



# GLOBAL HUMANITARIAN RESPONSE PLAN COVID-19

UNITED NATIONS COORDINATED APPEAL  
APRIL – DECEMBER 2020

GHRP JULY UPDATE: ANNEXES





## Annexes

### I Country and regional plans: situation and needs, response planning and requirements

Humanitarian Response Plans **HRP**

Regional Refugee Response Plans **RRP**

Regional Refugee and Migrant Response Plan **RMRP**

Other Plans **OTHER**

Intersectoral Plans **INTERSECTORAL**

### II Summary of response progress by specific objectives and by agency

#### SANA'A, YEMEN

Commodity Voucher through Trader's Network (CVTN) distribution in Ammar bin Yaser School (Amant Al Asimah), Sana'a. WFP supports more than 800.000 people in Amanat al Asimah with food assistance. WFP/Mohammed Awadh

---

**ANNEX I**

# Country and regional plans: Humanitarian Response Plans

4	Afghanistan
6	Burkina Faso
8	Burundi
10	Cameroon
12	Central African Republic
14	Chad
16	Colombia
18	Democratic Republic of the Congo
20	Ethiopia
22	Haiti
24	Iraq
26	Libya
28	Mali
30	Myanmar
32	Niger
34	Nigeria
36	oPt
38	Somalia
40	South Sudan
42	Sudan
44	Syria
46	Ukraine
48	Venezuela
50	Yemen
52	Zimbabwe

# Afghanistan HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$395.7M**

### OF WHICH:

HEALTH: \$107.6M  
NON-HEALTH: \$288.1M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.1B**

### OF WHICH:

COVID-19: \$395.7M  
NON-COVID-19: \$735.4M

## PEOPLE

IN NEED: 13.95M  
TARGETED: 11.1M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 30 June, some 31,359 people across all 34 provinces in Afghanistan were confirmed to have COVID-19 and 735 people have died. Almost five per cent of the total confirmed COVID-19 cases are among healthcare staff. Less than one per cent of the almost 38 million population has been tested. As of the end of June, case numbers were continuing to climb and the peak of the pandemic in the country had not yet passed. Without systemic tracking of mortality and a national death registry, the official death toll of the pandemic is believed to be an under-estimation.

To date, the Government with the support from WHO has established 11 laboratories across 7 provinces with the capacity to test 2,000 cases per day. Limited availability of fully trained medical professional and health workers has led to problems in laboratories which have forced temporary service outages due to contamination.

Accessing healthcare was already not easy for millions of people across the war-torn country and the overstretched health system is further exacerbated by targeted attacks. Between 11 and 23 May 2020, the UN documented 12 incidents in which parties to the conflict carried out deliberate acts of violence or interference with healthcare workers or facilities, affecting healthcare provision during the pandemic.

### Indirect impacts on peoples and systems

As a result of the pandemic, a nation-wide polio vaccination programme, originally planned to reach 9.9 million children, has been suspended. This is particularly concerning as 11 cases of polio have been reported since the start of the year in new areas which had not reported cases for several years, primarily Non-State Armed Group-controlled areas where house-to-house vaccination campaigns have been banned since May 2018.

Afghanistan is home to 12.4 million acutely food insecure people (IPC 3 & 4), including almost 4 million at the emergency level, already making it one of the world's largest hunger crises. Fear of COVID-19 contagion has also reduced access to essential nutrition services. Analysis from the Ministry of Public Health's nutrition database showed a 46 per cent decrease in admissions for treatment of

severe acute malnutrition within health centres – 'inpatient' treatment – and a 12 per cent decrease in 'outpatient' treatment in May 2020.

The Ministry of Education has extended the suspension of schools until the end of August 2020 resulting in more than 11 million children missing critical education opportunities. Assessment data indicates a surge in child labour with increases in sending children to work or to beg, while nearly half of the respondents reported an increase in violence against children. Exploitation through forced marriage is further reported with over 24 per cent of respondents fearing or reporting having experienced forced marriage, forced labour, trafficking and recruitment into armed groups as a result of COVID-19.

## Response priorities and challenges

### Priorities and early achievements

Through a revised Humanitarian Response Plan, 11.1 million people are targeted with immediate assistance, up from a planned 7.1 million people at the start of the year. Of the total, 5.4 million will receive COVID-19 related response packages, while a broader 6.8 million will continue to receive other multi-sector humanitarian assistance. Key response highlights include:

- Some 34,000 polio surveillance volunteers are engaged in surveillance, case identification and contact tracing. A surveillance system traced more than 500,000 people and screened more than 400,000 people at points-of-entry.
- More than 4.1 million people have been reached with risk communication and awareness raising messages on COVID-19. Hygiene materials have been distributed to more than 1.9 million vulnerable people. Psycho-social support has reached more than 172,000 people while more than 1.2 million people have also received protection-focused COVID-19 messages. Close to 420,000 people have been reached with awareness raising sessions on prevention that were focused on shelter and household item use.
- More than 4 million people have received emergency food assistance and nutrition treatment has been delivered to 126,102 children with severe and moderate acute malnutrition.

# Afghanistan

HRP

This work is being closely coordinated with wider efforts by development actors who have identified 35 million people living in poverty who they plan to reach with a social safety net response.

## Challenges and impact to operations

With the suspension of some commercial flights impeding humanitarian movement, the United Nations Humanitarian Air Service has stepped up to facilitate and maintain domestic and international flights for humanitarian personnel and goods through an airbridge connecting Kabul and Doha three times a week.

Reducing the impact of COVID-19 on the population of Afghanistan and humanitarian personnel is essential to ensure the continuation of service delivery. In June, there has been a surge in suspected cases of COVID-19 among humanitarian personnel. The UN has started work to establish an intensive care unit to enable partners to stay and deliver. This work requires rapid funding and partners are actively seeking funding avenues.

# Burkina Faso HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$105.9M**

### OF WHICH:

HEALTH: \$17.1M  
NON-HEALTH: \$88.8M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$424.3M**

### OF WHICH:

COVID-19: \$105.9M  
NON-COVID-19: \$318.4M

## PEOPLE

IN NEED: 2.9M  
TARGETED: 2.2M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 28 June, 962 cases of COVID-19 had been confirmed with 53 deaths. While nine of the country's 13 regions have been impacted by COVID-19, the Centre region remains the epidemic's epicentre. The health impact of the COVID-19 pandemic has been limited in terms of the number of cases, but secondary effects associated with the pandemic are exacerbating pre-existing vulnerabilities.

Low access to healthcare and weak epidemiological surveillance puts the whole population at risk. Insecurity in northern and eastern parts of the country has led to the closure of 12 per cent of health centres and left another 13 per cent at minimum functional capacity, preventing and limiting access to needed healthcare services for 1.6 million people. By June 2020, more than 921,000 people had been internally displaced by insecurity and conflict, most staying in crowded and precarious conditions. Ongoing outbreaks of polio and measles create further challenges. The pandemic has impacted primary healthcare access due to fears relating to the spread of the virus.

Testing for COVID-19 remains low, and the risk of the virus' spread to IDP communities or parts of the country with weak or no health services is extremely worrying. Burkina Faso lifted most pandemic-linked internal restrictions related to COVID-19 at the end of April 2020; while the country's national borders remain closed at the end of June 2020, there is a consideration of a phased reopening.

### Indirect impacts on people and systems

Movement restrictions and the economic slowdown have resulted in income loss, with significant consequences for the poor and vulnerable. GDP growth is expected to shrink to only 2 per cent from the previously expected growth of 6 per cent. Nearly 40 per cent of the population lives below the poverty line, with high levels of unemployment, especially among young people. With food and nutritional insecurity already on the rise, market disruptions will have a further negative impact, particularly in areas affected by insecurity and displacement. Forecasts indicate that Burkina Faso will see food insecurity more than triple to over 2.1 million people in June 2020.

The temporary suspension of schools affected 5.1 million children in a context where more than half of children of primary and lower secondary school age were already out of school. Immunisation campaigns and preventive programmes have been disrupted. The situation has also affected emergency nutrition response, and protection concerns, including around the containment measures and related to GBV, are on the rise. The revised 2020 HRP indicates a 32 per cent increase in the number of people in need of humanitarian assistance to 2.9 million, up from 2.2 million in January 2020.

## Response priorities and challenges

### Priorities and early achievements

The HCT's priority has been to strengthen the planned response under the HRP 2020 to support and complement the implementation of the national preparedness and response plan for COVID-19 in the five regions covered by the HRP, ensuring access to and continuous provision of primary health care services and improved water, sanitation and hygiene (WASH), as well as urgently-needed multisectoral assistance for the most vulnerable.

Health response priorities and achievements to date include strengthened regional coordination, disease surveillance and testing, drugs and socks prepositioning, establishment of second laboratory; and identification of isolation areas in health facilities in affected areas.

The Food Security Cluster is targeting 1.8 million people in need of food assistance through the 2020 lean season, and 10,000 households with livelihoods assistance. Nutrition actors are strengthening nutritional surveillance and nutrition services in health centres. The WASH Cluster is providing WASH and Infection Prevention and Control (IPC) support to health centres. The Cluster is also supporting the installation of hand-washing facilities in public places and IDP sites, distributing IPC kits, and providing safe drinking water. Humanitarian partners have strengthened their communication efforts on preventive measures, through radio broadcasts and the use of radio programmes. The Shelter Cluster is working on mapping the density of urban collective centres and IDP sites and securing additional shelter to support decongestion of IDP sites. The Protection Cluster is also supporting decongestion in IDP sites among other prevention measures; 33,500 people have already been

---

## Burkina Faso HRP

reached with training initiatives. The Education Cluster is supporting the gradual reopening of schools as well as the development of distance learning solutions.

### Challenges and impact to operations

Burkina Faso continues to grapple with the intensifying security and humanitarian crisis, which has led to a substantial increase in internal displacement and worsened the already-minimal access to basic social services in a context of fragility and underdevelopment. Humanitarian access in hard-to-reach areas remains a challenge with an increasing number of attacks affecting civilian populations in border regions with Mali and Niger. In these worsening humanitarian conditions, COVID-19 could also heighten intercommunal tensions over access to services, food or medical supplies.

It is difficult for IDPs, refugees, and host communities to comply with recommended physical distancing measures due to crowded living conditions. The risk of widespread contamination is high in overcrowded places, particularly in areas where access to water is scarce. The risk of diversion of health efforts from preventing and managing other pathologies is significant.

# Burundi

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$38.0M**

### OF WHICH:

HEALTH: <sup>1</sup>  
NON-HEALTH: \$38.0M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$197.7M**

### OF WHICH:

COVID-19: \$38.0 M  
NON-COVID-19: \$159.7M

## PEOPLE

IN NEED: 1.74M<sup>2</sup>  
TARGETED: 0.89M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 3 July, a total of 191 confirmed cases has been reported with 2,615 tests administered. While this total remains relatively low, a downward trend in the use of health services has been observed between January and April 2020 compared to the same period in 2019, particularly for prenatal consultations, assisted childbirth, curative consultations, and bed occupancy. This could be an indirect impact of the pandemic.

### Indirect impacts on people and systems

COVID-19 severely impacted cross-border trade activities, caused the loss of income-generating opportunities and increased health care costs. COVID-19 related movement restrictions have also impacted the supply chain as well as the informal economy, contributing to increased commodity prices.

Combined with the recent flood effects, this has negatively impacted the availability of basic foods and essential items, leading to increased food prices and worsening the food security of the most vulnerable populations. For instance, as of May 2020, the price of beans increased by 39 per cent compared to 2019, and by 57 per cent as compared to the last five years.

COVID-19 is expected to cause job losses and reduce people's income and purchasing power in an urban landscape already characterized by a large proportion of the population (56 per cent) living in slum areas with a high prevalence of poverty. The informal sector, which accounts for 89 per cent of non-agricultural employment, is likely to be disproportionately affected, as will daily agricultural workers. The reduction of livelihood opportunities has also increased the risks of protection violations and human trafficking.

There are protection concerns for Burundian migrants returning from neighbouring countries and the subregions due to unsanitary conditions and many people's inability to pay for required quarantine fees. There are also undocumented reports of children separated from their families and/or not having access to services in quarantine

sites in which child protection actors do not yet have access. The risk of stigmatization and discrimination of returning migrants once they exit quarantine remains high.

## Response priorities and challenges

### Priorities and early achievements

2020 HRP priority areas are mainly located in the eastern and northern provinces, which are particularly affected by food insecurity and host IDPs and returnees. The western provinces, with higher incidences of health emergencies and natural disasters, have been prioritized for health, shelter and NFIs response. Through specific COVID-19 vulnerability mapping, humanitarian and development partners are identifying additional vulnerable areas, which are likely to include more urban centers with higher population density. These will also be prioritized in the response.

The most vulnerable people include IDPs, returnees, refugees, subcategories of single-parent or female-headed households, host communities and vulnerable populations affected by shocks, such as floods, landslides and food insecurity. Camps, transit centres and other types of informal and formal settlements are also at particular risk of contamination due to their congested nature, and need to be prioritized in terms of monitoring and implementation.

Humanitarian actors have increased the number of people targeted from 630,000 to 887,000 (53 per cent women, 58 per cent children, 15 per cent persons with disabilities, and 4 per cent older persons), to address the socio-economic impact of COVID-19. The food security sector is targeting 250,000 additional people while nutrition targets are increasing by 20 per cent for severe acute malnutrition and 40 per cent for moderate malnutrition.

Since 17 June, humanitarian flights organized by WFP have facilitated the transport of humanitarian personnel. Land borders with DRC and Rwanda were reopened on 15 April to allow the movement of goods and commodities. All returnees must quarantine and, since the end of June, returnees under the voluntary repatriation framework are submitted to COVID-19 testing.

The Ministry of Public Health, together with its partners, has

<sup>1</sup> Health requirements are included in the SRP/PRP and the Government Contingency Plan.

<sup>2</sup> Including those vulnerable to COVID-19.

## Burundi HRP

launched community awareness activities in French and Kirundi.

The “blue soap” initiative launched by UNICEF with CERF funding reached 2 million people in June, based on soap consumption recommended by Sphere standards. This has been included as one of the key interventions recommended for COVID-19 response by the Government, which committed as a complementary intervention to reduce the price of water in urban areas to facilitate handwashing.

No vaccination campaigns have been delayed or cancelled due to COVID-19 and scheduled campaigns were carried out through an adapted programme to ensure the safety of the population. However, hospital attendance trends indicate a decrease for routine vaccinations.

### Challenges and impact to operations

Despite efforts, the triage and isolation capacities of designated hospitals remain limited. Further efforts are needed to implement national guidelines related to COVID-19 prevention and treatment at the health district level. Furthermore, provincial steering committees are yet to be established in most provinces.

Quarantine facilities outside Bujumbura remain often ill-equipped to host large numbers of people and there is an urgent need to ensure that individuals in such facilities are provided with adequate food, water, and other basic supplies. Protection concerns for children and other vulnerable groups such as older persons have also been reported in some of the facilities.

More efforts are needed to better include specific segments of the population in community awareness campaigns, particularly women, people under 20 years of age and vulnerable communities, including those hosting returnees, of whom only 25 per cent reportedly have mobile phones.

# Cameroon

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$81.7M**

### OF WHICH:

HEALTH: \$18.2M  
NON-HEALTH: \$63.5M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$390.9M**

### OF WHICH:

COVID-19: \$81.7M  
NON-COVID-19: \$309.1M

## PEOPLE

IN NEED: 6.2M  
TARGETED: 3.4M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 26 June, 12,592 COVID-19 cases and 313 deaths are confirmed in Cameroon. Ongoing transmission is placing a massive strain on the health-care system which is already overwhelmed by a lack of capacity and ongoing disease outbreaks such as malaria, measles and cholera. As testing, isolation and treatment capacity gradually expand, the epidemic continues to spread across the country with all ten regions now affected and only six regions have testing capacity. 820 confirmed cases are in areas affected by violence in the Far North, South West and North West.

People affected by violence in the Far North, the North-West and South-West regions and Central African refugees in the eastern regions face significant difficulties in accessing essential services, including health and food. COVID-19 has exacerbated these vulnerabilities. The Government's decentralized COVID-19 response strategy and growing empowerment by regional authorities has raised new challenges, including the lack of trained health staff and weak logistical and financial capacity to procure PPE and other medical supplies.

The humanitarian situation has worsened due to the strain on the weakened health system and decreased coping strategies to secure household level food security. Since COVID-19, restrictions in movement, continued violence coupled with a deteriorating economic situation has prompted new projections by humanitarian partners with over 6.2 million people in need of humanitarian assistance for the remainder of 2020. This is an additional 2.3 million people needing assistance compared to before the pandemic.

### Indirect impacts on people and systems

Transport across land, air and sea borders is permitted with Government authorization and supervision. However, a slowdown in supply has been noted with delayed waiting time in ports and issuance of air cargo authorizations. Cameroon is continuing to transport essential supplies to landlocked neighbours Chad and CAR.

The drop in oil prices has meant massive losses to Cameroon's economy and budget cuts have led to reduced social protection programmes and unemployment. A UNDP

socio-economic analysis conducted in April-May highlighted that over 82 per cent of businesses experienced decreased production. In major towns, unemployment and income losses have witnessed almost 65 per cent of households experiencing a deterioration in living standards.

