Chad, DRC, Egypt, Ethiopia, Iraq, Jordan, Kenya, Lebanon, Niger, Rep. of Congo, Rwanda, Sudan, Tanzania, Turkey, Uganda, Zambia.



REGIONAL REFUGEE AND MIGRANT RESPONSE PLANS (RMRP)

21

Argentina, Aruba*, Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao*, Djibouti NEW Dominican Republic, Ecuador, Ethiopia NEW Guyana, Mexico, Panama, Paraguay, Peru, Somalia NEW, Trinidad and Tobago, Uruguay, Yemen NEW



OTHER APPEALS AND COUNTRIES WITHOUTH PRE-EXISTING HUMANITARIAN APPEALS

11

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

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

* Aruba (Netherlands), Curaçao (Netherlands)

1.3
Forward-looking risk analysis at country level

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

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

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

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

COVID-19 Risk Analysis Index

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

Vulnerability indicators include:

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

Response capacity indicators include:

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

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

INFORM COVID-19 Risk Index

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

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

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

Lack of Coping Capacity considers:

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

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

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

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

Analysis of country-level economic and food security vulnerability

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

Risk monitoring and analysis system

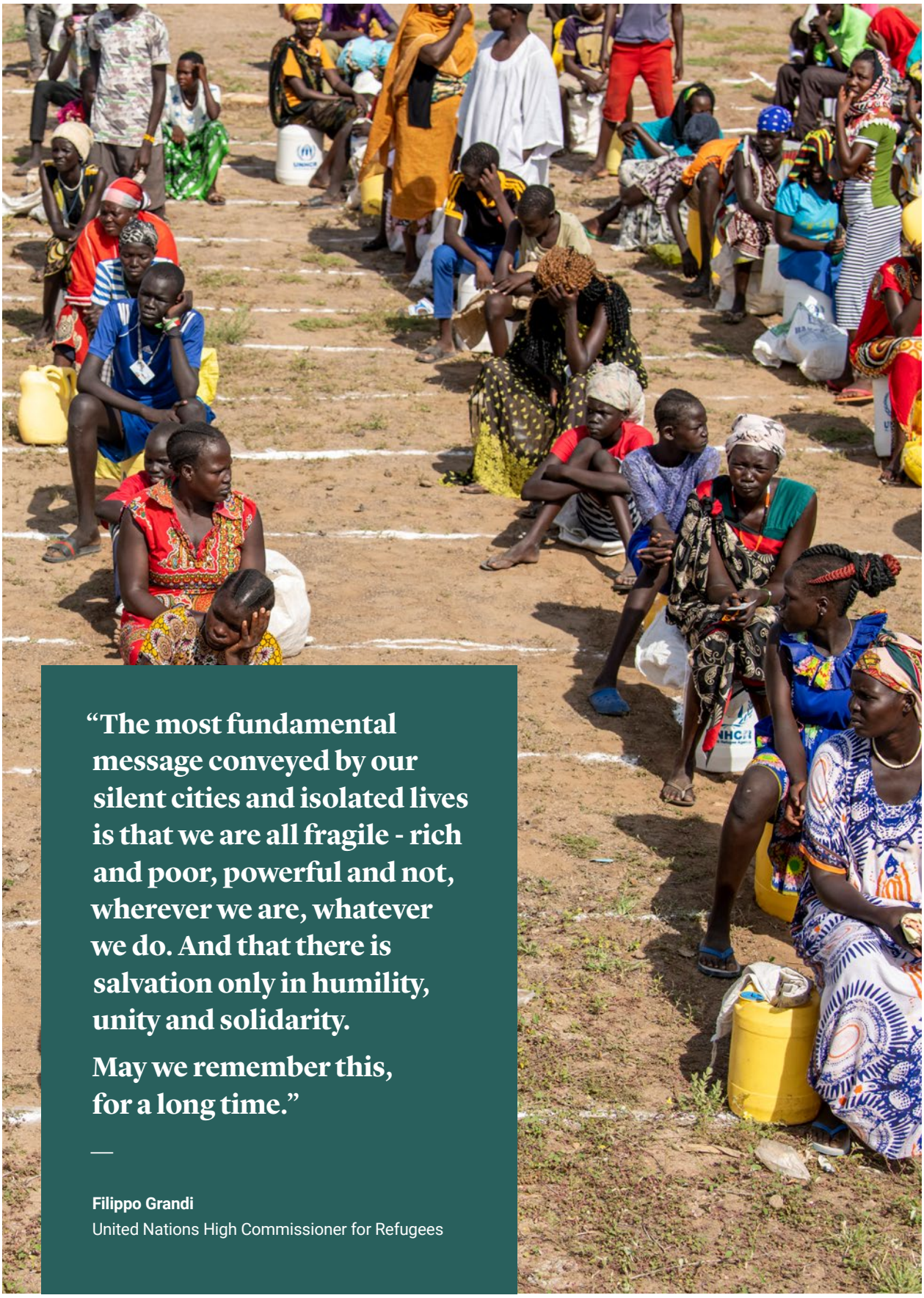
FAO is establishing a data facility to set up a risk monitoring and analysis system to capture the current and potential impacts of COVID-19 on agricultural production, food security and livelihoods, with a focus on 22 priority countries already in or at risk of food crisis contexts. In these countries,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

