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


Photo: UNICEF

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[57] www2.unwomen.org/-/media/field%20office%20eseasia/docs/publications/2020/04/ap_first_100-days_covid-19-r02.pdf?la=en&vs=3400

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

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

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

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

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

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

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

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

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

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

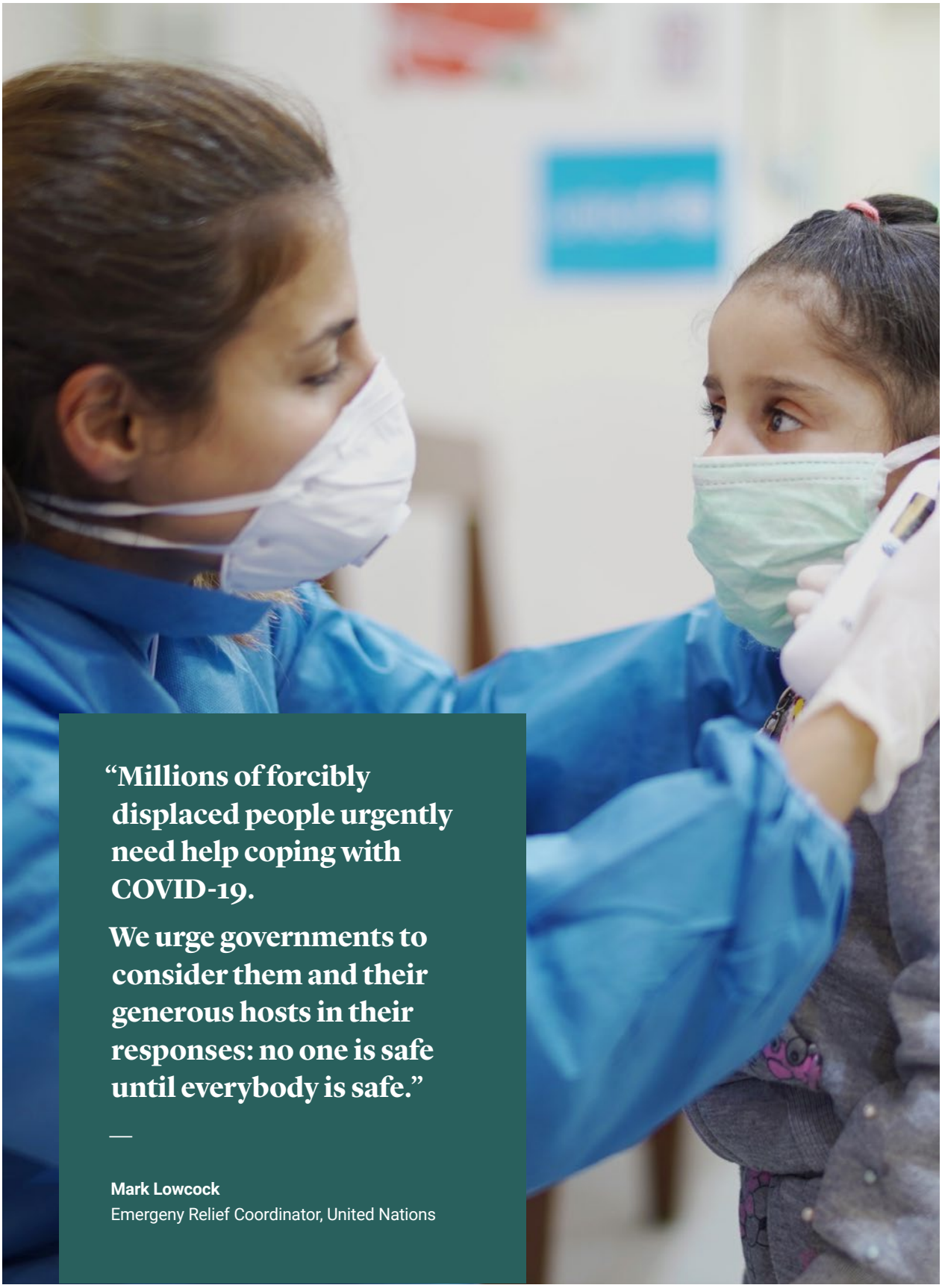
UNU-WIDER[58] estimates the adverse impact on poverty to over 500 million people, and the International Labour Organisation expects a devastating 200 million jobs losses in the second quarter of 2020, including 125 million in Asia-Pacific. According to early estimates from ESCWA, the Arab region is set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