Due to a diversion of critical investments in healthcare, including HIV, and sexual and reproductive health services, displaced people are facing increased difficulties in accessing essential healthcare. Displaced people are unable to practice social distancing due to overcrowded shelters and lack access to potable water, soap and PPEs. Access to family planning services has decreased leading to greater risks of unplanned pregnancies, under resourced maternal health clinics and heightened child and maternal mortality rates.

## Response priorities and challenges

### Priorities and early achievements

In support of the Government's National Preparedness and Response Plan, the UN and I/NGO health partners have prioritized setting-up contact tracing mechanisms, training of Emergency Response Teams, expanding treatment and isolation facilities, providing PPEs and training healthcare workers.

A Risk Communication and Community Engagement strategy was adapted to better respond to information needs of communities and mitigate the impact of the lifting of Government restrictions. As of mid-June, almost 17 million people were reached with the COVID-19 prevention campaign.

Non-Food Items and Cash and Vouchers Assistance is addressing protection issues exacerbated by the pandemic and a national Distance Education Program was launched aiming to reach 3.9 children.

The WASH sector installed handwashing devices and soap in more than 2000 sites while UNDP facilitated the procurement of medical equipment for regional healthcare centres and hospitals.

The GBV sub-sector developed a collaborative platform and networks with youth association groups on accelerating access to family planning services in the context of COVID-19. Coordination and health partners continue to

# Cameroon

HRP

work closely to strengthen the Government's response coordination, to align humanitarian activities at regional level with regional Government response plans.

Funding permitting, pre-existing emergency programmes are maintained for criticality levels one and two, including food distributions, following strict social distancing and hygiene measures.

## Challenges and impact to operations

Despite efforts by the Government to decentralize case management capacities, ongoing gaps include a limited number of facilities equipped with respiratory platforms, a shortage of testing kits, limited health-care personnel capacity and PPE.

The Government's decision to lift several key preventative measures on 30 April, at a time when Cameroon started recording a sharp rise in new cases, continues to raise concerns among key stakeholders. Limited testing capacity at sub-national level implies published figures are lower than expected.

Humanitarian actors have adapted implementation strategies to mitigate the risks from COVID-19. For example, in April there was a 90 per cent decrease in food distribution in NW/SW due to COVID-19 restrictions. In May access improved and 34 per cent of target distribution were implemented. The main shortfall is due to a lack of funding.

Meanwhile, many frontline humanitarians do not have access to basic protection equipment.

# Central African Republic HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$152.8M**

### OF WHICH:

HEALTH: \$7.7M<sup>3</sup>  
NON-HEALTH: \$145.2M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$553.6M**

### OF WHICH:

COVID-19: \$152.8M  
NON-COVID-19: \$400.8M

## PEOPLE

IN NEED: 2.6M  
TARGETED: 1.8M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 29 June, 3,613 COVID-19 cases and 47 deaths have been confirmed out of 23,904 people tested (15.1 per cent). Cases have been confirmed in 22 out of 35 health districts and local transmission has sharply increased, accounting for 85 per cent of total cases. Health structures are completely overwhelmed and unable to provide the necessary services to the most vulnerable in a context where almost half the population needs lifesaving health services. National laboratory analysis capacity is limited to 400 tests per day and no laboratory facilities are available outside of Bangui, thus causing delays in the transmission of results.

### Indirect impacts on people and systems

Armed clashes and inter-communal violence have erupted across the country, leading to onset displacement of hundreds of thousands of people, grave violations of International Human Rights and Humanitarian Law and attacks against civilians and humanitarian workers.

COVID-19 is exacerbating already existing protection risks, with increased stigmatization of vulnerable groups, including 684,000 IDPs and particularly the over 245,000 IDPs in sites. Under the pretext of preventing the spread of COVID-19, armed groups and local authorities have threatened IDPs and forced some of them to leave the sites.

1.3 million children have lost access to education, thereby also losing access to WASH facilities and feeding programmes, and increasing their exposure to protection risks, including GBV and recruitment by armed groups. A 15 per cent increase in GBV cases has been observed in Bangui since March.

The latest IPC assessment (May to August) indicates a sharp increase in food insecurity, with more than half of the population (2.36 million people) acutely food insecure, of whom 750,000 are in the emergency phase, with an additional 632,000 food insecure people compared to September.

In June 2020, a perception survey indicated that 58 per cent of interviewees admitted that their ability to respond to their

basic needs has deteriorated since the epidemic began due to prices increases (47 per cent), losses in household revenues (25 per cent), and border closings (22 per cent).

## Response priorities and challenges

### Priorities and early achievements

Seventy per cent of health services were already provided by humanitarian organizations and priority has now been given to scale up and decentralize the COVID-19 response. Thirty-two organizations are setting up isolation centers across 20 priority areas. Four centers are currently fully operational, while 13 more are underway.

Thanks to facilitation measures put in place, humanitarian actors continue to operate across the country, implementing risk mitigating measures by road and air. Despite the dangerous operating environment and the growing needs, they continue to provide assistance to over 750,000 people every month and are de facto the only safety net for a population in distress.

Regular HRP activities have been integrated with and adapted to COVID-specific interventions, as proven by the multisector approach of isolation centers and decentralization of the response.

Humanitarian, development and peace actors have joined forces and invested in the local production of masks for non-health personnel and the most vulnerable groups, also generating livelihoods opportunities, with 103,000 tissue masks having already been distributed in 7 prefectures.

Prioritizing the most vulnerable households, 2 million people have been reached with lifesaving information related to COVID-19: over 10,000 radios have been distributed and more than 102,000 children benefitted from remote learning programs. In addition, 139 additional boreholes have been set up; 241 water points created and 9 pumps have been installed; 5,800 hygiene kits have been distributed and over 3,300 handwashing stations have been installed, including in health centers and IDP sites; and 314 rapid housing units have been allocated as medical isolation or consultation rooms.

Humanitarian actors plan to further scale up cash-based

<sup>3</sup> Requirement for health does not include requirements under the National COVID-19 Plan.

# Central African Republic

HRP

interventions to distribute \$1.5 million to over 90,000 people for COVID-19 related multisector assistance in cash or vouchers over the next months.

An inter-agency media tracking initiative to monitor misinformation and fear associated with COVID-19 treatments among the communities and stigmatization of the vaccination issue was established. Health and protection actors developed and disseminated key messages on stigmatization, misinformation and manipulation related to COVID-19.

## Challenges and impact to operations

Challenges persist in case management, including due to insufficient PPE supplies, extremely limited availability of oxygenation and respiratory equipment, and shortages of qualified personnel and capacity for infection prevention and control in healthcare facilities, particularly outside Bangui. Available PPE stocks in country and in the pipeline represent only 2 per cent of the identified needs and are completely insufficient, thus increasing the risk of further transmission among communities and humanitarian personnel on the frontline.

The immediate priority is to ensure the continuity and further scale-up of critical lifesaving operations, including by procuring and expediting the delivery of urgent humanitarian cargo (especially PPEs) as well as bringing in surge staff to increase the humanitarian community's ability to address the ever-growing needs.

Immediate funding is needed to support the prepositioning of stocks also due to the rainy seasons and risk of flooding, as well as to scale up services and assistance especially in IDP sites. Sustained agricultural support is crucial to enable 240,000 households to produce their own food and increase their income. It is also important to increase the capacity and availability of skilled health personnel as well as to address other ongoing epidemics and nutritional needs, without which morbidity and mortality rates will increase.

# Chad

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$124.2M**

### OF WHICH:

HEALTH: \$38.1M  
NON-HEALTH: \$86.1M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$664.7M**

### OF WHICH:

COVID-19: \$124.2M  
NON-COVID-19: \$540.5M

## PEOPLE

IN NEED: 6.4M  
TARGETED: 3.8M

## Impact of COVID-19

### Immediate health impacts on people and systems

From a slow spread after the initial case on 19 March in the capital, N'Djamena, the number of daily COVID-19 confirmed cases in Chad rose sharply in early May. The curve flattened in early June, and now only small numbers of new cases or deaths are reported daily. As of 30 June, Chad had a cumulative total of 866 confirmed cases in 15 of 23 provinces, including 79 among health workers. N'Djamena still has the highest proportion of cases (approximately 89 per cent), with a case fatality rate of 8.5 per cent.

Increased pressure on health systems is already being felt, with resources redirected to preventative measures and responding to COVID-19 cases. At the same time, fear of potential transmission within health structures also impacts on people's willingness to seek medical help.

Measles and polio vaccination campaigns have been disrupted due to restriction of movement and gatherings and limited PPE availability for health workers. There is an ongoing measles epidemic, with over 8,000 cases in 2020, and a resurgence in cVDPV2 (vaccine-related polio), with 37 cases with paralysis and three environmental cases.

### Indirect impacts on people and systems

Almost 2.5 million children have been unable to attend school since March 2020, leading to a break in school feeding programmes. Children who lost or are separated from their primary caregivers for numerous reasons, including cross-border movement and internal displacement, are also now at a high protection risk.

With the onset of the lean seasons, food insecurity is likely to rise due to blockages and disruptions in food supply chains and reduced access to markets and pastures. Local cereal prices rose between 25 to 50 per cent since January. The number of people targeted for food assistance has increased from 1.02 million in December to 2.35 million, while the number of people estimated to need livelihoods support has increased from 2.09 million in December 2019 to 3.37 million in June. Due to the socio-economic impact of COVID-19 containment measures, close to 1.9 million children (up from 1.7 million) will be acutely malnourished during 2020, and 627,000 (up from 527,000) are expected to need treatment for SAM.

In the Lake Chad province, COVID-related containment measures limiting freedom of movement and access to livelihoods combined with ongoing armed conflict have led to harmful coping mechanisms for survival. The socio-economic inclusion of refugees is also jeopardized as they remained confined to camps, unable to carry out agricultural and commercial activities.

Despite recent easing of some measures, decreased income and purchasing power have already impacted some seasonal workers, as well as animal breeders unable to access pastures and water for their livestock. In some areas, people may not be able to reach their fields for planting season.

Returning migrants and third country nationals coming into Chad are particularly vulnerable, especially in the harsh terrain of the north, where there are limited shelter facilities, health services, food and drinkable water during isolation in quarantine.

In the current context, women and girls are often deprived of or lack access to healthcare services because of social norms.

## Response priorities and challenges

### Priorities and early achievements

Leadership from the Head of State, and restructured national structures, now brings increased multi-sectoral coordination and enhanced interaction and coordination between national and international partners. PPEs and other health commodities and supplies have been provided, and over 13,000 community liaisons from all health districts in the country have been trained in COVID-19 protection and prevention measures. Continuity of treatment for people affected by HIV has been assured. Training has been provided to healthcare staff, community health workers and laboratory technicians on biosafety. Laboratory capacity has been increased, particularly at provincial level.

Sectoral interventions by all Clusters have been reprioritized and adapted to the COVID-19 context. Initiatives through 23 local radio stations and in different local languages aim to reach 60 per cent of the total population with messaging on COVID-19 prevention and access to services. In the Eastern refugee camps (Ouaddai, Wadi Fira and Ennedi Est), 92 youth workers have been trained on COVID-19 sensitization.

## Chad HRP

By the end of June, 46,016 people were reached with critical WASH supplies. In IDP sites, 575 hand washing devices were installed, tents were distributed to support health centres; over 2,500 shelters were constructed; and some 6,731 households have received NFI kits and hygiene kits. For children, new distance learning programmes, and psychosocial support activities help maintain access to education, share child-friendly information and address stigma.

### Challenges and impact to operations

Chronic underfunding and global supply challenges are impacting the humanitarian community's ability to respond. The receipt of goods and materials is delayed: transit times are longer, some supplies are not available on the global market, and under-funding means orders cannot be placed. There are global shortages in some commodities, such as nutritional inputs.

Some technical equipment and PPE supplies have now been received in Chad, but more is needed, particularly for sub-national health structures. Strengthened Point of Entry monitoring and provision of services along borders is still required and vulnerable migrants, including victims of trafficking, remain blocked in-country due to continued airport closures. There are negative impacts on the protection and assistance offered to displaced persons, including the suspension of family reunifications and registration activities; school closures; reduced access to SGBV prevention and response activities for at-risk groups.

# Colombia

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$329.4M**

### OF WHICH:

HEALTH: \$189.4M  
NON-HEALTH: \$140M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$539.1M**

### OF WHICH:

COVID-19: \$329.4M  
NON-COVID-19: \$209.7M

## PEOPLE

IN NEED: 10.4M  
TARGETED: 2.38M<sup>4</sup>

## Impact of COVID-19

### Immediate health impacts on people and systems

After a period of a relatively stable trends, the number of confirmed COVID-19 cases has been growing exponentially since mid-April. As of 1 July, Colombia had recorded 102,009 cases with 3,470 deaths across all of its 32 departments. The remote and hard-to-reach Amazonas department, half of whose population is indigenous and with limited access to health care, now has the highest infection and mortality rates in the country. In other rural departments witnessing exponential growth, such as Chocó and Nariño, the pandemic is compounding multiple other humanitarian challenges.

Current ICU capacity is likely to be exceeded by the end of July, with over 215,000 active cases expected by then and several departments having already reached critical levels of ICU utilization.

Provision of other health services has been impacted due to the redirection of resources to the COVID-19 response and infections among health personnel. The Health Cluster reports increased barriers to accessing sexual and reproductive health services, including pre- and post-natal care, and attention to sexual violence. According to national authorities, several indicators have deteriorated, including maternal mortality, which has increased by 12 per cent compared to the same period in 2019. Attacks and threats against medical missions and medical personnel have been on the rise, generating increased concern.

### Indirect impacts on peoples and systems

The humanitarian consequences of the pandemic and the nationwide quarantine are having severe socio-economic impacts on the most vulnerable populations, including on the more than 450,000 people internally displaced since the signing of the 2016 Peace Agreement. Food insecurity is estimated to have increased from 3.3 million earlier this year to 10.2 million. Of these, 3 million people are projected to be severely food insecure and require urgent life-saving assistance. There are also growing concerns related to reports of acute malnutrition in some regions. Indigenous

and Afro-Colombians are particularly vulnerable, as are the 1.8 million Venezuelan migrants and refugees.

Educational institutions have been closed for over 100 days, especially affecting children and adolescents in remote and rural areas exposed to armed violence, poverty and conflict, leaving them without access to safe spaces and regular school meals. Many municipalities are unable to implement online learning activities as internet and computers are not part of the essential household basket for a vulnerable family.

Prior to COVID-19, 61.5 per cent of people were working in the informal sector, and are now facing particular high challenges, as Colombia expects the greatest economic contraction in its history with unemployment rates already reaching 21.4 per cent. Women are disproportionately affected by these economic impacts of the pandemic.

Protection challenges are also being compounded by the indirect effects of the pandemic. The number of calls to the national domestic violence hotline has increased by 153 per cent between 25 March and 11 June. Despite these developments, social isolation measures simultaneously increased the obstacles to access to basic services and referral pathways. There have been incidents related to armed violence, with Non-State Armed Groups (NSAGs) fighting for territorial expansion in the period following the announcement of preventive isolation measures, leading to new displacements and confinements. Overall, 14,533 people have been displaced and 45,101 experienced confinement in 2020. This development has also serious implications on the protection of children, as forced recruitments increased by 113 per cent this year.

## Response priorities and challenges

### Priorities and early achievements

The humanitarian community in Colombia has reached over 700,000 people in the past months – in 29 out of the country's 32 departments – with COVID-19 related responses, particularly with protection, WASH, food security and nutrition support. Protection, education and other actors quickly adapted response modalities to enable remote support. Early recovery activities were launched as soon

<sup>4</sup> The PT of the COVID-19 Response (1.28 million) and HRP (1.10 million) are not exclusive and can include double counting. The highest Cluster PIN and PT were used to prevent multiple counting in the case of the COVID-19 response. The actual numbers could therefore be higher.

# Colombia

HRP

as possible to mitigate the socio-economic impact of the pandemic.

In response to the rapid spread of COVID-19 in the remote department of the Amazonas, the Health Cluster developed a one-month specific emergency response plan, in collaboration with the Ministry of Health. The humanitarian community provided a variety of medical and protection equipment, as well as food assistance to 5,000 most vulnerable people. Health and WASH personnel were deployed to guarantee the continuation of a health system that was on the brink of collapse. To facilitate the risk communication in a department with half of its population being indigenous, partners supported the authorities with translating risk communication messages into local languages. The overall response contributed to a reduction in active cases, in contrast to trends in the rest of the country.

## Challenges and impact to operations

Humanitarian actors are highly limited in their response due to the precarious funding situation of all of Colombia's response plans which remain the most underfunded worldwide. Operations in some areas have been affected by flight suspensions and movement restrictions, which impact the mobility of organizations and supply chains although the response effort is still ongoing. Due to continuing lockdown measures and increased insecurity in certain areas of the country, humanitarian access remains a challenge.

# Democratic Republic of the Congo HRP

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$274.5M</b>	HEALTH: \$122.1M NON-HEALTH: \$152.4M	<b>\$2.1B</b>	COVID-19: \$274.5M NON-COVID-19: \$1.79B	IN NEED: 25.6M TARGETED: 9.2M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 28 June, 6,689 cases of COVID-19 have been confirmed, with 152 deaths. Twelve provinces (out of 26) and a total of 82 health zones (out of 305 in the affected provinces) have confirmed COVID-19 cases. The city-province of Kinshasa remains the epicenter of the epidemic with 89 per cent of all confirmed cases. Besides Kinshasa, the hardest hit provinces are Kongo-Central (298), Haut-Katanga (183), South Kivu (121) and North Kivu (75).