COVID-19 Global Information Management, Assessment and Analysis Cell

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

[7] WFP Economic and Food Insecurity Implications of the COVID-19 Outbreak. An update with insights from different regions, 14 April 2020.

[8] Contact: OCHA Needs and Response Analysis Section ocha-cd-apmb-naras@un.org. Partners include UN agencies and NGOs.



> **“The most fundamental message conveyed by our silent cities and isolated lives is that we are all fragile - rich and poor, powerful and not, wherever we are, whatever we do. And that there is salvation only in humility, unity and solidarity.**
>
> **May we remember this, for a long time.”**
>
> —
>
> **Filippo Grandi**
> United Nations High Commissioner for Refugees

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

2.0 Humanitarian situation and needs analysis

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

2.1

Update on the public health impact of COVID-19

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

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

Health effects on people

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

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

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

Effects on public health services

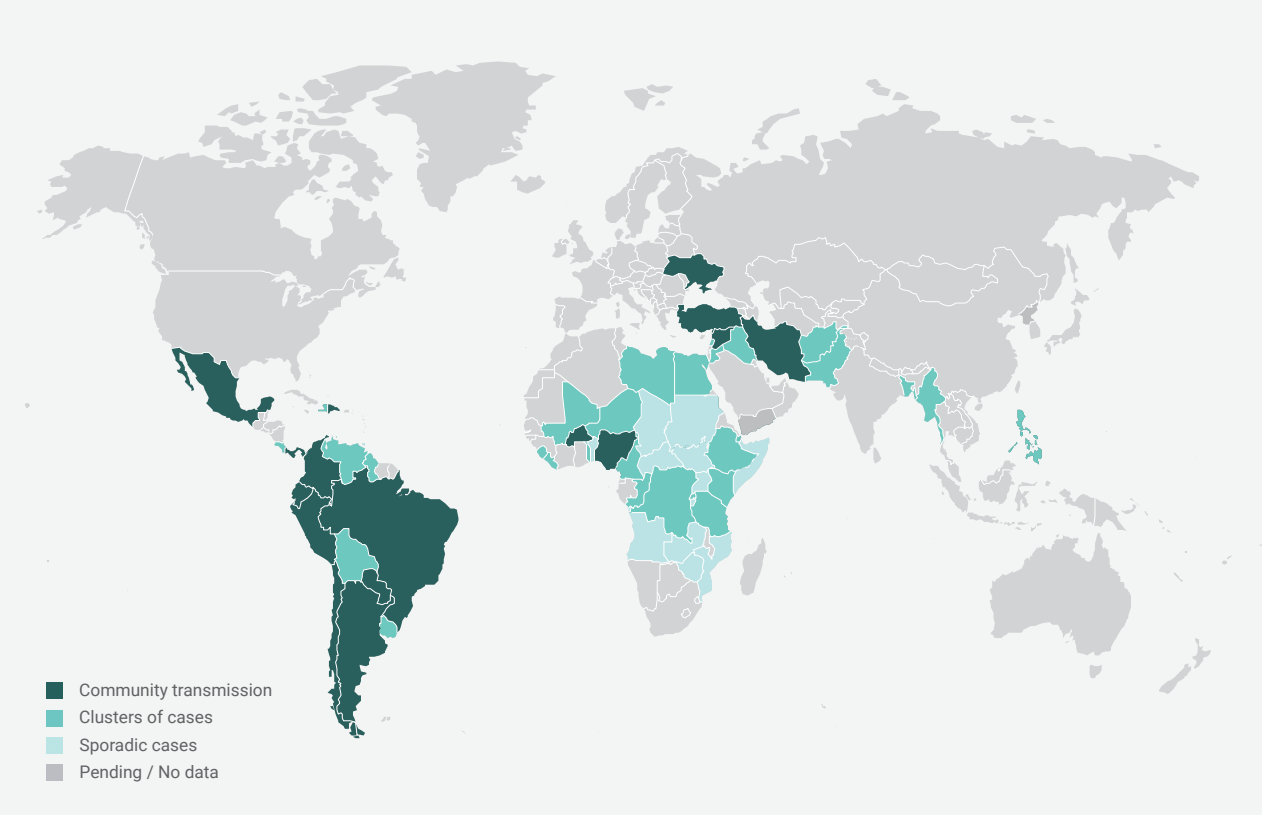
In addition to the direct impacts on individual and community health, COVID-19 has caused major disruptions to essential health and humanitarian services worldwide. For example, in many GHRP countries, essential immunization services have been interrupted or are suboptimal, increasing the risk of vaccine-preventable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