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

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

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

[58] United Nations University World Institute for Development Economics Research



> **"Millions of forcibly displaced people urgently need help coping with COVID-19.**
>
> **We urge governments to consider them and their generous hosts in their responses: no one is safe until everybody is safe."**
>
> —
>
> **Mark Lowcock**
> Emergeny Relief Coordinator, United Nations

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

3.0 Progress of the response

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

3.1

Progress of the response against the strategic priorities and specific objectives

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

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

In addition, new/emerging constraints include:

- Restrictions of movements of aid personnel (with a positive, stronger reliance on local actors) and of goods into countries.
- Restriction of movements of aid personnel within countries (requiring special authorization required for critical movements).
- People's lack of access to humanitarian assistance.
- Violence and threats against humanitarian personnel and assets perceived to be vectors of COVID-19.

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

Strategic priority 1

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

Progress by specific objective

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Response gaps and challenges

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

Inclusivity, older age, gender and disability

- More consultations must take place with older persons, adolescents, children, women, persons with disabilities and people with mental health and psychosocial needs, to better understand their specific needs and risks. Consultations are also required for a meaningful participation in the response.
- Communication about COVID-19 prevention and response (including protective measures) needs to be made accessible and tailoredequally effective to all audiences. This includes ensuring that websites, telephone, radio, videos and, leaflets are accessible,; using local languages, plain language (and age-appropriate when targeting children), subtitles and sign language.
- Health triage policies and protocols must be implementedput in place to ensure that decisions about access to medical treatment are based on medical grounds, scientific evidence and ethical principles, rather than age or disability status.
- More generally, all responses should be more disability, age and gender -inclusive, including in the design of targeting methodology and selection of delivery mechanisms.
- Given the predominant role of women as front-line health-care and social workers and as such in prime positions to identify trends at the local

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

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

- Gender-based violence prevention- and- response services must be more accessible to, and prioritized for children and adults with disabilities, including using remote gender-based violence case management support, inclusion of gender- based violence response services in other essential services, accessible hotlines and age-adapted interventions. Health workers and community workers should be trained to detect signs of abuse of children and adults with disabilities. Free and informed consent regarding gender-based violence services should remain a priority in the COVID-19 response.
- Without appropriate care and support to gender-based violence survivors resulting fromdue to services disruption, the long-term impact will be an increase in unwanted and/or teenage pregnancies, child and maternal mortality, sexually transmitted infections, psychological trauma and an intergenerational cycle of violence.
- Existing mental health and psychosocial support services should be maintained and scaled up, and those developed or adapted as part of the COVID-19 response should be accessible to and inclusive of persons with disabilities, migrants, displaced population, people with pre-existing physical and health conditions and all age groups.
- Mechanisms for the protection of children and adults living in institutions, such as relocation to family-based/community- based settings, should be established. If staff have deserted the facilities or if these are understaffed, human resources may be mobilizsed from civil- society organizations and/or other trained protection stakeholders. Accessible remote means for family members and other support persons to remain in contact may also be supported.
- For persons with disabilities requiring special assistance, interventions should involve service providers, including local partners to ensure the continuation of essential services and stocking of WHO list of essential medicine and develop innovative accessible delivery mechanisms.
- Social services should be accessible for children and adolescents affected by the pandemic. Health workers and community workers should be trained to detect signs of abuse of children and use a clear referral system for response.
- Remote/ distance- learning options should be accessible to all children including those with disabilities, such as through modification of learning materials. More generally, there is scope to increase the role that learning infrastructure and the education system can play in reaching communities with critical messages to contain the spread and reduce morbidity and mortality, and to prevent new infections when schools reopen.
- With high proportions of intergenerational households in many contexts, as well as active community engagement, young people should be engaged in the humanitarian response, for example, to help in spreading information through social media and acting as culture brokers through behaviour- change communication.