Of the 943 hospitalized patients, 96 per cent were mild cases, 2 per cent moderate cases and the remaining 2 per cent presented severe complications.<sup>5</sup>

### Indirect impacts on peoples and systems

COVID-19 is straining the country's already very fragile health system. Health coverage was about 30 per cent before the outbreak and only 27 per cent of health institutions had standard capacities (personnel, equipment, medical inputs, protocols). A major risk is the prevention and management of other pathologies (measles, Ebola, cholera, malaria, malnutrition), potentially leading to new epidemic outbreaks. As a result of COVID-19, thousands of children are at risk of not receiving life-saving vaccinations, in particular against measles, as parents remain reluctant to visit health facilities. In the DRC, even before COVID-19, only 35 per cent of children are fully vaccinated before their first birthday. In the first two months of 2020, coverage of vaccinations against early childhood diseases dropped by 8 to 10 per cent according to UNICEF. This translates into more than 107,000 children who did not receive their yellow fever vaccination and over 84,000 children who did not receive their measles vaccination in January and February<sup>6</sup>. Likewise, preventive health services, prenatal and postnatal care are expected to drastically decrease resulting from

declining attendance out of fear for contamination, putting women and children at risk. Health cluster partners are planning to conduct an assessment in order to determine the actual drop in attendance rates.

The closure of schools in March 2020 is affecting 18 million children. The World Bank has downgraded growth projections from 3.9 per cent to -2.2 per cent and GDP is expected to contract by 2.2 per cent this year. Should the disease spread widely, the economy could contract by 3.8 per cent, which would lead to significant loss of income and livelihoods.

## Response priorities and challenges

### Priorities and early achievements

The health response to the most vulnerable people directly affected by the epidemic is ongoing, with a focus on prevention (including sensitization and WASH activities) and healthcare. Through UNICEF and partners, more than 29 million people have been reached through sensitization and outreach activities<sup>7</sup>. More than 467,000 people have been reached with critical WASH supplies and services. One million reusable protective masks are being locally produced by NGOs and women's associations and over 200,000 have already received masks<sup>8</sup>. World Vision International also donated supplies to support 161 health facilities in 36 health zones<sup>9</sup>.

The response to the indirect impact focuses on limiting the deterioration of livelihoods, reducing protection risks and ensuring access to basic services for the most vulnerable people. UNICEF is providing access to distance learning for some 4.5 million children through partnerships with 296 radio stations and 23 TV channels<sup>10</sup>. In order to help reduce overcrowding in displacement sites and improve social distancing, UNHCR and its partners have built 2,584 emergency shelters for IDPs in Ituri province.

5 Bulletin épidémiologique COVID-19, Ministère de la Santé – OMS, 27 juin 2020.

6 <https://news.un.org/en/story/2020/05/1064212>

7 UNICEF DRC COVID-19 Sitrep, 24 June 2020. [https://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF per cent20DRC\\_COVID-19\\_Situation per cent20Report per cent2310.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20DRC_COVID-19_Situation%20Report%202310.pdf)

8 UNICEF DRC COVID-19 Sitrep, 24 June 2020. [https://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF per cent20DRC\\_COVID-19\\_Situation per cent20Report per cent2310.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/UNICEF%20DRC_COVID-19_Situation%20Report%202310.pdf)

9 World Vision donates medical supplies to fight COVID-19 in the DRC, 19 May 2020. <https://www.wvi.org/stories/congo/world-vision-donates-medical-supplies-fight-covid-19-drc>

10 UNICEF DRC COVID-19 Sitrep, 24 June 2020.

# Democratic Republic of the Congo

HRP

There are currently no additional food security activities ongoing in response to COVID-19. However, food security cluster partners are planning blanket interventions targeting 450,000 people in the capital city of Kinshasa. These interventions are still in the planning phase and the caseload remains to be confirmed. In terms of nutrition, several actors are conducting training and nutritional awareness activities throughout the capital on breastfeeding and supplementary feeding for over 123,000 people. The moderate and severe acute malnutrition figures in Kinshasa remain low, but nutrition partners are planning interventions to support intensive therapeutic nutrition units in hospitals and ambulatory nutrition units in health centers for improved treatment of malnutrition cases.

## Challenges and impact to operations

COVID-19 restrictions currently in place have an impact on humanitarian access (including for travel of humanitarian personnel and access to affected populations) as well as on targeting efforts. The new (June) Ebola outbreak in Equateur Province comes in addition to the many health emergencies already at hand in the country.

Natural hazards such as floods and heavy rains, regular population movements as a result of military operations and armed group activity, and other sudden emergencies most often lead to new displacements and the creation of spontaneous sites where social distancing remains difficult and access to adequate sanitation or health care insufficient.

As a public health crisis with humanitarian consequences, the monitoring and reporting of the COVID-19 collective response is a major challenge (with very little cumulative data per sector available).

# Ethiopia

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$506M**

### OF WHICH:

HEALTH: 100M  
NON-HEALTH: \$406M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.65B**

### OF WHICH:

COVID-19: \$506M  
NON-COVID-19: \$1.14B

## PEOPLE

IN NEED: 20.8M  
TARGETED: 16.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

Since the first confirmed case on 13 March, there have been 6,048 confirmed cases and 107 deaths in Ethiopia as reported by the Ethiopian Public Health Institute on 02 July.

Health workers, health facilities, medical supplies, and water are being repurposed for the COVID-19 response, causing additional stress to the fragile health care system. Regular essential primary healthcare services are hampered or suspended, disproportionately affecting women as fewer mothers, adolescents and children under five will be able to access the Expanded Programme for Immunization, treatment for common illnesses, other Mother and Child Health services, reproductive health services, and mental health and psychosocial support. The shortage of personal protective equipment, hygiene supplies and water further aggravates the risk. Access to One Stop centers and Sexual and Reproductive Health Centers is reduced due to limitations of movements.

### Indirect impacts on people and systems

Movement restrictions and confinement guidance associated with the state of emergency constrains access to essential services. Healthcare services are also increasingly stretched and the financial capacity to access healthcare is decreasing as more households fall into poverty. As a result, people suffering from other health conditions, including preventable communicable diseases and non-communicable diseases, are not accessing services and receiving the treatment and support they require, potentially leading to an increase in morbidities and mortality.

School closures and loss of income are disproportionately affecting women and children. Domestic violence against women and children is increasing due to prolonged confinement and increased tension in the household as well as less access to protection services by victims of abuse and violence.

The pandemic will also negatively impact supply chains including food supplies to markets, increasing prices of staple commodities and affecting the purchasing power of beneficiaries receiving cash transfers. COVID-19 is forecasted to have a serious impact on the food security

due to delays in movement of commercial goods, localized price increases, and provision of humanitarian assistance.

## Response priorities and challenges

### Priorities and early achievements

The HRP was revised in early June to reflect the changes in needs and requirements due to the impact of COVID-19 and desert locust. The revised HRP presented an increase from \$1.0B in January to \$1.65B in June (combining COVID and non-COVID-19 responses) and changes in people targeted from 7 million people in January to 16.5 million people in June. There will be a mid-year revision of the 2020 HRP which will start in early July.

Partners have responded to the pandemic by re-programming existing resources to contain the spread of the virus. In general, activities entailing direct contact with beneficiaries such as workshops/trainings, field assessments, registration and verification of beneficiaries, have been interrupted or modified. Others have been delayed as a result of social distancing measures as well as government-imposed protection restrictions. This notwithstanding, partners continue to deliver, adapting operational modalities to COVID-19, and only 7 per cent of activities affecting 81 districts have been delayed or suspended.

The Logistics Cluster undertook a gaps and needs analysis in May and has continued to update it to reflect the current changes in the logistics landscape due to COVID-19 challenges.

Approximately 500 IDP sites nationwide were analyzed for steps to follow in the event of a COVID-19 alert, and Risk Communication and Community Engagement activities were undertaken reaching up to 9,000 beneficiaries a week, with audio-messages, and door-to-door sensitization campaigns.

### Challenges and impact to operations

Movement restrictions have been sustained nationally and regionally due to the mitigation measures implemented by neighbouring countries. Cargo-transport capacities are overstretched, and this is exacerbated by the reluctance of transporters to operate in areas highly impacted by COVID-19. In addition, due to COVID-19, partners have an increased need for storage capacity, particularly mobile

# Ethiopia

HRP

storage units for shelter in waiting areas for truck drivers, screening centers and quarantine centers near ports of entry and supplies entry corridors.

WASH IPC measures in treatment and quarantine centers are urgent and critical as the number of COVID-19 patients and returnees who require quarantine and isolation has dramatically increased. Equally urgent is the provision of a minimum of WASH facilities in prioritized IDP sites and IDP host communities.

Heavy rainfall in the last belg/spring season (February to April) resulted in floods affecting around 4.7M people, of whom about 300,000 were displaced. According to the Government's Emergency Public Health Institute, more than 9,000 cholera cases including 117 deaths have been reported. Furthermore, due to the current focus on response to COVID-19, little attention is given to other communicable and non-communicable diseases.

# Haiti

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$144.4M**

### OF WHICH:

HEALTH: 105M  
NON-HEALTH: \$39.3M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$472M**

### OF WHICH:

COVID-19: \$144.4M  
NON-COVID-19: \$327.6M

## PEOPLE

IN NEED: 10.9M  
TARGETED: 10.9M

## Impact of COVID-19

### Immediate health impacts on people and systems

Since the last GHRP update, Haiti has seen an exponential increase in confirmed COVID-19 cases with a 650 per cent increase between 22 May and 22 June. As of 29 June, 5,722 cases were confirmed with 98 deaths. Due to limited testing capacities in the country, lack of adherence to social distancing measures, and stigmatization of COVID-19 patients, the actual number of cases, and most probably deaths, is likely much higher.

The pandemic has already had a devastating impact on the continuity of critical health services. It can be assumed that the provision of all core health services has been reduced, including vaccination campaigns, pre-natal care and childbirth in health facilities. Many people no longer seek treatment due to fear of contagion. Some hospitals have closed because they do not have enough personal protective equipment (PPE) for their staff. Routine immunization programmes have slowed down as some health centres suspended vaccinations, so the risk of reemergence of measles and other communicable diseases has spiked. Malaria and diphtheria rates are higher than at the same time last year. Since surveillance capacity is currently concentrated on COVID-19, the situation regarding other diseases is still being analysed.

### Indirect impacts on peoples and systems

The number of Haitians in need of humanitarian assistance has increased from 4.6 million to 5.1 million. Food security remains a key concern, as currency devaluation, inflation (the price of the basic food basket has increased by 25 per cent), disruption in production and supply chains and a sharp drop in remittances are further limiting people's access to food. Of the 4.1 million people in need of food assistance today, those most vulnerable and facing emergency levels of food insecurity are estimated to have increased from 1.2 million to 1.56 million people.

The current disruption of schooling because of COVID-19 was preceded by months of school closures in late 2019 due to the socio-economic unrest. Against the backdrop of the worsening economic crisis, this results in an unprecedented educational crisis marked by a significant loss of learning and a massive increase in drop-out rates across the country.

Protection risks are being exacerbated by the pandemic. Gender-based violence (GbV) and violence against children is on the rise, although tracking, reporting and response has been affected by the reduction in social services, including education. Discrimination, social stigmatization and violent incidents against COVID-19 patients and facilities remain a concern.

## Response priorities and challenges

### Priorities and early achievements

The UN and NGO partners have been supporting the Government of Haiti to considerably increase its health response capacities, including in setting up and preparing 17 facilities and 29 priority COVID-19 care centres. Almost 140,000 PPE items have been distributed to frontline health responders, and over 1,400 essential personnel have been trained in management of suspected and treatment of confirmed cases, IPC and PPE use. Epidemiological surveillance continues to be strengthened at the border with the Dominican Republic, and a system to monitor returnees for 14 days has been set up. The number of laboratories with capacity for COVID-19 testing have increased from two to four, with support from the UN. Cholera rapid response teams have been reoriented towards the COVID-19 health response, and their number is being increased from 15 to 40 to support the most under-covered areas for an initial period of three months.

The humanitarian community continues to support the Government in ensuring the continuity of routine health services, especially maternal and newborn health, through the provision PPE, setting-up advance triage posts, provide hygiene materials for the health facilities, providing supplies and medicines and improving working conditions for personnel. The number of people targeted with food assistance has been scaled up 1.2 million to 1.56 million, with an extended timeframe for support; some 380,000 of the most vulnerable people were reached between January and May. Protection partners are adapting their response, with a particular focus on GbV and violence against children, for instance by ensuring the availability of GbV hotlines and enhancing the capacity of health structures to receive GbV survivors. Water, sanitation and hygiene services are provided for families with children affected by acute malnutrition and for deportees and returnees.

## Haiti HRP

### Challenges and impact to operations

Some WASH, health, nutrition, shelter and protection activities have been suspended, including nutritional screenings and community-based GbV awareness-raising campaigns. Other activities have adapted to ensure adherence to social distancing measures. Entry of humanitarian staff and cargo into the country has been a significant challenge, and efforts are underway to address it; for example, a protocol for staff movement has been established with the Dominican Republic, and a WFP regional aviation service is under development. The lack of funding is hampering response, particularly in logistics and food security.

# Iraq

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$264.8M**

### OF WHICH:

HEALTH: 65.3M  
NON-HEALTH: \$199.5M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$662.2M<sup>11</sup>**

### OF WHICH:

COVID-19: \$264.8M  
NON-COVID-19: \$397.4M

## PEOPLE

IN NEED: 4.1M  
TARGETED: 1.8M

## Impact of COVID-19

### Immediate health impacts on people and systems

Iraq has seen a significant spike in COVID-19 cases. Throughout March and April, the virus spread relatively slowly, and it was not until mid-May that the daily count of new cases rose above 100. Between the last week of May and the second week of June, the cases recorded accounted for more than 70 per cent of all cases recorded since the start of the pandemic. Similarly, the number of deaths also doubled during this time. Despite the upsurge, the overall case fatality rate (CFR) has decreased compared to the start of the outbreak. Based on results from the more than 400,000 tests, Iraq's positive test rate stands at 6.9 per cent and the case fatality rate at 3.5 per cent. COVID-19 mortality continues to disproportionately affect older persons and men.

### Indirect impacts on people and systems

The economic effects of the pandemic and the containment measures imposed to curb the spread of the virus have resulted in a disruption of trade, transport sectors, banks and financial services and loss of employment. These disruptions could have a long-lasting impact on already fragile communities and lead to an overall increase in socio-economic vulnerabilities. In conjunction with this, the COVID-19 outbreak could also lead to rising humanitarian needs, especially among vulnerable communities with limited coping strategies. While food availability has not been disrupted, access to food has been affected by COVID-19 restrictions. In the wake of the pandemic there have also been reports of an increase in domestic violence including rape, sexual harassment of minors and suicide related to spousal abuse.

## Response priorities and challenges

### Priorities and achievements

The humanitarian response is focusing on the 1.77 million people assessed to be in acute need of humanitarian assistance in the 2020 Humanitarian Needs Overview. To ensure their needs are met and to scale up further, the humanitarian community has mapped the potential

vulnerability to COVID-19 to identify the most vulnerable locations and groups. Based on this, humanitarian partners are responding by: 1) providing immediate health-related response, including measures to prevent the spread of the disease; 2) ensuring adjusted response to new and changing needs due to the different operational environment; and 3) providing food assistance, multi-purpose cash and livelihoods support for the most vulnerable.

Health partners have distributed personal protective equipment (1,170 gowns, 35,970 masks and 61,020 gloves), lab test kits for polymerase chain reaction and rapid diagnostic tests and equipment to four Government-identified COVID-19 management hospitals and 16 laboratories country-wide. Health partners have also supported the set-up of 11 COVID-19 hospitals and the operation of 162 isolation beds. Some 140 health workers have been trained on infection prevention and control, active case finding/contact tracing and case management.

Preventing transmission of COVID-19 in displacement sites remains a priority. To mitigate the risk of an overburdened healthcare system, humanitarian partners are working to prepare camp sites to manage some of the mild cases in isolation areas, while also having space for quarantining contacts or those with travel history. The Camp Coordination and Camp Management Cluster has developed a vulnerability index to see where capacities need to be strengthened in formal displacement camps. Water, sanitation and hygiene partners have ensured over 100,000 hygiene kits have reached vulnerable households in camps and informal settlements.

Humanitarian partners have adopted innovative approaches to ensure affected people continue to benefit from humanitarian services despite the difficult operating environment characterized by humanitarian access challenges, delayed supply chains and reduced physical presence of humanitarian staff.

Humanitarian partners are looking at the effects of shortage of or lack of access to cash liquidity on operations, programming as well as local markets. Education partners have developed protocols for safe return to education facilities. Food security partners have ensured that 271,000

<sup>11</sup> The total humanitarian financial requirements for the humanitarian response in Iraq, including the COVID-19 component, stands at US\$662.2million (\$519.8 million in the original HRP, some of which has been repurposed for COVID-19 response, plus \$142.4 million in new requirements).

## Iraq HRP

people in camps have received food assistance in a timely manner and expanded agriculture-focused activities to support increased livelihood needs of the most vulnerable.

### Response gaps and challenges

#### Challenges and impact to operations

One of the main challenges to the response has been the persistent shortage of personal protective equipment, test kits and hospital equipment. Health partners have procured locally, but high prices and insufficient supply are causing delays.