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

[9] WHO, 2020. Coronavirus disease (COVID-19) technical guidance: Surveillance and case definitions, available online: www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/surveillance-and-case-definitions

[10] Country-level case and death trends may be followed here: https://covid19.who.int

COVID-19: Transmission classification



Source: World Health Organization, as of 6 May

Number of cases and deaths

NUMBER OF CASES
GHRP COUNTRIES
565 k

NUMBER OF DEATHS
GHRP COUNTRIES
26 k

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

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

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

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

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

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

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

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

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

Projected effects on health and health services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Situation and needs

Spread and severity of the pandemic.

The incidence informs on the trajectory of the epidemic

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

Situation and needs

Sexual and reproductive health

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

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

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

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

2.2

Update on the socioeconomic impact of COVID-19

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

Main macroeconomic and country-level effects

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

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

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

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

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

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

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

[22] www.imf.org/en/Publications/WEO/Issues/2020/04/14/weo-april-2020
[23] www.imf.org/en/Topics/imf-and-covid19/COVID-Lending-Tracker
[24] WFP *Economic and food security implications of the COVID-19 outbreak,* 14 April 2020
[25] WFP *Economic and food security implications of the COVID-19 outbreak,* 14 April 2020; WFP acute food insecurity projection analysis, 21 April 2020

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

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

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

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

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

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

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

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

[26] FAO Food Price Index

[27] WFP food price tracking, Headquarters, week 22 April

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

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

Collateral effects on people

Update on the effects on livelihoods and food security

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

- Loss of jobs due toas a result of health shocks and gGovernment containment measures (e.g. stay- at- home orders) and closure (temporary and permanent) of businesses of all sizes, resulting in loss of income for highly vulnerable workers such as daily workers, the urban poor, migrant workers, remittance-s recipient households, and all informal sector workers especially where safety nets are not available.
- Disruption in the local, national and global supply chains, and in the agricultural input supply chains, reducing informal labourers' access to farmland and impacting day labourers' wages, area of land cultivated, etc.
- Disruption and distortion ofin consumption patterns, and, as a result of a combination of all of the above aspects, increased risk of undernourishment, especially for low- income households in countries with high commodity-import dependence.

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

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

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

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

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

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

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

With over 80 per cent of the world's refugees and nearly all of the IDPs living in low- to middle-income countries with already weak economic and health systems, socioeconomic impacts are disproportionately high for the forcibly displaced and Stateless whose access to formal labour markets, education and public health services is often not on par with citizens of a country. With movement restrictions and lockdowns, forcibly displaced populations such as refugees and asylum seekers, returnees, IDPs, Stateless persons, as well as host communities, are increasingly unable to make a living. Border closures and movement restrictions will also lead to extended periods of family separation. This will have an immediate impact on children's mental health and well-being and put them at risk of exploitation and abuse.

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

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

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

[31] https://reliefweb.int/sites/reliefweb.int/files/resources/Uganda_FSOU%2004_2020_Final.pdf

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

Update on the effects on protection and rights, including gender

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

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

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

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

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

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

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

[33] www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/04/Policy-Brief-on-COVID19-and-Older-Persons.pdf
[34] www.helpage.org/newsroom/press-room/press-releases/coronavirus-older-people-in-low-and-middleincome-countries-must-be-protected-to-prevent-global-humanitarian-catastrophe/
[35] www.unwomen.org/en/digital-library/multimedia/2020/4/infographic-covid19-violence-against-women-and-girls
[36] COVID-19 Disorder Tracker, ACLED, https://acleddata.com/#/dashboard

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

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

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

The main protection impacts noted to date include:

- Border closures and restrictions on access to asylum and asylum procedures, and humanitarian resettlement. As of 20 April 2020, UNHCR estimated that 167 States have partially or fully closed their borders to contain the spread of the virus, of which 57 are making no exception for people seeking asylum.
- Incidents of large-scale deportations, including of children, with countries of origin being unprepared for their arrival. Where deportations have been stopped, incidents of extended immigration detention, including of children.
- Increased spontaneous and induced returns in the Americas and in Asia and the Pacific in particular.
- Limitations on or discriminatory freedom of movement for people living in internal displacement camps and sites.
- Intensification of conflict in some regions (CAR, Colombia, DRC, Lake Chad Basin, Libya, the Sahel and Yemen).
- Limited access to life-saving assistance and services for refugees, IDPs and other people of concern, and restricted UNHCR and partners' access to them.
- Xenophobia (for example, refugees and migrants from Venezuela facing stigmatization and negative perceptions from host communities associated with a fear of spreading the virus).
- Increased risk of violence against children, with limited access to help due to predominantly remote modes of case management, and vulnerability to separation due to restrictions or forced movement and suspension of family tracing and reunification, with heightened risk of negative coping mechanisms and exploitation.
- Increased risk of gender-based violence for households in lockdown situations.
- Increased risk of exploitation and trafficking of vulnerable groups due to the socioeconomic impacts of the pandemic.
- Stigmatization and discrimination of population groups thought to carry the virus, such as older people, people with disabilities, and IDPs, refugees and returnees in particular. This leads to targeted attacks on collective sites, as well as heightened tensions within communities, and isolation of vulnerable groups, and discouraging or reducing access to services, including for health treatment.
- Forced evictions, with many refugees or IDPs unable to pay rent and left homeless.
- Increased forced displacement due to some non-State actors taking advantage of lockdowns to gain and solidify territory, causing further displacements.

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

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

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

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

Update on the effects on education and society

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

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

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

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

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

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

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

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

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

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

School closures

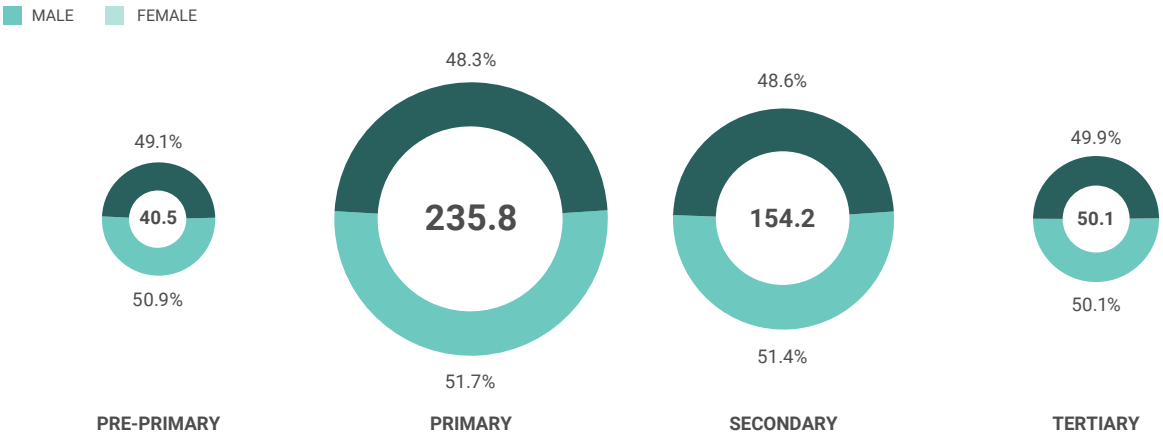
33%
OF ALL CHILDREN AFFECTED BY SCHOOL CLOSURES LIVE IN COUNTRIES WITH A HRP

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

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

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

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



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

[40] WFP Global Monitoring of School Meals During COVID-19 School Closures https://cdn.wfp.org/2020/school-feeding-map

Update on the effects on supply chains and logistics

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

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

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

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

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

Situation and needs monitoring

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

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

[43] Twenty foot Equivalent Unit.

Situation and needs

Mobility, travel and import/export restrictions in priority countries

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

Situation and needs

Food security [47]

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

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

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

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

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

Situation and needs
Education

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

Situation and needs
Gender-based violence

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

Situation and needs
Child protection

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

Situation and needs
Nutrition

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

Situation and needs

Protection

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

2.3
Most affected population groups

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

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

Older persons

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

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

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

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

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

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

Persons with disabilities

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

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

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

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

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

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

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

Children and youth

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

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

[49] www.internationaldisabilityalliance.org/blog

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

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

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

[53] www.nutritioncluster.net/Joint_statement_on_COVID_19_and_Wasting

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