Mobility, access and delivery capacities

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

  Increased mobility will also contribute to the movement of humanitarian aid workers and enable staff rotation to avoid burnout.
- Suspended and disrupted access to services will lead to predictable increased health needs in the short and medium term, requiring creative solutions to secure the continuity of health care.

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

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

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

Supply chains [60]

- The provision of essential supplies including personal protective equipment and test kits has been a challenge due to the supply chain obstacles outlined earlier. This is compounded by the varied, extensive and ever-changing restrictions on entry/exit of the flow of cargo and humanitarian personnel across countries. This will improve with WFP air cargo services that began on 30 April as part of the GHRP. NGOs should access common supply chains for personal protective equipment and medical supplies procured by UN agencies and transported through WFP free-to-use upstream supply chain services. The platform to request service delivery is now active.
- Insufficient funding severely limits the ability to plan for and negotiate contracts, and to roll out logistics services at the scale required to ensure the supply chain needs and timely transportation of critical cargo for the global response. Without additional funding, support in ensuring the health and welfare of humanitarian personnel may be limited, including a reduction in medical evacuation services.

  Early challenges in securing visibility of pipelines and the services required resulted in an underestimation of services. Initial plans considered twice-weekly connections (14 flights/month) between international consolidation hubs and regional staging areas. Based on updated demand planning from partners, the number of planned connections has increased to 50 flights/month. In addition, the initial GHRP included a small contingency of air cargo from international and/or regional consolidation hubs onward to country points of entry. Based on the latest partner demands, medium-sized air freighters will be based in regional hubs connecting to countries (anticipated at 15-20 rotations per month from each hub). Since initial planning, the unit price of air freight has increased drastically.

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

Needs assessments and coordination

- Although challenging, data collection and conducting participatory mapping exercises should be scaled up together with national authorities and local communities to identify key mobility corridors and congregation areas, such as densely populated urban settlements, for targeted prevention activities and to inform regional and national preparedness and response plans (ensuring migrants and concepts of mobility are included in planning processes).
- Coordination among authorities, local communities and humanitarian partners needs to improve to ensure that COVID-19 responses are evidence-driven and do not impact negatively the implementation of essential health and other programmes.
- Where appropriate, connections should be sought with socioeconomic impact assessments supported by UNDP, and with Cash Working Groups to inform programming decisions including multipurpose cash transfers.

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

Response monitoring

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

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

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

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

Strategic priority 2

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

Progress by specific objective

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

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

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

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

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

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

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

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

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

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

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

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

Response gaps and challenges

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

Inclusivity, older age, gender and disability

- As mentioned for strategic priority 1, consultations must take place with older persons, children, adolescents, women, persons with disabilities, and people with mental health and psychosocial needs to better understand their specific risks and ensure meaningful participation in the response, with targeted actions to reduce risks and a robust monitoring framework. Regular visits by community health workers for households with higher support needs should take place where the situation allows.
- The analysis of risks posed to older people must be strengthened at country level, recognizing that older people face a combination of disproportionate incidence of serious illness and death, risk of discrimination in the allocation of scarce resources, psychological distress from losing life-long partners and friends to the virus, and pre-existing and systematic barriers to accessing information, services and assistance provided through the humanitarian system.
- In line with the UN Secretary-General's call to governments to make the prevention and response of violence against women a key part of their national response plans for COVID-19, gender-based violence services and responses to protect women and girls must be further prioritized and designated as an essential service within COVID-19 response plans