Curfews and movement restrictions, closure of public offices and community centres, and social distancing measures have also challenged the response. Although governorate-level negotiated access arrangements have allowed humanitarian partners to implement life-saving health services and other time-critical activities, some programmes have been delayed. Gender-based violence response services have reduced by around 50 per cent for case management, 60 per cent for psycho-social support, and 50 per cent for awareness raising activities.

Lack of funding remains a key challenge to the scale and speed of service provision. Flexible funding is required to ensure a timely and effective response throughout the crisis.

# Libya

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$46.7M**

### OF WHICH:

HEALTH: \$16.7M  
NON-HEALTH: \$29.9M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$129.8M**

### OF WHICH:

COVID-19: \$46.7M  
NON-COVID-19: \$83.2M

## PEOPLE

IN NEED: 1M  
TARGETED: 345,000

## Impact of COVID-19

### Immediate health impacts on people and systems

COVID-19 has continued to spread across the country at a relatively slow rate. However, there are concerns that the true scale of the pandemic is not yet known due to the low level of testing. Most confirmed cases have been reported from Sebha in the south, followed by Tripoli and Misrata, although cases have also increased in locations in eastern and central Libya, including in Benghazi, Sirt and Ejdabia.

The fragmented governance in Libya has delayed a national preparedness and response plan for COVID-19. In the absence of a coordinated national response, many municipalities have issued their own directives and taken measures deemed appropriate. Further complicating these efforts is a weak disease surveillance system and lack of reporting to the disease early warning and response network.

### Indirect impacts on people and systems

Recent assessments show that humanitarian needs are deepening and widening. As a result, the estimated number of people in need has been revised to one million people, up from 893,000. Food availability is limited, and the cost of basic goods has increased by 23 per cent compared to before the COVID-19 outbreak. Food insecurity is also increasing among migrants, with a recent assessment highlighting that one in three migrants in Libya is food insecure. Based on a recent assessment, 76 per cent of residents and 87 per cent of displaced households have adopted negative livelihood coping strategies. About 38 per cent of displaced households have reduced health expenditures to cover basic food needs.

Movement restrictions aimed to curb the outbreak have added to the challenges. Many people, especially women, displaced people, migrants and refugees are significantly affected. The worsening economic situation and related impact on people's access to work and livelihoods have increased the risks of domestic violence. The postponement of school openings creates pressure and stress on families, particularly on women who carry the extra burden of home-schooling.

While national immunization campaigns have re-started, shortages of vaccines are putting the lives of over a quarter

of a million children under one year of age at risk. Measles outbreaks, which occur in Libya roughly every two years, present a significant risk. This comes amid ongoing armed conflict, disrupted regular health care services, and regular cuts to electricity and safe water supplies.

## Response priorities and challenges

### Priorities and early achievements

The humanitarian response to address the impact of COVID-19 is focused on: 1) preventing the spread of COVID-19 and reducing morbidity and mortality in Libya; 2) decreasing the deterioration of human assets and rights, social cohesion and livelihoods; and 3) protecting, assisting and advocating for displaced people, refugees, migrants, returnees and host communities particularly vulnerable to the pandemic.

So far this year, humanitarian organizations have reached 178,000 vulnerable people with food, hygiene kits and other essential household items and supported health service delivery and continuation of specialized protection services, including psychosocial support. In coordination with authorities, at least 79,000 people have been reached with COVID-19 related support. Key response activities include:

- Increasing community awareness by distributing more than 28,000 materials providing guidance on risk communication and community engagement
- Advocating for expansion of the national testing strategy by ensuring patients with influenza-like illnesses or severe acute respiratory infections are included, in addition to migrants, and people in detention centres.
- Increasing capacity for testing, tracing and treatment by deploying emergency medical teams to support contact tracing; supporting the establishment of health clinics at three main points of entry; supplying staff with PPE and temperature screening cameras; training more than 40 health staff on case management; and supporting the expansion of testing capacity from two to 13 labs nationwide.
- Improving hygiene practices by training health staff on infection, prevention and control, including waste management in collective shelters, detention centres, health facilities and schools, and providing hygiene kits to low-income households.

## Libya HRP

### Challenges and impact to operations

Despite continued advocacy and efforts to end the fighting, hostilities have continued with nearly 28,000 people newly displaced by conflict since May. Where fighting has stopped, people have been unable to return home due to unexploded ordnance contamination. The UN continues to work with all parties to the conflict to de-escalate the situation and avoid further civilian casualties and displacement.

Humanitarian access continues to be a challenge. In May, humanitarian organizations reported more than 1,000 access constraints, a 19 per cent increase since March. Almost 74 per cent were related to COVID-19 precautionary measures. The global challenges in transport and availability of essential supplies also complicate efforts to bring sufficient supplies into Libya.

Despite these challenges, continued engagement with all authorities has resulted in the successful de-confliction and securing of authorizations enabling humanitarian personnel and supplies to reach those in need. However, moving supplies from Tripoli to other parts of the country, particularly to the east, remains a challenge.

# Mali HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$75.4M**

### OF WHICH:

HEALTH: \$2.1M  
NON-HEALTH: \$73.3M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$474.3M**

### OF WHICH:

COVID-19: \$75.4M  
NON-COVID-19: \$398.9M

## PEOPLE

IN NEED: 6.8M  
TARGETED: 5.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

The number of COVID-19 cases rose from 28 including 2 deaths on 31 March to 2,181 cases, including 116 deaths on 30 June. While cases are mainly located in Bamako district, there is now some concern regarding the increasing trend in the regions, particularly in Timbuktu. In light of the humanitarian needs analysis, humanitarian actors will target 5.5 million out of 6.8 million people in need through the revised HRP. The growing COVID-19 crisis is exacerbating pre-existing vulnerabilities while further increasing humanitarian needs as the expected socio-economic deterioration will affect the most vulnerable.

The virus is spreading in an environment where the health system is already weakened by conflict and insecurity. 23 per cent of health facilities in conflict-affected areas are not functioning and those that are do often not have the required equipment and treatment capacity. Containing the virus will be difficult if it spreads further within IDP sites (over 250,000 IDPs are recorded in Mali) or host families, in prisons, and military camps. In a context of high COVID-19 numbers, the system will not be able to cope (hospitals have almost reached full capacities). As COVID-19 spreads, the cessation of mass vaccination campaigns may lead to new disease outbreaks. More than seven million children under the age of 5 may miss out on the vaccination campaigns initially scheduled for April.

### Indirect impacts on people and systems

The global economic recession and its consequences on the Malian economy are leading to an anticipated drop in GDP growth from 5 per cent to 0.9 per cent. Prices of basic food items have increased in the capital and in the regions in view of the possible disruption of the supply chain resulting from the effects of the border closures and the related slower customs and excise modalities for imports.

As host communities feel the economic impact, this may limit access of refugees, migrants, and IDPs to land and other natural resources in order to cater for their basic needs, such as food and energy. The number of food insecure people could reach five million people between June-August, of which more than 1.3 million will be severely affected, an increase of 107 per cent compared to the 2019

lean period.

Children are particularly vulnerable in the present context, and care structures' response capacity for non-accompanied children or children associated with armed groups are negatively affected. Women are at heightened risk of sexual and gender-based violence as a result of confinement measures and reduced access to livelihood opportunities. Where protection and care services for families with increased socio-economic vulnerabilities are reduced, negative coping mechanisms, such as violence, exploitation and abuse will rise. COVID-19 may trigger an increase in inter-community clashes over access to services, food or medical supplies. Risk of widespread contamination is high in crowded places where vulnerable people gather (IDP sites, prisons etc.).

## Response priorities and challenges

### Priorities and early achievements

Given the needs generated by COVID-19, humanitarian actors are implementing both ongoing, reprioritized, adapted, new and unforeseen COVID-19 related activities as part of the humanitarian response in support to the Government.

Partners continue to support the implementation of the Government's COVID-19 plan, through the Health cluster, in providing Health centers equipment, WASH and medical supplies.

Cluster members are providing NFI kits to IDPs and host families to improve personal hygiene and are ensuring that IDP settlements are re-organized including relocation to ensure social distancing measures are respected.

All students from IDP sites, returnees, host communities and local population are targeted for activities ensuring the continuity of education in a safe and protected learning environment. WASH related activities target personal protection, hand washing, access to water and emergency latrines, adequate waste management to avoid the spread from healthcare centers while ensuring minimal access to EHA services.

The Food Security Cluster continues to prioritize food distribution for 1.3 million people at risk by August and is adapting its food distribution arrangements, increasing the use of cash transfers and livelihood protection. These

## Mali HRP

adapted modalities reduce risk of exposure to COVID 19 for personnel and beneficiaries.

### **Challenges and impact to operations**

Despite the WFP emergency cargo and passenger flights, the supply chain remains difficult with a decline in imported goods due to the closure of the borders in May.

Humanitarian access to hard-to-reach areas and to zones of people in need remains a challenge resulting in limited COVID-19 response. Humanitarian partners, through the HCT, are undertaking advocacy to safeguard humanitarian action countrywide.

The current HRP 2020 is only 26 per cent funded, triggering a high risk of unmet humanitarian needs. The impact of COVID-19 on humanitarian activities is increasing implementation and operational costs as preventive measures are respected to mitigate the risk of the spread of the virus.

# Myanmar

HRP

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$58.8M</b>	HEALTH: \$21.6M NON-HEALTH: \$37.2M	<b>\$275.3M</b>	COVID-19: \$58.8M NON-COVID-19: \$216.5M	IN NEED: 960,861 TARGETED: 914,987

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 6 July, 313 COVID-19 cases have been confirmed in Myanmar with six deaths. Imported cases make up the vast majority of confirmed cases since mid-May. The Government has maintained surveillance at international border crossings as well as at the community level. A number of hospitals have been designated for the treatment of COVID-19 patients and quarantine and contact tracing systems have been established. Laboratory capacity has been expanded significantly and the UN has continued to support the Government's testing strategy, including through the provision of tens of thousands of test kits.

Despite these efforts, a large-scale outbreak would pose very serious challenges for the health system, particularly in humanitarian settings. Internally displaced persons (IDPs) in overcrowded camps and non-displaced stateless persons in rural areas of Rakhine with limited access to healthcare, safe water and sanitation services will be particularly vulnerable in the event of local-level outbreaks. The confirmation of several COVID-19 cases in a refugee transit centre in northern Rakhine in early June was a stark reminder of the very serious risks that remain among the most vulnerable communities.

### Indirect impacts on people and systems

Despite the relatively low number of confirmed cases, COVID-19 continues to severely impact the economy, with disruptions to supply chains, reduced export demand, a halving of tourism revenue and reduced foreign remittances all compounding growing unemployment and a broader economic slowdown. Economic growth predictions are, at best, half that of 2019.

The rapid return of tens of thousands of migrant workers from Thailand, China and elsewhere has generated additional urgent needs for basic assistance at points of entry and quarantine locations, placing further strain on already fragile health services and community resources, particularly in rural areas.

The pandemic has also disrupted food systems, limiting the availability of and access to nutritious food. Water scarcity and food shortages, combined with ongoing conflict, are expected to exacerbate nutrition-related vulnerabilities,

especially among children and women. The long-term impact on nutrition could be severe.

Educational facilities and child-friendly spaces within displaced communities remain suspended, though schools are to reopen in July. These closures have increased child protection risks, learning loss and school dropout rates, with children in displaced and vulnerable communities less likely to return to school, and adolescent girls exposed to heightened protection risks, including gender-based violence (GBV). Schools have been widely used as quarantine facilities, creating further complications for the timely and safe resumption of education.

## Response priorities and challenges

### Priorities and early achievements

The Humanitarian Country Team has updated the COVID-19 Addendum to the 2020 Myanmar Humanitarian Response Plan, which now extends until the end of 2020. The update provides for support for an additional 10,000 returning migrants, with COVID-19-specific financial requirements having increased by US\$13 million to \$275.3 million.

Humanitarian organizations are continuing to scale up COVID-19 prevention and response preparedness in camps, displacement sites and conflict-affected areas, as well as supporting Government efforts to assist returning migrant workers in quarantine facilities. Activities include further strengthening surveillance systems, enhanced infection prevention and control measures in public places, quarantine and health facilities, case management and contact tracing.

Response activities include:

- **Education:** Continuing remote support to children, teachers, and parents and caregivers; remote support to volunteer teachers and implementation of home-based learning packages.
- **Food Security:** Adapted distribution arrangements to reduce the risk of transmission; expanded number of distribution points to further reduce risks.
- **Protection:** Ongoing work to ensure protection considerations incorporated into COVID-19 preparedness, prevention and response activities with a focus on child protection, GBV and mental health and psychosocial

# Myanmar

HRP

support. GBV data collection to be increased concurrent with implementation of legal, policy and administrative tools, and capacity-building with government partners.

- Shelter/NFIs/CCCM: Prepositioned ready-to-deploy shelter solutions in support of Government facility quarantine locations as well as other infrastructure to expand/enhance medical facilities and support the local production of PPE.
- WASH: Expanded hygiene promotion and RCCE activities; increased supply of hand washing stations/materials and disinfection materials.

## Challenges and impact to operations

The operating environment remains highly constrained and is becoming more challenging. Existing access restrictions – notably in non-government-controlled areas and conflict-affected parts of Rakhine and Chin states – will likely persist. The reach of health services into non-government-controlled areas remains limited, and the capacities of ethnic health organizations operating in these areas are severely stretched. For IDPs in camps, overcrowding, poor sanitary conditions and lack of space for self-monitoring and quarantine will exacerbate the virus risk and challenge the response.

Access constraints and a ban on mobile internet services in most conflict-affected townships in Rakhine continue to impede humanitarian assistance as well as communication of risk messages and referral instructions. The safe collection and transportation of specimen samples from conflict-affected areas and non-government-controlled areas also remains challenging.

International supply chain disruptions have restricted procurement of life-saving medical and other supplies. Enhanced disease surveillance and a clear understanding of patient referral pathways for camps is crucial, especially in non-government-controlled areas and areas of active armed-conflict, particularly as the monsoon takes hold across much of Myanmar, bringing with it additional health risks and logistical challenges.

# Niger

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$82.3M**

### OF WHICH:

HEALTH: \$15.7M  
NON-HEALTH: \$66.6M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$516.1M**

### OF WHICH:

COVID-19: \$82.3M  
NON-COVID-19: \$433.8M

## PEOPLE

IN NEED: 3.7M  
TARGETED: 3.0M

## Impact of COVID-19

### Immediate health impacts on people and systems

The first case of COVID-19 was reported in Niger on 19 March. As of 30 June, the Ministry of Health has reported 1,062 cases of COVID-19 from 6,825 tests; including 924 recoveries, 71 people undergoing treatment and 67 deaths. Niamey remains the epicentre of the pandemic with over 70 per cent of the confirmed cases while Zinder and Agadez are the other most affected regions.

The epidemic peaked on 9 April with 69 new cases followed by a consistent downward trend in the number of reported cases. However, weak surveillance and alert systems might obscure the real scope of the pandemic. Niger, which mostly limits screening to symptomatic cases, has a capacity of 1.8 tests per 10,000 people, compared to 5.5 tests in Namibia, 3 in Mauritius and 2.1 in Angola. On the other hand, as of 30 May, almost 7 out of 10 patients (69 per cent) have recovered, ranking Niger among the top four countries with the highest cure rate in Africa.

Healthcare structures dedicated to the treatment of COVID-19 have been set up but remain limited both in Niamey and in the regions. Even before the pandemic, disparities between urban and rural areas, difficulties in supplying medicines, shortage of qualified human resources and their uneven deployment had negatively impacted the provision of care. With 184 health workers exposed and infected by COVID-19, the population has been reluctant to seek services in health centres, leading to a vicious cycle of strong community transmission and a high mortality rate of 6.24 per cent. The increasingly weakened health system and low attendance of health care structures are threatening to reverse the few gains in vaccine coverage against measles and polio and the decrease in maternal and infant mortality rates.

### Indirect impacts on people and systems

The Covid-19 pandemic has seriously impacted Niger's socio-economic situation and exacerbated existing vulnerabilities. The Government has revised its GDP growth projections from 6.9 per cent to 1 per cent. The budget deficit is expected to reach 5 per cent compared to the 2.7 per cent forecast and the inflation rate is 4.4 per cent, up from 2.6 per cent.

Due to the economic downturn and containment measures, 5,6 million people will be at risk of food insecurity during the lean season from June to September (23 per cent per cent of the total population), compared to 1,9 million anticipated at the beginning of the year. In addition to the deterioration of the nutritional situation forecast by the March IPC analysis, Covid-19 has resulted in the erosion of infant and child feeding practices (IYCF) and childcare practices, a slowdown in nutrition awareness and prevention activities and the reduction of access to health and nutrition services. The number of children suffering from SAM is expected to increase by 35 per cent and the number of children suffering from MAM by 27 per cent.

As schools and universities reopened on 1 June, there are concerns about the capacity of authorities to guarantee the health and safety of children, particularly during the rainy season (June-September).

Out-of-school children are particularly exposed to the risks of abandonment by their families who have difficulties in meeting their needs. Street children and "talibé" children are at high risk of exploitation, recruitment by armed groups, stigma and violence, as evidenced by the recent forced return of 8,500 talibé children and their Koranic teachers from Nigeria in the context of COVID-19.

Other high-risk groups include employees in the informal sector, households who depend mainly on cash transfers, families whose members are affected by chronic diseases and COVID-19, women and girls, adolescents and people with disabilities.