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

- Mental health and psychosocial support should also be scaled up for all population groups most affected by the pandemic. A priority should be given to integrate mental health and psychosocial support and services in different sectoral coordination mechanisms and responses. Effective communication and basic psychosocial support skills that promote well-being among all affected population groups should be used by all COVID-19 responders. Addressing the mental health needs of health-care and social-care workers and other emergency responders should be an integral component in all countries.
- In addition to sectoral water, sanitation and hygiene responses, particularly in urban slums, multisector comprehensive interventions should be encouraged, such as rehabilitation or construction of WASH facilities in health centres, markets, schools and public places.
- Cash and voucher assistance programmes, particularly multi-purpose cash grants, should be implemented wherever possible, as they are an efficient and often preferred mechanism to help people meet their basic needs and decrease the adoption of negative coping mechanisms, especially in a situation of restricted mobility that prevents many from reaching their sources of labour and income. Such transfers can address health (strategic priority 1) and non-health needs (strategic priority 2). Many humanitarian actors have worked quickly to adjust standard operating procedures and guidelines for cash and voucher assistance programming to ensure they can deliver safely in COVID-19 settings.[63] Some country operations (Iraq, Yemen, Ethiopia, Afghanistan, among many others) are using multipurpose cash grants to cover purchase of basic needs and public health items, including masks, soap and hand sanitizers.

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

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

- Social protection systems across crisis contexts should be set up or expanded in collaboration with government and development actors as appropriate. This includes a vertical expansion (to adjust for increased local market prices and multisector needs, as appropriate) to capture populations on the brink of acute vulnerability as well as those not previously covered (e.g. migrants, refugees). Recommendations from the Grand Bargain sub-workstream on Cash and Social Protection for working with and alongside social protection systems as part of the COVID-19 response are under development.[64]
- Early action is indispensable to avert a potential food crisis. A scale-up of assistance to food security and livelihoods is essential to avoid further deterioration of needs, particularly in fragile contexts and where the approaching lean season and hurricane/monsoon season further threaten household food access. Upcoming planting and harvesting seasons represent a critical opportunity to ensure small-scale producers' food security and contribute to wider food availability for their communities and beyond. Collective advocacy and action are needed to facilitate the functioning of agricultural input supply chains at critical times in the season, as well as to ensure that people along the food supply chain are not at risk of COVID-19 transmission.

  Activities must ensure the functioning of the food supply chain, including between rural, peri-urban and urban areas, focusing on vulnerable smallholder farmers and food workers. People along the food supply chain must be protected from the risk of COVID-19 transmission by raising awareness of actors about food safety and health regulations as well the rights and responsibilities of workers. Food losses due to movement restrictions and limited access to markets should be avoided by supporting local storage and processing facilities and keeping local markets functioning in compliance with national hygiene regulations. Efforts must be stepped up to stabilize incomes, access to food, livelihoods and food production for the most acutely food insecure, as they tend to suffer disproportionately from restricted access to markets.
- Increased attention should be paid to education interventions including distance learning and support to teachers in the context of this pandemic. Experience from previous public health crises has shown that once older children lose access to education, they are less likely to return. This is particularly the case for the most vulnerable children, who end up in child labour, child marriage and face other life-threatening protection risks. For younger children, even a few months of missed education can have long-term effects on their lifelong learning, requiring additional and intensive remedial efforts to catch up.

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

Mobility, access and delivery capacities

- The humanitarian response is hampered by movement restrictions and closure of internal and international borders. Delays and price increases are affecting the procurement and delivery of goods and services.
- Concurrent epidemics, such as acute watery diarrhoea and cholera in countries such as Djibouti and Yemen, and recurrent natural disasters such as floods in Bangladesh and Nigeria, will further compound humanitarian needs across all areas of intervention, including health, WASH, food security, nutrition, protection, gender-based violence services, mental health and psychosocial support.

Supply chains

- Logistics constraints remain extremely acute. Procurement, consolidation, prioritization and delivery of critical items require visibility of pipeline requirements and service demands. Operational partnership with private actors and governments, efficient coordination and prioritization, and appropriate resourcing allow WFP to provide essential supply chain services to the humanitarian community.
- Competition is high between humanitarian actors and governments over essential items such as masks, with quotation of prices only valid for a few days. Payment capacities are also directly affected by the closure of banks in some countries.
- The majority of the suppliers of personal protective equipment and other related items are not located in the affected areas. Sending the purchased material to the destination is complicated by the lack of available cargo, increasing cargo prices, high customs taxes, and preemption by local authorities upon arrival if specific measures are not implemented to secure the delivery.

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

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

Monitoring

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

Response monitoring

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

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

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

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

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

Strategic priority 3

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

Progress by specific objective

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

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

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

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

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

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

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

Response gaps and challenges

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

Inclusivity, older age, gender and disability

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

- Advocacy should continue for the inclusion of vulnerable and marginalized groups, such as stranded migrants regardless of legal status, and IDPs to be included in national response plans and have access to COVID-19 testing and care in line with the Sustainable Development Goals and Universal Health Coverage.
- As COVID-19 amplifies some of the protection threats and risks for IDPs, refugees, migrants and asylum seekers, life-saving protection responses including for gender-based violence must be maintained and expanded.

Mobility, access and delivery capacities

- Border closures and movement restrictions have resulted in limited access to territory and asylum procedures including reception, registration and refugee status determinations, as well as suspension of asylum procedures and violations of principle of non-refoulement. Restrictions on freedom of movement and other rights are maintained for longer than necessary.
- Restrictive measures imposed by authorities often prevent organizations from delivering aid in line with global humanitarian principles. Such challenges are leading donors to delay new funds while many humanitarian organizations are forced to close their programmes in countries such as Yemen.
- Collective shelters face particular constraints to effectively implement physical distancing. To overcome this, humanitarian partners in several countries including Afghanistan and Iraq are supporting quarantine for contact/travel history cases and establishing isolation spaces within IDP sites.
- Surge response capacities need to be strengthened, especially technical support, supplies and delivery.

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

- Public health services must be bolstered in low-income settings, including urban slums and humanitarian crises, to better prevent and respond to the pandemic. Health systems, including for mental health services, that have entered this pandemic with already weak capacities (e.g. Syria, Yemen, Afghanistan, Somalia, South Sudan and Sudan) face an exacerbation of poor access to services for migrants, as well as constraints in health financing. This, along with barriers to access hard-to-reach populations and maintain supply chains, threaten the continuity of care to migrants on essential health services.
- Migrants, refugees, asylum seekers and IDPs also require mental health and psychosocial support to mitigate the additional stress and challenges caused by the pandemic, considering that human and financial resources for mental health services are often very limited in some of the GHRP countries.
- Technical guidance and tools must be developed to ensure risk communication messages are culturally and linguistically tailored, and that migrants, displaced populations and other vulnerable groups are included in national, regional and global outreach campaigns to avoid stigmatization. Gaps in literacy levels and in access to digital tools between men and women must also be factored in. Activities must ensure that displaced populations and migrants living in urban areas and out-of-camps settings, as well as in border areas, have access points to assistance and information during movement restrictions and to health services.
- Specialized training is needed for operational partners who are playing an increasingly prominent role, including to set up quarantine and isolation facilities in displacement sites and at points of entry, and support families and broader communities of those under quarantine or isolation.
- Preparedness for response on a no-regrets basis must increase specifically for those countries not yet badly hit but very likely to be affected, and with ill-prepared health and social safety net structures. Ongoing efforts to decongest densely populated refugee camps and settlements need to be further scaled up in anticipation of COVID-19 to facilitate a measure of physical distancing.

Needs assessment and monitoring

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

Response monitoring

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

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

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

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

3.2

Adherence to the guiding principles and key considerations for the response

Application of the guiding principles for the response

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

- Respect for humanitarian principles.
- People-centred approach and inclusivity, notably of the most vulnerable people, stigmatized, hard-to-reach, displaced and mobile populations that may also be left out or inadequately included in national plans.
- Cultural sensitivity and attention to the needs of different age groups (children, older people), as well as to gender equality, particularly to account for women's and girls' specific needs, risks and roles in the response as care providers (including caring for those sick from the virus), increased exposure to gender-based violence with confinement measures, large numbers of front-line female health workers in the response, and key role as agents at the community level for communication on risks and community engagement.
- Two-way communication, engagement with and support to capacities and response of local actors and community-based groups in the design and implementation of the response, using appropriate technology and means to account for mobility restrictions and physical distancing.
- Complementarity and synergies between agency plans and responses, including with development actors.
- Preparedness, early action and flexibility to adjust the responses and targets to the fast-evolving situation and needs.
- Building on existing coordination mechanisms.
- Duty of care for agency staff and volunteers.