Internally displaced persons, returnees, refugees and host communities living in conflict areas bordering Nigeria (Diffa and Maradi regions), Burkina Faso and Mali (Tahoua and Tillabéri regions) are particularly vulnerable due to their precarious living condition and insecurity. In addition, 63,000 migrants remain stranded in overcrowded reception and transit centres in Agadez, Niamey, Tahoua and Zinder.

## Response priorities and challenges

### Priorities and early achievements

As of 17 May, almost 120,000 children under five were admitted for SAM treatment (30,1 per cent of the annual target). From April to May, 335,686 pregnant and lactating women and mothers of children aged 6-23 months were

# Niger

HRP

reached with counselling on IYCF coupled with COVID-19 prevention messages.

NFI kits were adapted with increased quantity of soap, the inclusion of individual hygiene items, and larger household capacity to store water. Almost 324,000 people were reached with awareness raising activities on COVID-19 and hygiene promotion. From March to June, over 42,500 individuals received NFI kits. Some 71 schools, 100 health facilities and 108 public places were provided with hand washing facilities. Support was provided to the government to set up quarantine sites in Agadez and Niamey for returning Nigerien migrants.

Education partners are supporting the Government to collect data on school dropouts and to detect cases of sexual abuse such as early marriages. Protections actors have reinforced psychosocial support as well as GBV awareness for 12,000 people. Child protection actors continue to work to prevent child separation and abandonment.

## Challenges and impact to operations

Major challenges pertain to insufficient health capacity in quantity and quality, particularly outside urban centres and the high number of health workers infected with COVID-19, representing 20 per cent of all infected people. The response to Covid-19 has been further complicated by low adherence to social distancing rules, low community involvement and stigmatization of affected individuals.

Additional resources are needed for the roll-out of combined health and nutrition campaigns, such as the seasonal malaria chemoprevention campaign with screening of acute malnutrition and the vitamin A supplementation associated with vaccination campaigns, such as for polio or measles. Data collection on admissions for acute malnutrition and quality of care requires strengthening.

With the re-opening of schools, it is urgent to strengthen prevention activities, given the significant gap in the availability of masks and WASH equipment in schools.

Funding gaps, and continued insecurity in the West (Tahoua and Tillaberi), South and South-East (Maradi and Diffa) regions, and the extension of the State of emergency in Diffa, and some Departments in the Tillaberi (10) and Tahoua (2) regions are also hampering adequate response to the growing food insecurity.

# Nigeria

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$242.4M**

### OF WHICH:

HEALTH: \$85.3M  
NON-HEALTH: \$157.1M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.08B**

### OF WHICH:

COVID-19: \$242.4M  
NON-COVID-19: \$838M

## PEOPLE

IN NEED: 10.6M  
TARGETED: 7.8M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 28 June, over 24,000 COVID-19 cases and 558 deaths have been confirmed in Nigeria<sup>12</sup>. Borno, Adamawa and Yobe (BAY) States recorded over 600 cases, with almost 80 per cent of cases in Borno state. Limited capacity and pace of testing could be resulting in serious underreporting<sup>13</sup>.

The impact of the humanitarian crisis in the conflict-affected BAY States presents one of the most significant vulnerabilities to the spread in Nigeria. IDPs are at high-risk due to the extreme congestion in IDP camps - less than one square meter per person in some locations - which makes it impossible to practice social distancing measures.

The humanitarian situation is worsening due to COVID-19, mainly against the backdrop of damaged health infrastructure and ongoing stressors on the health system, and an increase in projections from 7.9M pre-COVID, to 10.6M people in need for the remainder of 2020. A tightening of pre-existing movement restrictions, deterioration in security, rapid economic decline coupled with strained public services will further increase humanitarian needs and compound existing operational challenges.

### Indirect impacts on people and systems

Nigeria, as one of the biggest three economies in Sub-Saharan Africa, will undergo its worst recession in 40 years due to the outbreak<sup>14</sup>. As a significant producer of crude oil, reduced revenue has resulted in a large-scale cut in public expenditure and financing, hampering the government's ability to fund social safety net programs which will see a rise in vulnerabilities. Income inequality will impact livelihoods and poverty. A disruption to supply chains and agricultural production will severely hamper affected communities. Health resources are being diverted from primary and preventive healthcare, and tackling other health emergencies, including a disruption of

vaccination campaigns and other essential health services in inaccessible areas. About 400,000 IDP children are impacted by the closure of schools and learning activities.

The short, mid and long-term effects of the crisis on individuals that lost livelihoods will increase dependency on food assistance, thereby expanding the current humanitarian burden across the BAY States and beyond. Food consumption is expected to deteriorate further as vulnerable households approach the lean season (June-August) and expose households to intersecting health and nutrition vulnerabilities. Initial estimates by WFP indicate that an outbreak in the BAY states would impact the economic livelihoods of 7 million people resulting in an increase in the number of food-insecure individuals by 3.4 million<sup>15</sup>.

## Response priorities and challenges

### Priorities and early achievements

Humanitarian actors are maintaining critical programmes to ensure partners deliver to the most vulnerable IDPs, refugee returnees and host communities. In a context of rising COVID-19 cases, high level of congestion in IDP camps, porous borders with neighbouring, and constant movement of people due to conflict around the Lake Chad Basin, CCCM, Shelter and NFIs sectors' partners have developed a decongestion strategy to advocate for additional land to decongest Borno's 49 highly congested camps due to fears that as many as 430,000 IDPs could become infected in the event of a simultaneous outbreak in 'highly congested' camps.

The country's testing capacity has increased from 5 to 23 labs<sup>16</sup>, including one in Borno. Measures are in place to ensure routine health services remain available to all camp and host communities. Existing community-based surveillance has expanded in all accessible areas for diagnostics, potential isolation, and case management. Access to emergency obstetric care and skilled birth

<sup>12</sup> <https://covid19.ncdc.gov.ng/>

<sup>13</sup> UN in Nigeria, Briefing Note 2 (april 2020). COVID-19 Pandemic, Potential Impact on the North East.

<sup>14</sup> <https://www.worldbank.org/en/news/press-release/2020/06/25/nigerias-economy-faces-worst-recession-in-four-decades-says-new-world-bank-report>

<sup>15</sup> UN Nigeria, Briefing Note 2, *ibid*.

<sup>16</sup> A communication by NCDC Nigeria, 10 May 2020 <https://web.facebook.com/NCDCgov/photos/a.1273809412682079/3206373329425668/?type=1&theater>

# Nigeria

HRP

attendance, including postpartum monitoring, is a priority.

Joint planning and monitoring mechanisms across the sectors are ongoing, for example the Health and Nutrition Sector are treating children with acute malnutrition. Health, WASH and CCCM, Shelter sectors are targeting infection prevention and containment, improvement of water and sanitation facilities. Nutrition interventions are modified to minimal or no-touch approaches to reduce the risk of exposure.

## Challenges and impact to operations

Underfunding and limited health infrastructure are a significant challenge. There are five hospital beds available for every 10,000 people in Nigeria. Access to people in inaccessible areas and land to support the decongestion of overcrowded IDP camps, remains a major challenge for prevention, testing and treatment. The humanitarian team continues to promote humanitarian principles, standards and an allocation of land to reduce human to human transmission through decongestion of reception centers and camps.

The lack of adequate MUAC and RUTF are impacting the scale-up of Mother/Family MUAC approaches and pipelines to cover a possible increase in SAM.

Movement restrictions have significantly impacted access to protection services by the most vulnerable. There is a need to restore access and resume protection monitoring activities.

# occupied Palestinian territory HRP

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$42.4M</b>	HEALTH: \$19.1M NON-HEALTH: \$23.3M	<b>\$390.4M</b>	COVID-19: \$42.4M NON-COVID-19: \$348M	IN NEED: 2.4M TARGETED: 1.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

On 5 March, the Palestinian Authority (PA) declared a State of Emergency across the oPt after detecting the first COVID-19 cases in Bethlehem. As of 30 June, 2,698 Palestinians were confirmed positive, of which 97 per cent are in the West Bank (including East Jerusalem) and three per cent in the Gaza Strip, with eight deaths and 625 recoveries. Thirteen patients suffering from COVID-19 are in serious or critical condition.

The number of confirmed COVID-19 cases quadrupled over the second half of June, following a gradual lifting of public health restrictions, with the epicenter in the Hebron governorate. The PA have reinstated lockdowns and other restrictions across the West Bank. Palestinians entering the oPt from Jordan, Egypt and Israel, are required to be medically checked and to undergo mandatory quarantine at home or at quarantine facilities. However, these requirements have not been enforced strictly for Palestinians entering the West Bank from Israel.

Due to COVID-19 imposed access restrictions, patient referrals from the Gaza Strip for critical care in West Bank hospitals fell by over 90 per cent in April and May, compared to previous months. The financial situation for East Jerusalem hospitals has been further undermined following the decline in referrals from the rest of the oPt due to the same reasons.

### Indirect impacts on people and systems

According to the World Bank, the Palestinian GDP could decline by some 10 per cent in 2020 due to COVID-19 imposed restrictions. Unemployment in the first quarter of 2020 reached some 45.5 per cent in Gaza and 14.2 per cent in the West Bank.

Additionally, the PA is facing an unprecedented fiscal crisis, due to a loss of revenue brought on by the COVID-19 pandemic and following their decision to stop accepting clearance revenues that Israel collects on their behalf, in response to Israel's stated intention to annex parts of the West Bank. The PA has now lost 80 per cent of its monthly revenue. This gap cannot be filled by donors. Starting in May, the PA suspended payment of public employees' salaries and social assistance benefits to the poor families and, from

September, it will no longer pay for essential health services, such as childhood immunization.

Movement restrictions have reduced access to social services, with greater impact on vulnerable people, older persons, persons with disabilities, Bedouin communities, households isolated by the West Bank Barrier and undocumented residents of East Jerusalem.

Also concerning are overcrowded living conditions in poor areas and in 19 UNRWA refugee camps housing some 800,000 people.

School closures have affected 1.43 million children, impacting significantly on those who could not benefit from distance-learning.

Mental health service providers have reported a surge in cases of GBV affecting women and children.

## Response priorities and challenges

### Priorities and early achievements

Following the recent surge in cases, the continued priorities are to scale up testing, trace contacts, isolate and treat confirmed cases, and limit transmission at governorate level.

- Efforts led by the PA included administering over 92,000 tests, and establishing 51 formal and informal quarantine facilities, and 18 treatment facilities in the West Bank and two in Gaza.
- Health partners provided testing kits and laboratory supplies for some 20,000 tests, medical supplies for critical cases, and PPE kits and other protective items for 50,000 frontline health workers.
- A communication campaign reached 1.5 million Palestinians through 14.9 million content views on social media and six million text messages with messages about virus transmission and prevention.
- Protection partners adapted to deliver GBV and mental health and psychosocial services remotely, reaching thousands through online platforms and phone hotlines.
- Education partners supported the development of e-learning platforms reaching more than 100,000 children, providing sanitation and hygiene support to enable some 78,000 students to take their 12th grade exams, and establishing a framework for reopening schools in August.

## occupied Palestinian territory HRP

- WASH and shelter partners supported quarantine centres, providing water, NFIs, hygiene kits and cleaning materials.
- Food security partners scaled up food e-voucher allocations to include emerging vulnerable groups, adapting modalities for food distribution and providing support to vulnerable farmers and herders.

### Challenges and impact to operations

Coordination between the three authorities operating in the oPt – the PA, Hamas, and Israel – began to deteriorate in May. The PA's decision to halt all coordination with Israel, has posed significant bureaucratic challenges and has stalled the import of medical supplies. Also, a rise in tensions between the PA and Hamas has impeded the delivery of social services in Gaza.

Global shortages have also impaired the procurement of essential supplies. There is a need for testing kits, ventilators, ICU beds, and multiple PPE and consumables. Overall, health facilities, especially in Gaza, remain largely unprepared for a surge in cases.

Movement restrictions and physical distancing measures limit the ability for humanitarian actors to undertake in-person assessment and monitoring. The provision of cash assistance has been disrupted, as banks have stopped receiving clients. Cash for work interventions have also been impacted, due to the closure of educational facilities and other institutions.

# Somalia HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$225.6M**

### OF WHICH:

HEALTH: \$81.0M  
NON-HEALTH: \$144.6M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.0B<sup>17</sup>**

### OF WHICH:

COVID-19: \$225.6M  
NON-COVID-19: \$784.3M

## PEOPLE

IN NEED: 5.2M  
TARGETED: 3M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 2 July, there were 2,924 Covid-19 cases in Somalia, with 90 deaths. Somalia has 18 isolation facilities with 376 beds. Testing and contact tracing are ongoing, including in overcrowded IDP settlements. Health partners have deployed over 1,000 rapid response teams, reaching over 4,000 IDP settlements by the third week of June. With 2.6 million IDPs in Somalia and more than 560,000 people displaced so far in 2020, testing at IDP sites remains insufficient.

### Indirect impacts on people and systems

Somalia is experiencing a triple threat: COVID-19, flooding and the worst Desert Locust upsurge in decades. Heavy Gu' (April-June) rains caused flooding affecting 1.2 million people, with 29 people killed and 436,000 displaced. Flooding contributed to increased acute watery diarrhea (AWD)/cholera<sup>18</sup> while above average rains created a conducive environment for further locust breeding. Notwithstanding ongoing control efforts, the Gu harvest could be 20 to 30 per cent lower than average due to the combined impacts of Desert Locust and other pest infestation and flooding. Without sustained humanitarian assistance, 3.5 million people are projected to fall into Crisis or emergency food insecurity (IPC Phase 3 or higher) during the third quarter of the year.

Heavy Gu' (April-June) rains caused flooding affecting 1.3 million people, with 29 people killed and 505,000 displaced.

COVID-19-related Government directives, disruptions to imports and flooding have impacted the availability of basic commodities and driven up prices. Despite the Federal Government's suspension of taxes on basic commodities from April to June, the purchasing power of many Somalis, especially daily-wage and casual labourers, is significantly reduced.

Whilst the resumption of livestock export in April 2020 is positive, livestock exports from June to August, the peak demand period, are expected to be 30 to 50 per cent below average. Moreover, the labour market remains stagnant due to COVID-19 restrictions, especially for the most vulnerable, including IDPs.

Closure of schools has left more than one million students without a physical classroom. While some states have shifted learning to radio, TV and internet, this is only accessible to 12 per cent (132,000 people) of affected students.

With almost 264,000 people forcibly evicted in 2019 and close to 65,000 in the first four months of 2020<sup>19</sup>, humanitarians have advocated with national authorities for a nation-wide moratorium on evictions during the COVID response<sup>20</sup>. In April, a directive was issued in South West State to suspend evictions in Baidoa. Advocacy continues for broader adoption of a moratorium.

## Response priorities and challenges

### Priorities and early achievements

Recognizing the significant contextual shifts since the finalization of the 2020 HRP (January), the HCT launched a rigorous HRP prioritization exercise to ensure a needs-based, prioritized and credible humanitarian ask in response to the "triple threat." Clusters and partners reviewed the PiN, people targeted and financial requirements, and identified interventions for scale up, reduction and adjustment in light of COVID-19.

At least 294,300 people have received essential health assistance and 33,260 people received case management services, while over 690,000 people have benefitted from infection prevention and control activities. Over 45 metric tonnes of essential medical supplies have been airlifted to various states, 2,000 PPEs distributed, 20 ventilators delivered to De Martino Hospital in Mogadishu and 3,346

<sup>17</sup> The decreased financial requirements reflect a rigorous HRP prioritization exercise, not an improved humanitarian situation in Somalia. In addition to still facing the needs identified in the original 2020 HRP, Somalis are experiencing new challenges and constraints, for which funding is urgently required.

<sup>18</sup> Between January 2020 until mid-June 4437 AWD/cholera and 24 deaths were reported in 23 districts, more than a three-fold increase over the same period in 2019 (1041 cases and 1 death).

<sup>19</sup> HLP AOR eviction portal (<https://evictions.nrcsystems.net/dashboard.php>)

<sup>20</sup> The moratorium is applying to: Public and private properties, Land/properties used for housing; Land/properties used for commercial and productive purposes (shops, offices, spaces in marketplaces).

## Somalia HRP

community health workers trained. WASH and Health partners have intensified AWD/Cholera prevention and response activities, increased training for private water operators to ensure safe water handling and strengthened coordination with state-level Health and Water Resource Ministries. The Protection and CCCM Clusters have worked jointly to reinforce referral systems for identified protection cases. Humanitarian partners have provided two-month food rations and scaled up food assistance, reaching 2.3 million people in May. Moreover, 296,387 mothers and caretakers of children 6 to 23 months received individual infant and young child feeding counselling, and 88,613 children under the age of five years were admitted for severe acute malnutrition treatment. Among the 10.9 million people reached through COVID-19 risk communication and community engagement, 1 million are IDPs in 867 sites.

### Challenges and impact to operations

Delivery of services has been affected by insufficient PPE and trained health care workers. Moreover, security has not improved, impacting humanitarian interventions and delivery of supplies. Adaptation of programmes, including suspension or reduction of some activities, increases the risk of poor health outcomes. Additional isolation centers are required, while improved triage and infection prevention and control in healthcare facilities is critical. Gender-based violence referral, mental health services and psychosocial support must be expanded. Continuity of WASH interventions to mitigate post-floods and cholera impact, especially in high-risk locations such as displaced sites and at points of entry, is essential. Most clusters are underfunded, requiring partners to further reduce activities.