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

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

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

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

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

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

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

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

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

Interagency collaboration

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

- UNICEF, WHO and IFRC developed a Risk Communication and Community Engagement (RCCE) Action Plan guidance to support risk communication, community engagement staff and responders working with national health authorities, and other partners. This comprehensive guidance presents tools and information on how to develop, implement and monitor an action plan for communicating and engaging effectively with communities, local partners and other stakeholders.. A draft global RCCE guidance has been produced and currently under finalization.
- Through the coordination mechanisms established for the COVID-19 Response, including the UN Crisis Management Team, the Supply Chain Task Force and the Supply Chain Inter-Agency Coordination Cell, UN and non-UN actors are working closely together to set up the system required to identify, certify, source, allocate, direct and deliver essential supplies where they are needed most. In a collaborative effort across UN and non-UN actors, WHO is leading the prioritization and destination of medical equipment while WFP is serving as logistics lead. Through this, WFP is coordinating the delivery of prioritized health and humanitarian cargo while leveraging existing infrastructure, partnerships, and capabilities. UNICEF is leading the WHO-administered "COVID-19 Global Supply Coordination platform" which collates all agency supply requests into one forum.
- Through these coordination forums and WFP's existing partnership with the private sector and engagement with governments (including military), the collective assets, services and expertise of actors will be leveraged to deliver the supply chain backbone of the response. Where militaries are mobilized and/or peacekeeping operations are present in-country, WFP may provide dedicated expertise to coordinate and minimise any duplication or gaps, such as supporting the humanitarian community in the use of national military and civil defence assets where appropriate, and coordinating the use of foreign military assets where required.

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

- IOM is working with partners and stakeholders at community, national, regional and global levels to ensure coordination and synergy between various actors and responses, and avoid duplication of efforts. It is planning to set up a support facility to global clusters to utilize existing Displacement Tracking Matrix datasets for country-level sectoral or multi-sectoral analysis as needed.
- IOM aims to support UN outpatient clinics and provide staff through its global network of qualified health workers, including physicians, nurses and laboratory staff, across 40 tentatively identified locations where IOM already has medical presence. IOM is a member of the UN medical evacuation Task Force and has been closely working with UN partners at all levels to jointly find effective solutions to support UN staff in the most effective way possible during the peak of the pandemic.
- UNFPA is coordinating with WHO and other UN partners at the global and local level to ensure access to personal protective equipment to prevent person-to- person transmission of COVID-19 in sexual and reproductive health and gender-based violence lifesaving service delivery points. UNFPA is also working to ensure an uninterrupted supply chain for lifesaving sexual and reproductive health commodities to the last mile, particularly in humanitarian settings, despite the immense international and local challenges caused by the COVID-19 pandemic.

Humanitarian and development collaboration

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

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

Community engagement

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

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

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

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

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

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

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

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

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

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

- UNDP is working in close collaboration with national, municipal and local authorities to support inclusive and integrated crisis management, supporting business continuity actions (especially teleworking and procurement support) for key public crisis management services, and reinforcing existing public services, for example expanding shelters for survivors of domestic violence, and advising on appropriate virus transmission reduction models, as an alternative to lockdowns. National partners are in a leadership role on UNDP supported multi-stakeholder socio-economic impact assessments.
- UNFPA is working closely with national ministries, national Red Cross Red Crescent societies, and local NGOs including women's led and youth organizations under the existing cluster/sector coordination system while utilizing pre-existing and contingency partnerships with NGO partners.
- Recognizing that more than 61% of refugees live in urban environments, UNHCR has developed a Live Resource Guide for Municipal Migrant and Refugee Sensitive COVID-19 responses in partnership with Mayors Migration Council. It has also reached out to refugee-led organisations, faith-based organisations and other civil society actors to seek new and innovative ways of collaborating to reach out to all segments of society, combat misinformation and enhance global solidarity.
- UNICEF is strengthening its collaboration with civil society organisations through cash programming.
- UNRWA is planning to increase its community engagement activities and mobilize Palestinian youth to disseminate messages in their communities to prevent the spread of the COVID-19

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

Partnership with NGOs

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

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

“COVID-19 has changed every aspect of our lives. But women and girls are shouldering a double burden made heavier by lingering inequalities and harmful gender stereotypes.”