# South Sudan HRP

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$387.3M</b>	HEALTH: \$91.4M NON-HEALTH: \$296.0M	<b>\$1.9B</b>	COVID-19: \$387.3M NON-COVID-19: \$1.5B	IN NEED: 7.5M TARGETED: 7.4M <sup>21</sup>

## Impact of COVID-19

### Immediate health impacts on people and systems

The number of confirmed COVID-19 cases continues to rise in South Sudan. As of 28 June, 1,989 cases were confirmed, with 246 recoveries and 36 deaths. At least 16 counties have been affected across the country, with Juba, the capital city, being most affected. Insufficient testing capacity in the country limits the ability to accurately assess the scope of the pandemic. Health infrastructure is constrained, with a very small number of intensive care beds (134), equipment and skilled human resources. Patient bed capacity with key medical equipment necessary for COVID-19 case management is only available in Juba.

### Indirect impacts on people and systems

The COVID-19 pandemic strains the already weak health system. COVID-19 related movement restrictions have constrained deployment of personnel and medical supplies, affecting the ability of the health system to respond to the ongoing outbreak and other non COVID-19 health needs.

Falling global crude oil prices and the COVID-19 pandemic mitigation measures have had a negative impact on the economy. A growing number of people living in urban areas are identified as vulnerable due to a number of factors including plummeting oil prices, rising food prices, loss of employment and livelihoods. The rural poor are also becoming more vulnerable and food insecure due to the disruption to trade exacerbated by COVID-19. Meanwhile, COVID-19 related morbidity, movement restrictions, social distancing rules and labour shortages have a negative impact on the general food supply in South Sudan. Overall, an additional 1.6 million people will be in need of humanitarian assistance during the remainder of 2020.

The country has close to 1.6 million people internally displaced and 300,000 refugees. Over 430,000 people (26 per cent) of all IDPs are sheltering in camps or camp-like settings. The congested nature of the sites presents a high risk of COVID-19 transmission.

The COVID-19 outbreak also has significant, differentiated effect on women, older persons, adolescents, youth, children and persons with physical and psychological disabilities.

South Sudanese women and girls already face extreme levels of gender-based violence (GBV), much of which goes underreported. Despite the pervasive nature of GBV, there is limited availability and access to GBV services.

Quarantine measures, school closures and movement restrictions have also disrupted children's routine and social support structures. Left without access to a protective environment at school, the risk of children being neglected, abused or exploited increases significantly.

## Response priorities and challenges

### Priorities and early achievements

The humanitarian community is supporting the national COVID-19 response to mitigate the transmission and improve capacities for surveillance, contact tracing, rapid response, testing and case management. The capacity of the existing COVID-19 wards has been expanded from 24 to 134 beds. To address the anecdotal reports of increasing community deaths, the Ministry of Health in collaboration with partners is planning to deploy COVID-19 mortality surveillance teams.

Humanitarian partners are focused on supporting the public health response, while sustaining provision of essential services. Prevention and mitigation measures are supported through risk communication and community engagement activities. Key achievements by the UN and NGOs in support of the national response include:

- More than 4 million people reached with risk communications messages.
- 300,000 internally displaced people reached with COVID-19 preventive messaging in Protection of Civilians sites and camp-like settings;
- 265 health facilities supported with infection prevention and control supplies;
- 134 beds made available for admission of severe and critical COVID-19 patients;
- 350,000 refugees and host community members have received soap on a monthly basis;
- 3.2 million people reached with advanced food rations ahead of the lockdown and travel restrictions;

21 5.8 million are targeted out of the 2020 HNO and an additional 1.6 million market-dependent newly vulnerable populations in urban and rural areas.

## South Sudan HRP

- Eight weekly radio shows held on COVID-19 related protection and human rights issues;
- Two national helplines established to provide remote support and facilitate referrals for gender-based violence survivors during COVID-19.

### Challenges and impact to operations

Medical supplies and equipment, including Oxygen Concentrators, PPE and visibility of the pipeline are identified as critical gaps. The capacity of humanitarian partners to import emergency life-saving relief items is contingent on the availability of funding.

COVID-19 has magnified pre-existing access constraints, including bureaucratic impediments, violence against humanitarian personnel and movement restrictions. These are coupled with longstanding access restrictions related to inter-communal violence, armed clashes and roadside ambushes. The spike in intercommunal fighting is impacting humanitarian service delivery and putting aid workers at a greater risk.

# Sudan

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$283.5M**

### OF WHICH:

HEALTH: \$128M  
NON-HEALTH: \$155.6M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.63B**

### OF WHICH:

COVID-19: \$283.5M  
NON-COVID-19: \$1.35B

## PEOPLE

IN NEED: 12.2M<sup>22</sup>  
TARGETED: 8.75M<sup>23</sup>

## Impact of COVID-19

### Immediate health impacts on people and systems

COVID-19 cases have continued to increase. As of 24 June, there were 9,257 people confirmed to have COVID-19 in Sudan, including 572 fatalities. Official figures of confirmed cases underestimate the extent of the pandemic in Sudan due to limited testing capacity. For the majority of cases, the transmission chain remains difficult to establish. Movement restrictions have slowed the distribution of critical medical supplies from the national medical supply fund – and reportedly, only 15 per cent of essential medicines and supplies are available on the open market. Several states and cities have closed private health practices to contain COVID-19 – limiting people's access to medical/health care for non-communicable diseases. The disease surveillance system is overwhelmed by response to COVID-19.

### Indirect impacts on people and systems

Polio supplementary immunization activities have been suspended through to end of year. Measures put in place to contain and mitigate the spread of COVID-19 are exacerbating the ongoing economic crisis in Sudan. Such measures are restricting access to livelihood activities, impacting poor households' ability to cover daily food needs. The inflation rate spiked from 82 per cent in March to almost 114 per cent by the end of May. Rising inflation is disproportionately affecting the poor, vulnerable IDPs and refugees.

Prices of sorghum, millet and wheat increased by 20 to 50 per cent between April and May. An estimated 9.6 million people (21 per cent of the population) are experiencing Crisis or worse levels of food insecurity (IPC Phase 3 or above) and are in need of urgent action. This is the highest figure ever recorded in the history of IPC in Sudan compared to previous years. Around 2.2 million people are facing an Emergency acute food insecurity situation (IPC Phase 4) and around 7.4 million people are facing Crisis acute food insecurity (IPC Phase 3). The states with highest acute food insecurity are South Kordofan, Blue Nile, North Darfur, Central Darfur, West Darfur, Red Sea, Kassala, South Darfur,

North Kordofan and East Darfur<sup>24</sup>.

IDPs, refugees, asylum seekers and returnees face increasing risks of gender-based violence (GBV) and exploitation such as trafficking, child labor, and early marriage. Refugees are highly vulnerable due to overcrowding in refugee camps and settlement locations. Due to lockdowns and additional movement restrictions, refugees' already limited livelihoods opportunities have further reduced, exacerbating risks of protection concerns.

## Response priorities and challenges

### Priorities and early achievements

Risk communications and community engagement efforts are ongoing. An estimated total 31 million people - 74 per cent of Sudan's population - have been reached with various communication channels, including media outlets. Infection control supplies are being dispatched to the States. Partners continue to train rapid response teams as well as community members in surveillance. The implementation of localized response plans activated in all major refugee camp locations is underway. Partners are distributing a two-months food ration (cash and in-kind). GBV hotlines have been set up to provide remote services including referrals. To ensure continuity of essential health services which have been overwhelmed by COVID-19 response, partners are prioritizing disease surveillance; enhancement of supply chain for medical supplies and stepping up preparedness and response to anticipated emergencies such as floods and disease outbreaks.

### Challenges and impact to operations

While airports remain closed to commercial flights, as of early June, Khartoum International airport is open for humanitarian passenger flights, under strict quarantine measures. Meanwhile, internal UNHAS passenger flights are grounded, limiting the ability of staff to move to field locations. Movement of humanitarian supplies by road is delayed due to fuel shortages and the time required to process permits. Delay in clearance of medical supplies is constraining response. Additionally, lack of fuel and

22 This includes 9.3 million people in the HNO/HRP and an additional 2.8 million as a result of COVID-19.

23 This includes 6.1 million in the HRP and an additional 2.7 million as a result of COVID-19.

24 IPC July 2020.

## Sudan HRP

movement restrictions impacts timely transportation of supplies. As part of the measures to prevent the spread of COVID-19, ships passing through Port Sudan - the main port for the imports of strategic commodities - remain in quarantine for 14 days, which delay any consignments, including vital medicines and medical supplies.

Despite an increase in testing capacity to more than 800 tests per day in June, testing remains low. Lab capacity is increasing, but the collection of samples and transportation to the lab for processing is causing delays in confirming cases. UNHAS is supporting the transport of samples for testing. Other gaps include supplies for isolation centers; PPEs for medical staff; low stock of medicines and medical supplies to sustain COVID-19 and non-COVID-19 related illnesses, and limited capacity to support ICUs and ventilators.

# Syria

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$384.2M**

### OF WHICH:

HEALTH: \$157.5M  
NON-HEALTH: \$226.7M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$3.82B**

### OF WHICH:

COVID-19: \$384.2M  
NON-COVID-19: \$3.43B

## PEOPLE

IN NEED: 11.1M  
TARGETED: 9.8M

## Impact of COVID-19

As of 14 July, the Syrian Ministry of Health had confirmed 417 cases of COVID-19, including 19 deaths and 136 recoveries. An additional six cases were reported by local authorities in north-east Syria (NES) and five laboratory-confirmed cases had been registered in north-west Syria (NWS). Reported figures represent a sharp increase over the past month and underline why the Syrian population continues to be considered at high risk, particularly when combined with low levels of testing, recent relaxation of precautionary measures, the spread of COVID-19 in neighboring countries and a weak health system.

The socio-economic impacts of COVID-19, including from mitigation measures such as border closures and movement restrictions implemented from March to May, have affected large segments of the population. These measures have added to consistent macroeconomic decline in recent years, further spurred by the regional financial crisis in Lebanon. The latter has contributed to the depreciation of the Syrian Pound (SYP), which reached its lowest informal exchange rate against the US Dollar in June (SYP 3,200 to US\$ 1). As a result, prices of essential goods and services have surged, further impacting a population already struggling to make ends meet.

The price of an average food basket in early June stood at SYP 76,327, approximately 35 per cent higher compared to May – and over 200 per cent higher when compared to June 2019. Locally produced and procured relief items, notably WASH, sanitation supplies and medicines, have also been affected by these price hikes, increasing humanitarian response costs and affecting the implementation of humanitarian activities.

These developments exacerbate existing humanitarian needs: according to WFP, 9.3 million people are considered food insecure as of late May, an increase of 1.4 million people in the past six months alone. Surveillance data shows the most severe deterioration of the nutrition situation in NWS since the beginning of the emergency response in Syria, with acute malnutrition rates in some

places substantially rising above emergency thresholds of 15 per cent in children under five years old, particularly in hard to reach areas and those hosting large numbers of IDPs. Mitigation measures have spurred the loss of jobs, particularly for those reliant on daily wage labor or seasonal work, increasing the likelihood of more people being pushed into food insecurity and no longer able to cover basic needs related to shelter, WASH, education, nutrition and health in the coming months.

In north-west Syria, where at least 1.3 million people live in IDP sites, overcrowding in collective centers and other shelters increases infection risk. Women, children and other vulnerable groups such as persons with disabilities and older persons are disproportionately affected by the deteriorating conditions, including with regard to protection issues and gender-based violence, that are reported to be on the rise in parts of the country. Maintaining basic humanitarian services to mitigate the impact on at-risk populations is crucial.

## Response priorities and challenges

Surveillance and testing capacity remain bottlenecks. The daily testing capacity has risen to 345 – with significant variations across the country<sup>25</sup>. Just over 12,000 tests have been conducted in six laboratories and one testing site (out of 17 planned)<sup>26</sup>. Increasing capacity of rapid response teams and sample collection also remain priorities to improve case detection. More than 3,600 humanitarian personnel, particularly health care workers, have been trained in infection, prevention and control, and 1,180 health care workers have been trained in case management. Twenty-four (out of 54 planned) isolation centers have been set up at governorate level, equipped with life-saving essentials<sup>27</sup>.

Within Syria, many humanitarian partners have reported that the volatility of the informal exchange rate has led to temporary suspension of local procurement, including PPEs and other vital COVID-19 related materials, affecting programme delivery. In NES and NWS, these challenges are coupled with restrictions and disruptions of imports that

25 Daily testing capacity varies significantly across Syria, with 250 tests performed on average within Syria, ninety in Turkey and five in NES.

26 Testing laboratories and sites are distributed as follows: one Central Public Health Laboratory (CPHL) in Damascus; three public health laboratories in Aleppo, Latakia and Homs; one testing facility in Idleb; one in Qamishli, currently operating two days a week, and one testing site in Tell Refaat.

27 Isolation centres are geographically distributed as follows: 14 in areas served by the Syria hub, 4 in Turkey and 6 in NES.

## Syria HRP

are vital to the response; gaps in PPE such as protective gowns, goggles and surgical and N-95 masks also persist. Few of the needed COVID-19 community-based treatment centres are operational, also due to the lack of health care workers after years of crisis. In NES, significant gaps in case management capacity remain, with none out of the 103 Intensive Care Unit beds being fully operational yet. In addition, the procurement and delivery of critical medical equipment, such as ventilators, cardiac monitors, defibrillators, oxygen concentrators, and oxygen cylinders remains a challenge; even where funding is available, global supply shortages and logistics present significant obstacles. PPE needs of non-health partners remain a priority.

Partners have integrated risk mitigation measures and communication into their activities. By the end of April, 4 million people were reached with expanded water services, critical for hand-washing and other preventive measures. Education and protection related activities at community level and for specific vulnerable groups have been more seriously impacted by mitigation measures.

Awareness-raising activities, including television and radio campaigns, from partners within Syria have reached more than 12 million people. In NWS, humanitarian partners have distributed 720,000 integrated food parcels with soap, including 420,000 with COVID-19 prevention messaging. In NES, awareness activities have reached at least 30 sub-districts, including at least 51 individual communities and twenty last resort sites sheltering displaced people. At the same time, misinformation and rumors, complacency, and inadequate risk mitigation behaviors are widely reported across all areas of the country and require continued community engagement efforts.

# Ukraine

HRP

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$46.9M</b>	HEALTH: \$19.3M NON-HEALTH: \$27.6M	<b>\$204.7M</b>	COVID-19: \$46.9M NON-COVID-19: \$157.8M	IN NEED: 3.4M <sup>28</sup> TARGETED: 2.1M <sup>29</sup>

## Impact of COVID-19

### Immediate health impacts on people and systems

Since the first confirmed case of COVID-19 was detected on 29 February, the virus has spread exponentially throughout the country. As of the end of June, there were nearly 45,000 confirmed cases, with over 1,100 deaths and nearly 90,000 suspected cases. Medical personnel accounted for 15 per cent of those infected nationwide, which is a decrease from 20 per cent in May. The mortality rate has somewhat stabilized at around 2.6 per cent, slightly lower than other European countries. Since quarantine measures began to be eased in late May, however, the daily number of confirmed cases has begun to increase significantly, with the highest recorded daily infection rates reported during the last week of June.

Eastern Ukraine – ravaged by over six years of armed conflict and with weakened health systems and an ageing population – may face a COVID-19 outbreak of considerable scale. While the reported number of confirmed cases in the region remains relatively low, the recent rise in confirmed cases in both government-controlled areas (GCA) of Donetsk and Luhanska oblasts, and more in the area outside the government's control (NGCA) is concerning. To date, most health facilities in GCA have reported receiving patients with suspected cases of COVID-19, while there remains considerable underreporting in NGCA.

Ensuring adequate laboratory testing capacity remains a challenge, with reported gaps in terms of referrals, equipment, staff knowledge, human resources, equipment for contact tracing and accurate information. While the Government has invested efforts in strengthening the capacity of selected healthcare facilities designated to support COVID-19 response, there is urgent need to prioritise other healthcare facilities which lack PPE and equipment, particularly those located in the vicinity of the five Entry-Exit Crossing Points (EECPs) along the 'contact line'.

### Indirect impacts on people and systems

The 'contact line' separating GCA and NGCA closed in mid-March, resulting in family separations, as well as the cutting

off of access of over half a million people living in NGCA to travel to GCA to receive their pensions and social payments, to banks and other services and to their families. Many settlements along the 'contact line' had limited or no access to public transportation, cutting them off from food markets, health care and essential services.

In mid-June, some of the EECPs partially reopened for civilian crossings, but the lack of coordination, procedures and clear communication regarding their operation continues to cause complications, endangering the lives of those crossing. The limited and uncoordinated openings of the EECPs between March and June have allowed more than 8,000 people to cross the 'contact line' in both directions in total, far fewer than the 1.1 million crossings per month seen prior to COVID-19, including some 300,000 older persons people seeking their pensions. To date, the complications about crossing procedures remain, while advocacy for safe reopening of the EECPs continue.