—

Henrietta H. Fore
Executive Director, UNICEF

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

4.0 Financial requirements and funding status

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

4.1
Funding overview

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

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

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

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

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

It aims to underpin the UN's longer term multi-sectoral support to national recovery/development responses to the socio-economic impact of COVID-19. The Fund's coverage extends to all low and middle income programme countries,[71] however it excludes populations already included in the GHRP, helping to safeguard their progress towards the Sustainable Development Goals.

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

[71] **OECD Development Assistance Committee (DAC) Least Developed Countries:** Bhutan, Cambodia, Comoros, Gambia, Guinea, Guinea-Bissau, Kiribati, Lao PDR, Lesotho, Madagascar, Malawi, Mauritania, Nepal, Sao Tome and Principe, Senegal, Solomon Islands, Timor-Leste, Tuvalu, Vanuatu.
DAC Lower Middle Income Countries and Territories: Armenia, Cabo Verde, Côte d'Ivoire, El Salvador, Eswatini, Georgia, Ghana, Guatemala, Honduras, India, Indonesia, Kosovo, Kyrgyzstan, Micronesia, Moldova, Mongolia, Morocco, Nicaragua, Papua New Guinea, Sri Lanka, Tajikistan, Tokelau.
DAC Upper Middle Income Countries: Belize, Jamaica.

4.2
Financial requirements

Overview of GHRP cost components

REQUIREMENTS (US$)

$6.69 billion

	COVID-19 TOTAL	OF WHICH: HEALTH	NON-HEALTH	NUMBER OF PLANS
Global support services	**1.01 B**	–	–	–
Humanitarian Response Plans (HRPs)	**3.49 B**	1.30 B	2.18 B	**25**
Regional Refugee Response Plans (RRPs)	**993.6 M**	265.1 M	728.5 M	**5**
Regional Refugee and Migrant Response Plan (RMRPs)	**438.8 M**	132.4 M	306.4 M	**1**
Other plans	**156.9 M**	91.5 M	65.3 M	**2**
New plans	**605.5 M**	211.9 M	393.6 M	**9**
TOTAL	**$6.69 B**	**$2.00 B**	**$3.67 B**	**42**

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

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

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

The GHRP funding requirement includes:

- $5.69 billion for the COVID-19 response in the countries included in the GHRP. This amount includes requirements of UN agencies and NGOs implementing the response at country level.[74] See Annex 3 for details by country.
- $1 billion for global shared services benefitting the collective COVID-19 response, such as logistics, air bridge, central procurement, field hospitals, medical evacuations and data facility. This amount excludes those estimated in the first iteration of the GHRP for country-level costs, which are now counted in the country requirements above.

[74] For UNHCR, the agency appeal figure of US$745 million covers the global additional COVID-19 related needs for refugee, IDP and stateless in all UNHCR operations worldwide.

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

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

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

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

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

Global support services for the COVID-19 humanitarian response

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

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

Financial requirements (US$)

COVID-19 REQUIREMENTS

REQUIREMENTS
$6.69B

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	677.9 M	**750.0 M**
Yemen	HRP	**179.1 M**	101.6 M	77.6 M	3.20 B	**3.38 B**
Zimbabwe	HRP	**84.9 M**	35.0 M	49.9 M	715.8 M	**800.7 M**
Burundi *Regional*	RRP	**65.4 M**	36.5 M	29.0 M	209.9 M	**275.4 M**
DRC *Regional*	RRP	**155.7 M**	94.7 M	61.0 M	483.0 M	**638.7 M**
Nigeria *Regional* [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

4.3 Funding status

Funding received against the GHRP requirements

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

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

Consequences of funding gaps to achieve the strategic priorities

Common services for supply chains and medical evacuations

Funding is urgently needed to provide critical support to the supply chain without which services will not be rolled out at the scale required to ensure the supply chain needs of the global response. The number of air rotations transporting critical health and humanitarian cargo between hubs will be immediately impacted, risking the effective and efficient delivery of critical health and humanitarian relief items to those in need. Lack of medical supplies and equipment will result in increased health risks thus limiting progress on the GHRP strategic priorities. Support to ensure the health and welfare of humanitarian personnel will be severely limited, including a reduction in medical evacuation services. Shared services, personal protection equipment, medical evacuations, UNHAS and cargo flights are essential for the continuity of operations by all organizations including NGOs. Without functional supply chains, NGOs are likely to be forced to halt operations and possibly pull out of critical response locations.

Humanitarian response to COVID-19

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

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

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

[75] Guttmacher Institute, Estimates of the Potential Impact of COVID-19 on Sexual and Reproductive Health in Low and Middle Income Countries, Available at: www.guttmacher.org/journals/ipsrh/2020/04/estimates-potential-impact-covid-19-pandemic-sexual-and-reproductive-health

[76] WHO. Health Cluster. Gender-based Violence in Health Emergencies. www.who.int/health-cluster/about/work/othercollaborations/gender-based-violence/en

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

Monitoring of situation, needs and response

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

4.4
Funding flows and partnerships

Funding flows between Pooled Funds, UN agencies and partners

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

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

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

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

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

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

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

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

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

- **IOM** will increase funding to local partners while also encouraging NGOs to tap into more funds from the IOM Rapid Response Fund mechanisms grant facilities in places such as Ethiopia, South Sudan and Sudan. IOM has also initiated a set of additional steps to improve funding flexibility that will help ensure that NGO partners - local, national and international– can effectively respond to COVID-19 while continuing the critically important ongoing humanitarian work. IOM has put in place temporary measures to ensure fast-track, simplified and flexible funding arrangements that help NGO partners to focus on the situation on the ground and respond to evolving needs in a timely and effective manner.
- **UNFPA** has continued to provide more support and funding tools to NGOs, with a strong focus on localization. CERF allocation for COVID-19 response released early in April 2020 is playing a key role in enabling UNFPA to deliver against the commitments of the Grand Bargain on localization. In particular, it has enabled UNFPA to strengthen its partnership with local responders and served as a catalyst to enhance gender-based violence-sub-cluster coordination with all partners (notably national NGOs, government counterparts and INGOs) and strengthened capacity of implementing partners providing life-saving interventions.
- **UNHCR** has provided partners greater flexibility to make discretionary budget allocations; issued guidance that permits country operations to accelerate release of financial installments; allowed partners to charge the UNHCR projects for costs already incurred in respect of activities that will not be completed due to physical distancing measures and travel restrictions, reduced reporting requirements, and has issued instructions on how to accept documents digitally.
- **UNICEF** is making use of much needed simplification/flexibility in partnership processes to amend some of the 2,000 partnership agreements already active when the pandemic struck.
- **WFP** supply chain services directly serve the NGO community which faces increasing restrictions that inhibit their ability to mobilize, position, and transport supplies and staff due to the curtailment of commercial transport and cargo services. Historical trends show that on average 65% of passengers on UN humanitarian air services are I/NGOs. During the West Africa Ebola response – which put in place a supply chain backbone at a sub-regional level – approximately half of the volume of cargo transported was on behalf of UN Partners, the remainder was for NGOs, International Organizations, Red Cross/Red Crescent Societies, and governments. On 21 April 2020, a consortium of NGOs [Interaction and the Steering Committee for Humanitarian Response] warned that without the supply chain services laid out in the GHRP, NGOs will be forced to halt operations and possibly pull out of critical response locations. It should be noted that significant support to the COVID-19 response is being provided in terms of shared procurements services benefitting operational partners, including NGOs and partners. For example, to date UNICEF estimates that 72% of its response resources have been spent on procurement of specialized supplies in support of itself and partners.

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

Funding requirements of NGOs

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

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

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

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

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

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

[79] As per WFP historical data.

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

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

We are in the fight of our lives.

We are in it together.

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

António Guterres,
Secretary-General, United Nations