## Response priorities and challenges

### Priorities and early achievements

The COVID-19 response activities for eastern Ukraine aim to reach more than 2 million people on both sides of the 'contact line' whose humanitarian needs are further exacerbated by the pandemic. Activities underway include:

- Scaling-up testing capacity of laboratories nationwide and initiating capacity assessments of private laboratories to determine their ability to provide support to the state-owned ones. Additional laboratories continue to be established at the oblasts level. Essential PPE has been allocated to support the operations of the EECPs and rapid response teams.
- Four humanitarian convoys have been organized to NGCA between March and June 2020, three to Donetsk oblast and one to Luhanska oblast. A total of 205 MT of PPE, hygiene supplies, medical and other COVID-19-related supplies, food and light construction materials have been transported from GCA to NGCA.
- Contact tracing has been done for some 80,000 cases, including supporting self-isolation at home. More

<sup>28</sup> Based on the original 2020 HRP.

<sup>29</sup> Increase from 2 million in original HRP to 2.1 million due to COVID-19.

---

# Ukraine

HRP

than 850,000 people have benefitted from hygiene programmes implemented by at least 16 organizations.

- The UN, National Police and the Ministry of Interior Affairs have developed information materials for GBV survivors on how to keep safe from abuse or violence during the pandemic.

## Challenges and impact to operations

The 2020 HRP that is inclusive of the COVID-19 response is currently funded at 17 per cent (\$35 million of the revised \$204.7 million HRP requirement for 2020) as of 30 June. This represents a decrease of \$11 million compared to the funding level received at the same period last year. While the conflict-related humanitarian needs in eastern Ukraine still require a robust humanitarian response, the diversion of resources from the ongoing pre-existing humanitarian response may result in increased suffering of the conflict-affected population.

Livelihoods and economic recovery needs post-COVID-19 quarantine due to the economic downturn are expected to exceed resources and capacity – nationally and globally. The International Monetary Fund (IMF) states that Ukraine's GDP may shrink by 7.7 per cent in 2020 instead of the predicted 3.6 per cent growth<sup>30</sup>. The knock-on effects on the economic conditions in eastern Ukraine – already languished by over six years of armed conflict – are expected to be severe.

---

30 <https://www.kyivpost.com/business/business-update-april-14-imf-says-ukraines-economy-will-shrink-bounce-back-in-2021.html>

# Venezuela

HRP

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$87.9M</b>	HEALTH: \$50.4M NON-HEALTH: \$37.5M	<b>\$762.5M</b>	COVID-19: \$87.9M NON-COVID-19: \$674.6M	IN NEED: 7.0M <sup>31</sup> TARGETED: 4.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 7 July, there were 7,693 confirmed COVID-19 cases with 71 deaths in Venezuela. Cases have been increasing exponentially since 15 May, from 459 to over 7,000. Although most cases are imported, the rate of community transmission is increasing. Border areas are the most affected; thousands of people have returned to Venezuela as they lost their livelihoods in the severely affected neighbouring countries.

Cases requiring advanced health care are treated with existing capacities and humanitarian support. However, if the current trend in the number of cases continues, the health care system will come under strain and require additional support in terms of intensive care unit (ICU) capacity, ventilators and personal protective equipment (PPE) for health workers. The prioritization of the COVID-19 response could further impact the provision of other health care services, as resources are diverted. Impact on treatment for chronic conditions, healthcare for indigenous populations, sexual and reproductive health services, as well as efforts to control other outbreaks such as malaria, measles and diphtheria, are of particular concern.

### Indirect impacts on people and systems

Depending on the duration of the outbreak, the quarantine measures and the fluctuation of international oil prices and remittance flows, the contraction of Venezuela's economy is projected to be between 14 and 28 per cent in 2020<sup>32</sup>. The ability to generate income, especially for workers in the informal sector and those engaged in cross-border economic activity, has reduced. This may further compound food insecurity.

Over 60,000 people have returned to Venezuela from neighbouring countries since 6 April. Returnees are required to comply with Government health protocols, including a minimum two-week quarantine period in temporary shelters managed by the authorities, known as Puntos de Atención Social Integral (PASI). The high numbers of returns have

overstretched PASI capacity, especially along the Colombia-Venezuela border. Stigmatization of returnees and increased risk of gender-based violence (GBV) for returnee women and adolescent girls in transit and at temporary shelters are a concern.

As in other countries, quarantine measures further exacerbate existing protection risks, such as domestic violence or limited access to civil registration and other services for the most vulnerable people. GBV and violence against children, are reportedly on the rise. Access to remote learning modalities for the 9 million students<sup>33</sup> affected by school closure is frequently affected by limited internet connectivity and electrical supply.

## Response priorities and challenges

### Priorities and early achievements

The Ministry of Health, with support from the humanitarian community, continues to implement the National Prevention and Response Plan with 50 hospitals and health centres initially designated for COVID-19 response. The 2020 HRP targets 4.5 million people, including an estimated 2 million for the COVID-19 response. Additionally, risk communications and community engagement activities seek to reach 8.5 million people.

To date, over 1.1 million people have received COVID-19 related assistance, mostly in health and WASH. Strengthening of the epidemiological surveillance system is a priority, and health partners have supported testing capacity (including in decentralizing polymerase chain reaction (PCR) testing). They have also provided PPE and training to health personnel and supported access to health care for people at risk or with COVID-19. More than 87 health facilities have received WASH support. Intersectoral WASH activities are also implemented in temporary shelters and vulnerable communities, having ensured access to clean water to 382,000 people.

The response in the PASI has focused on improving the shelters, including WASH infrastructure, and the distribution of core non-food items, benefitting over 21,000 people.

<sup>31</sup> Estimated number of people in need, 2019.

<sup>32</sup> UNDP, El impacto económico del COVID-19 en Venezuela: La urgencia del financiamiento externo (2020). Available at: [https://www.latinamerica.undp.org/content/rblac/es/home/library/crisis\\_prevention\\_and\\_recovery/el-impacto-economico-del-covid-19-en-venezuela-la-urgencia-del.html](https://www.latinamerica.undp.org/content/rblac/es/home/library/crisis_prevention_and_recovery/el-impacto-economico-del-covid-19-en-venezuela-la-urgencia-del.html)

<sup>33</sup> UNESCO (2020), <https://en.unesco.org/covid19/educationresponse>

## Venezuela HRP

Protection partners have adapted response modalities, including provision of SGBV-related assistance to more than 1,300 people, most of them women. Additional efforts have been undertaken to increase accessibility of services and risk communication for people with disabilities and their caregivers.

Over 54,000 children have benefitted from educational kits and adjusted school feeding programmes. Distance modality education support, delivered through a variety of platforms such as radio podcasts, has reached 95,300 children and adolescents.

### Challenges and impact to operations

Additional support for returnees is required to ensure access to health care and basic goods and services. PCR testing needs to be scaled up and the results processing time reduced to facilitate quicker returns to areas of origin and ensure capacity at the PASI. The healthcare system needs to scale-up preparedness to be able to respond to the evolution of the outbreak.

Movement restrictions due to COVID-19 and continued shortages of fuel, have impacted humanitarian operations. The issuance of special movement authorizations by the COVID-19 Presidential Commission to maintain life-saving activities has partially facilitated access for some humanitarian organizations; however, more are required, especially to ensure reliable access to fuel. Whilst many response actions have continued through alternative modalities, the provision of therapeutic nutrition interventions at scale has been affected, in part due to disruptions in the supply chain.

# Yemen

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$385.7M**

### OF WHICH:

HEALTH: \$304.6M  
NON-HEALTH: \$81M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$3.38B**

### OF WHICH:

COVID-19: \$385.7M  
NON-COVID-19: \$3B

## PEOPLE

IN NEED: 17.9M  
TARGETED: 16.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

COVID-19 continues to spread rapidly across the country with deadlier consequences than elsewhere, while the number of publicly confirmed cases remains relatively low. The overall case fatality rate (CFR) is alarmingly high ranging between 20 and 25 per cent, about 4 times higher than the global average. Official data show that 75 per cent of confirmed cases are men, and people aged between 45 and 59 years have the highest CFR. Official reports are lagging behind actual infections due to lack of tests and other challenges. Experts warn that as many as 16 million people, 55 per cent of the population, are likely to be infected, and that 300,000 people will need hospitalization, including 200,000 people who may need ICU support to survive.

### Indirect impacts on people and systems

The humanitarian crisis in Yemen is already the worst in the world – more than 80 per cent of the population requires some form of humanitarian assistance or protection. Two-thirds of Yemenis are hungry, half are acutely vulnerable and do not know where their next meal will come from, nearly a quarter are malnourished, and 12 per cent are displaced. Economists estimate that up to 70 per cent of remittances, one of the country's main sources of foreign exchange, will be lost because of COVID-19, and the currency is collapsing. Basic food prices continue to rise, increasing the likelihood of a return to pre-famine conditions. Although Yemen has received COVID-19-related debt relief, extreme pressure on public revenue is impacting liquidity, stifling credit and further interrupting salary payments to civil servants who provide essential services. All indicators point to a dramatic deterioration in human development and a generational setback in achieving the sustainable development goals.

## Response priorities and challenges

### Priorities and achievements

Aid agencies scaled up the COVID-19 response through the 4S Health Response Strategy, prioritizing suppression of virus transmission through community engagement; procuring and distributing medical supplies; saving lives by supporting clinical readiness; and safeguarding the public health care system.

To suppress virus transmission, UNICEF activated and trained more than 19,000 community volunteers across the country to raise awareness about COVID-19, and together with mass media messaging, information has reached over 16 million people. An additional 6,000 mother-to-mother community volunteers were also activated.

By end of May, the UN and partners had procured more than 12,000 metric tons (MT) of medical equipment, testing kits and medicine; 8,616 metric tons had already arrived in country and another 3,567MT were in the pipeline. Thanks to a partnership between the private sector and the UN, in June 43 MTs of medical supplies arrived in Yemen in June facilitated by Hayel Saeed Anam Foundation on behalf of the International Initiative on COVID-19 in Yemen. Still more is urgently needed, especially oxygen and personal protective equipment.

Working with partners, WHO has equipped and added 21 ICUs to the to the existing 38 ICUs in COVID-19 designated hospitals since the beginning of May, and partners are deploying two high-capacity mobile field hospitals with nearly 100 beds, and providing salaries to 9,000 frontline health care workers. WHO continues to fund 333 five-person Rapid Response Teams that work in all districts detecting, assessing, alerting and responding to suspected COVID-19 cases. Efforts continue to increase the number of teams to 999.

Safeguarding the public health system at more than 4,300 non-COVID health care facilities to ensure services are not overwhelmed by COVID-19 cases is another priority. The focus is on providing the "Minimum Service Package" at these facilities, providing essential medicines and vaccines to those in most need; responding to other deadly diseases including cholera, diphtheria, dengue and malaria; and providing nutrition treatment to pregnant women and malnourished children. In May, 2,779 health facilities continued to treat malaria and 1,257 health facilities provided cholera response services.

Despite limited resources, more than 12 UN agencies and 240 international and national NGOs are doing everything possible to maintain existing levels of humanitarian assistance. This includes providing food assistance to more than 10 million people every month, cash assistance to 9 million people, and nutritional support to 2.5 million

## Yemen HRP

malnourished children. It also includes reaching 8.8 million people with primary health care; providing and rehabilitating the water supply for 11.3 million people; and providing shelter and emergency cash to 2.1 million IDPs and returnees.

### Challenges and impact to operations

The COVID-19 response in Yemen faces three major problems. The most challenging is the severe shortage of essential supplies and equipment including tests, protective equipment, ICU and hospital beds, oxygen and ventilators. The second major gap is funding for the aid operation; a pledging conference at the start of June left the response \$1 billion underfunded and pledges made are yet to be fulfilled. Of the UN's 41 major programmes, 31 will be reduced or closed in the coming weeks unless funding is urgently received. The third challenge is the operating environment. Fighting continues and has increased along 41 frontlines. While there has been some improvement, partners continue to face serious restrictions, particularly in northern Yemen, undermining donor confidence in the operation.

# Zimbabwe

HRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$84.9M**

### OF WHICH:

HEALTH: \$24.8M  
NON-HEALTH: \$60.1M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$800.7M**

### OF WHICH:

COVID-19: \$84.9M  
NON-COVID-19: \$715.8M

## PEOPLE

IN NEED: 7.5M  
TARGETED: 5.9M

## Impact of COVID-19

### Immediate health impacts on people and systems

The number of confirmed COVID-19 cases increased from 31, including 4 deaths on 28 April, to 716, including 8 deaths, by 5 July. All 10 provinces in Zimbabwe have confirmed COVID-19 transmission with Bulawayo, Harare and Matabele South recording the highest incidence. Of the 716 cases, 606 are migrant returnees.

### Indirect impacts on people and systems

Zimbabwe has received an influx of highly vulnerable migrant returnees. Further to 1,314 in April, from 1 May to 5 July, an additional 9,395 migrants reportedly returned to Zimbabwe from 56 Countries, 4,613 (43 per cent) of whom are women and 189 (2 per cent) children. The number of returnees continues to increase daily, with a projection of 20,000 new arrivals in 2020. As of 3 July, 1,119 individuals were quarantined in 44 centres operated by the Government mainly in Harare, including 34 schools, while private quarantine centres stand at 37.

COVID-19 has had a significant impact on essential health services: immunization coverage dropped from 30,110 in March to 20,432 in April 2020; the number of children delivered in health facilities dropped from 28,264 in March to 24,446 in April 2020; and the number of children admitted for treatment of acute malnutrition dropped from 1,842 in March to 1,180 in April and was 1,227 in May. The number of children receiving Vitamin A supplementation was also affected, dropping to 52,379 in April 2020 compared to 107,491 in March, and reaching only 83,879 in May. The number of pellagra cases increased to 217 in May from 86 in March 2020, and recent malaria, typhoid and diarrhoea outbreaks have created an additional burden on the already fragile health system.

Food insecurity increased, with WFP projecting that in June 2020 an additional 1.3 million people in rural areas and an additional 1.1 million people in urban areas would be food insecure. The national GBV Hotline recorded 915 calls in May and 584 calls in June, following a sharp increase of 1,312 in April from 649 in March); 94 per cent of the cases were women. The child help line has recorded a 43 per cent increase in calls since April. The closure of all 9,625 schools since March 2020 has disrupted learning and

other vital school-based activities -including school feeding, immunization, and mental health and psychosocial support- for children, increasing the risk of drop out and regression, especially for girls, learners with disabilities and those in remote and poorly resourced schools.

## Response priorities and challenges

### Priorities and early achievements

The updated COVID-19 Addendum to the Humanitarian Response Plan 2020 complements the Government-led response to COVID-19. It, prioritizes: the public health response to COVID-19; alternative remote learning and safe re-opening of schools; food and cash distributions with COVID-19 protection and prevention measures; agricultural assistance; continuity of essential nutrition services integrating innovative approaches, including family screening; scaling-up remote GBV service provision, including through mobile One Stop Centres (OSCs), and transport support for GBV survivors; comprehensive WASH response, including in health care facilities, schools and quarantine centres; and multi-sectoral response for migrant returnees.

Key achievements to date include: equipping of 80 health facilities nation-wide with capacity to isolate COVID-19 cases; training of 4,896 health care workers and support staff in 34 targeted districts in Infection Prevention and Control; food or cash assistance for over 2 million people in May 2020; development of Standard operating Procedures (SoP) on Mother-led Mid Upper Arm Circumference (MUAC) screening, enabling screening of 952,458 children under age 5 (46 per cent of target); dissemination of information on Infant and Young Child Feeding during COVID-19 to 444,548 caregivers (45 per cent of target); multi-sectoral GBV services for 4,198 GBV survivors (3,166 female, 1,032 male) through mobile One Stop Centres (OSC), with 136 survivors, including those with disabilities and their caregivers, receiving transport fees support; support for continuous provision of basic PPE needs for the most vulnerable women and girls, including through the self-manufacturing of cloth masks and soap at GBV community-based shelters and safe spaces; tracing and reunification of 398 unaccompanied and separated children (UASC) (86 per cent girls), including 122 children from quarantine facilities at borders; support to access to safe water for more than

## Zimbabwe HRP

50,800 people, delivery of sanitation and hygiene messages to more than 300,000 people and hygiene items to 1,600 people, and establishment of 178 handwashing stations for 14,964 people and PPE support to 49 health care facilities.

### Challenges and impact to operations

The main operational challenges include: lack of personal protective equipment (PPE); low testing capacity for both public and private laboratories; lack of capacity to refurbish WASH facilities critical for the reopening of schools as of end of July; constrained movement for communities and humanitarians due to the reinforcement of lockdown measures, including roadblocks; reduced availability of transport for people in rural areas to access essential services; and challenges using cash-based transfers following recent Government monetary policy change vis-a-vis exchange rates. Contextual challenges include: the crossing of migrant returnees through informal border points; supply chain strains resulting in shortages of food for households and livestock feed; and the evolving political context, with increased economic and monetary stress resulting in further inflation.

---

**ANNEX 1**

# Country and regional plans: Regional Refugee Response Plans

- 55** **Burundi** *Regional*
- 57** **Democratic Republic of the Congo** *Regional*
- 59** **Nigeria** *Regional*
- 61** **South Sudan** *Regional*
- 63** **Syria** *Regional 3RP*

## Burundi Regional RRP

### COVID-19 REQUIREMENTS<sup>34</sup>

#### REQUIREMENTS

**\$65.4M**

#### OF WHICH:

HEALTH: \$36.5M  
NON-HEALTH: \$29.0M

#### People in need

325,000 Burundian refugees and 2.5 million host community population.

#### Targeted population

325,000 Burundian refugees and 2.5 million host community population.

### TOTAL HUMANITARIAN REQUIREMENTS

#### REQUIREMENTS

**\$275.0M**

#### OF WHICH:

COVID-19: \$65.4M  
NON-COVID-19: \$210.0M

#### Countries covered

Democratic Republic of the Congo, Rwanda, Tanzania and Uganda.

## Impact of COVID-19

### Immediate health impacts on people and systems

COVID-19 has exacerbated the already precarious condition of Burundian refugees in the region. Pressure on the mostly inadequate health and sanitation systems available to Burundians living in remote areas of countries of asylum increases the risk of an outbreak with a devastating impact on morbidity and mortality of the refugee population.

### Indirect impacts on people and systems

Despite heightened tensions during the May elections, there has not been any major forced displacement inside Burundi or across borders. It remains crucial to preserve the asylum space for refugees who may not opt for voluntary return to Burundi in the immediate future and to respect the right to seek asylum. Voluntary repatriation of Burundian refugees in Tanzania has been suspended since 15 May due to the elections. To minimize the risk related to the spread of COVID-19, RRP partners are working towards enhancement of testing and creation of quarantine facilities for returnees for an anticipated resumption of voluntary repatriation in July.

Burundian refugees are at significant risk during the COVID-19 crisis as they reside in often overcrowded camps or settlements, in some cases with restrictions on freedom of movement and entirely depending on humanitarian assistance which does not meet minimum standards in some sectors. Refugees in urban areas and new arrivals are particularly vulnerable, as they mostly depend on independent livelihood activities to meet their basic needs. Confinement and movement restrictions make it more difficult for them to continue to work.

Critical gaps include the lack of adequate water and sanitation facilities in some camps and transit centers, insufficient capacity of camp-based health facilities

(infrastructure, equipment, staffing, essential medicines and materials including for infection prevention and control), inadequate referral systems and remote protection monitoring systems, shortages in therapeutic food items for malnourished children and depletion of refugees' livelihoods and purchasing power. There is also a high risk of further deterioration of the nutrition and food security situation of refugees as a result of negative impacts of COVID-19 on livelihoods and severe food ration cuts in several asylum countries. Slowed procurement and delivery processes present additional challenges.

## Response priorities and challenges

### Priorities and early achievements

While there has been no large-scale outbreak amongst Burundian refugee populations so far, several cases have been reported in Uganda and therefore the need for further preparedness is urgent. Prevention and response activities are focusing on the most urgent priorities, such as strengthening primary and secondary health care and selected WASH services; ramping up cash assistance, reinforcing shelters, and providing core relief items in congested urban and camp settings; strengthening risk communication, community engagement and case management, including protection monitoring and registration; and supporting remote learning for out of school students.

In Uganda, significant efforts are underway to increase reception capacity and quarantine facilities in border areas, while cash assistance programmes were upscaled in Kampala assisting over 4,000 refugee families.

To reduce overcrowding and ensure physical distancing, food and other distribution modalities have been modified. In the DRC, for example, RRP partners elaborated new Standard Operating Procedures (SOPs) for access to refugee settlements, for relocation operations, and for the

<sup>34</sup> The original 2020 budget for the Burundi RRP was 266 million. The table indicates preliminary budget breakdown as full reprioritization and revision exercise is ongoing. COVID-19 requirements for the Burundi refugee response in the DRC are reflected in the DRC HRP and have therefore been subtracted from the calculation of the Burundi RRP.

## Burundi *Regional* RRP

distribution of essential assistance. Using these SOPs, partners carried out awareness-raising campaigns on COVID-19 prevention measures for refugees, and ensured the safe distribution of soap, biomass briquettes, and cash for food and shelter. In Uganda and Rwanda, RRP partners assessed and mapped the capacities of health and WASH facilities and conducted risk communication and community engagement activities, with educational materials in Kirundi language. In Tanzania, RRP partners are engaged in the construction of permanent handwashing stations in Nyarugusu, Mtendeli and Nduta camps. Currently, 1,020 handwashing points have been installed and maintained in strategic locations. An additional 22 stations have been set up in areas surrounding the camps for the host community. Awareness campaigns across all camps is ongoing through hygiene promoters targeting the camp population and host communities. To support the mental well-being of refugees, RRP partners in Tanzania and Uganda continue to adapt and reinforce provision of Mental Health and Psychological Support (MHPSS) to persons of concern. This includes strengthening community messaging about coping with stress, ways to continue activities at home, and tips for parenting and healthy coping mechanisms.

### Coordination

Coordination structures are in place in all asylum countries, with dedicated Crisis Management Teams and Task Forces by sector. Thirty-seven RRP partners are working closely with UN Country Teams, Resident Coordinators and WHO on crisis management, business continuity arrangements, programme criticality, preparedness and response planning. Existing refugee response coordination structures continue to function, often through virtual communication. As the lead agency for the RRP response, UNHCR has developed a COVID-19 preparedness and response plan for all refugee settings and collaborates with the national authorities and WHO to ensure the integration of refugees into national preparedness efforts, in the spirit of “leaving no one behind.”

# Democratic Republic of the Congo *Regional* RRP

## COVID-19 REQUIREMENTS<sup>35</sup>

### REQUIREMENTS

**\$155.7M**

### OF WHICH:

HEALTH: \$94.7M  
NON-HEALTH: \$61.0M

### People in need

912,000 Congolese refugees and 1.4 million host community population.

### Targeted population

912,000 Congolese refugees and 1.4 million host community population.

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$639M**

### OF WHICH:

COVID-19: \$155.7M  
NON-COVID-19: \$483.0M

### Countries covered

Angola, Burundi, Republic of the Congo, Rwanda, Uganda, Tanzania and Zambia.

## Impact of COVID-19

### Immediate health impacts on people and systems

The COVID-19 pandemic is evolving rapidly in countries throughout the Southern and Great Lakes regions in Africa. Countries hosting refugees from the Democratic Republic of the Congo (DRC) have seen decreased access to health services due to closure or limited operation of health facilities, as well as stock-outs of medicines and other supplies. Concerns persist over the welfare of healthcare workers and patients due to shortages of protective equipment, while isolation and quarantine centres are limited or poorly equipped. While there are only a few confirmed COVID-19 cases among Congolese refugees as of June 2020, refugee communities remain vulnerable to the pandemic, especially the poor, older persons and persons with disabilities as well as those living in urban areas. Concerns remain about the potential for rapid spread of the virus in the crowded environments of camps or settlements, and frequent movements of the refugees from/to camps despite movement restrictions.

### Indirect impacts on people and systems

National efforts to contain COVID-19 have included movement restrictions, border closures, and nation-wide lockdowns. These have resulted in concerns over access to asylum, for example in Angola, Uganda and Zambia, as movement across borders is hindered by procedural and logistical constraints. Restrictions on movements also limit access to refugee communities, impacting provision of case management services, particularly for SGBV and child protection, all within a context where reported incidents of domestic violence, child neglect and mental health needs are increasing.

Many refugees earn their livelihoods through informal activities, such as trade, farming or fishing, and have been badly impacted by lack of income due to COVID-19

restrictions. The number of refugee households seeking support has increased, as they can no longer provide for their families. Further, the socio-economic impacts of COVID-19 lockdowns and restrictions are resulting in reported tensions between host and refugee communities in some countries, with renewed efforts needed to promote peaceful coexistence.

## Response priorities and challenges

### Priorities and early achievements

DRC RRP partners are committed to a 'stay and deliver' approach in the response to the COVID-19 pandemic. Partners have been working to ensure the inclusion of refugees in national preparedness and response mechanisms, and to complement national authorities' response with COVID-19 programming for refugees and host communities. Additional staff and training for health centres has been provided, including additional medication, equipment and protective gear as well as isolation and quarantine centres set-up to reduce the risk of transmission from new arrivals. In Lóvua refugee settlement, Angola, 23 health workers received training, one isolation centre and one quarantine centre was established, and one health centre received additional equipment.

Existing RRP programming has been adapted to maintain critical life-saving activities, including protection services, through remote modalities. Remote protection monitoring and response mechanisms have been established through community-based protection networks and hotlines to address SGBV and child protection risks and identify persons with specific needs. Partners have been supporting remote education in locations where schools have been closed, via radio, online and correspondence. In some countries, schools have re-opened, as of June 2020, and partners are supporting COVID-19 mitigation measures. In Zambia, more than 5,000 masks were provided benefitting

<sup>35</sup> The original 2020 budget for the DRC RRP was 621 million. The table indicates preliminary budget breakdown as a full reprioritization and revision exercise is ongoing. COVID-19 requirements for Burundi are reflected in the Burundi HRP and have therefore been subtracted from the calculation of the DRC RRP.

## Democratic Republic of the Congo *Regional* RRP

refugee and host community students.

Risk communication is a priority in the region, to raise awareness among refugees and host communities about COVID-19 prevention and available services, often combining COVID-19 information with protection messaging. In the Republic of the Congo, 8,620 people were sensitized through COVID-19 awareness-raising, including 2,847 also reached with SGBV messaging, through focus group discussions and door-to-door messaging. In the WASH sector, partners increased water production, treatment and distribution, as well as soap distribution and installation of handwashing facilities in public places to help reduce the spread of COVID-19. In Tanzania, 1,020 handwashing points were installed in communal locations across three refugee camps, including Nyarugusu, which hosts 76,482 refugees from the DRC.

Partners are expanding the use of cash-based assistance, an important modality for flexible and rapid support to refugees, struggling amidst the economic impacts of COVID-19. In Zambia, 3,150 refugees are currently receiving cash assistance, through mobile transfers, thus reducing the economic impacts of COVID 19 on their livelihoods.

### Challenges and impact to operations

Challenges include lack of funding, limited operational capacity of some stakeholders, weak referral systems, overcrowding in some locations impeding physical distancing efforts, shortage in food rations, slow procurement and delivery processes, price inflation and limited access to basic commodities in local markets, and lack of social and financial safety nets.

### Coordination

UNHCR, government authorities and partners have continued to work together through established refugee coordination structures. Regular virtual meetings are held, and some face-to-face meetings have resumed under COVID-19 mitigation measures. The DRC RRRP continues to serve as a regional coordination and planning tool to improve protection space, preparedness and response for refugees and host communities, whilst facilitating a more targeted and effective response to COVID-19

# Nigeria *Regional* RRP

## COVID-19 REQUIREMENTS<sup>36</sup>

### REQUIREMENTS



### OF WHICH:

HEALTH: –  
NON-HEALTH: –

### People in need

312,000 Nigerian refugees and 100,000 host community population.

### Targeted population

312,000 Nigerian refugees and 100,000 host community population.

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$138.4M**

### OF WHICH:

COVID-19: –  
NON-COVID-19: –

### Countries covered

Cameroon, Chad and Niger.

## Impact of COVID-19

### Immediate health impacts on people and systems

Armed attacks, kidnappings and human rights violations are still claiming civilian lives and causing displacement from Nigeria into neighboring countries. More than 20,000 refugees have arrived in Maradi, Niger since February. Moreover, COVID-19 is accelerating, moving from urban centers into rural areas where it will be more challenging to contain. Most Nigerian refugees live in overcrowded communities with poor accommodation in remote camps and settlements characterized by weak health and WASH systems, making the application of COVID-19 barrier measures extremely difficult. While refugees have access to national health systems, state services, infrastructure and personnel are over-stretched, under-resourced and require massive support. To date, no Nigerian refugees are known to be infected by the coronavirus despite the disease spreading particularly fast in Nigeria and Cameroon.

### Indirect impacts on people and systems

Government restrictions imposed to battle the propagation of the virus have reduced work and livelihood opportunities for refugees. Coupled with disruptions to food production and distribution, reliance on humanitarian assistance is more pronounced. Given the strained resources and onset of the lean season, this will have a negative impact on the already fragile food security and nutritional status of Nigerian refugees and their hosts.

With COVID-19 prevention hinging largely on sound hygiene practices, water supply remains sub-standard in most refugee hosting areas and critical needs persist in sanitation. Lack of schooling opportunities due to temporary closures are depriving students of a protective learning environment, WASH facilities and school feeding, and putting them at higher risk of recruitment by armed groups as well as child marriage and child labor. Also, other protection risks,

including SGBV, are heightened in this context. Persons with specific needs as well as those with chronic health conditions face bigger threats with reduced access to services and livelihoods. As a consequence of all these challenges, vulnerable populations could increasingly resort to negative coping mechanisms.

## Response priorities and challenges

### Priorities and early achievements

RRRP partners are reinforcing national healthcare systems, WASH facilities, and services as well as adapting protection, education and livelihoods interventions. In Niger, partners provided staffing support to national health services and trained healthcare workers in refugee hosting areas. In Maradi, arriving refugees are being relocated to safer villages with access to basic services and less congested living conditions. In Cameroon, handwashing stations were installed in Minawao camp, the Transit Center, as well as in refugee sites, and 70,000 bars of soap were distributed. Refugee artisans are manufacturing masks for local populations thus improving their socio-economic inclusion. One-off multi-purpose cash is provided to urban refugees in Cameroon and Chad to offset livelihoods losses in the COVID-19 context.

To strengthen access to territory and asylum and ensure the right to return is enjoyed in a dignified manner in compliance with health measures, protection and health teams were deployed to monitor official and unofficial borders in the region. Innovative approaches to delivering essential protection services are being established, such as online and phone consultations to meet physical distancing measures. In Cameroon, a toll-free hotline was put in place for protection issues and COVID-19 messages/feedback, and a network of 110 community focal points are assisting social workers to provide remote GBV case management.

Risk communication messages and community engagement

<sup>36</sup> The revision of the Nigeria RRP is in progress. COVID-19 requirements for Cameroon, Chad and Niger are reflected in the Cameroon, Chad and Niger HRPs respectively and have therefore been subtracted from the calculation of RRP requirements. The non-COVID-19 components of the Nigeria Regional Refugee Response plan (\$138 million originally) are also reflected in the corresponding HRP country plans.

## Nigeria *Regional* RRP

approaches were also adapted with audio and radio content replacing large group discussions. In Niger, regional and country-based partners supported a famous hip-hop artist to bring more attention among youth to COVID-19 risks and protective measures.

To prepare for the safe reopening of schools and learning in a protective environment, partners are working with education ministries to support students' access to distance education programmes, enhance health training for teachers, support community awareness-raising activities while upgrading WASH facilities in schools. In Chad, teachers are continuing to support the community by distributing homework to students and visiting the most vulnerable pupils in the camp.

### Challenges and impact to operations

With rains starting, RRRP partners are strengthening flood mitigation measures alongside COVID-19 preparedness and emergency response mechanisms. Access to refugee sites may be reduced, transportation of goods will be even more challenging and expensive, and shelter needs will increase.

With ongoing government restrictions, monitoring and advocating for refugee and asylum-seekers' access to safety and to seek asylum remains essential. Stigmatization and discrimination against refugees in the context of COVID-19 is another potential risk.

### Coordination

To support Governments and mitigate the impact of COVID-19 on Nigerian refugees and their hosts, 40 partners are working within the Refugee Coordination Model to complement national preparedness and response plans in close alignment with WHO's Country Preparedness and Response Plans (CPRP). In this framework, partners support the inclusion of Nigerian refugees in national contingency plans including preparedness to respond to outbreaks in refugee areas.

# South Sudan *Regional* RRP

## COVID-19 REQUIREMENTS<sup>37</sup>

### REQUIREMENTS

**\$128.8M**

### OF WHICH:

HEALTH: \$51.4M  
NON-HEALTH: \$77.4M

### People in need

2.2 million South Sudanese refugees and 2.7 million host community population.

### Targeted population

2.2 million South Sudanese refugees and 2.7 million host community population

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.34B**

### OF WHICH:

COVID-19: \$128.8M  
NON-COVID-19: \$1.21B

### Countries covered

Democratic Republic of the Congo, Ethiopia, Kenya, Sudan and Uganda.

## Impact of COVID-19

### Immediate health impacts on people and systems

The South Sudanese refugee population remains the largest in the region and is one of the most vulnerable. Whether in camps, settlements or urban areas, refugees are living in extremely precarious conditions, exacerbated by the COVID-19 pandemic. Despite border closures, lockdowns and other movement restrictions, there is a steady flow of new South Sudanese arrivals in asylum countries such as Ethiopia and Sudan. Most refugees face high levels of poverty, limited access to livelihood opportunities, and are hosted in some of the poorest regions of host countries, where communities are already struggling to meet basic needs. While there has been no large-scale outbreak amongst the South Sudanese refugee population by June 2020, cases of COVID-19 have been reported and are slowly rising, particularly in Uganda.

The majority of South Sudanese refugees continue to rely on food distributions, which due to funding shortfalls often do not meet minimum standards. Food rations for South Sudanese in Ethiopia are reduced by 15 per cent, and by 30 per cent in Kenya and most recently Uganda, compounding the socio-economic impacts of the COVID-19 pandemic. In most refugee hosting countries, levels of acute malnutrition remain high. Severe acute malnutrition affects many South Sudanese refugees, and anemia is prevalent among refugee children. An analysis of the profiles of the refugee population, based on age, vulnerabilities and pre-existing medical conditions, against the background of limited health systems capacities, ongoing cross-border movements and the remoteness and dispersion of many refugee hosting areas, have demonstrated that the refugee population remains at high risk of infection from COVID-19.

### Indirect impacts on people and systems

The replenishment of hygiene material requires longer term planning and additional funding as the pandemic unfolds. Increase in prices, limited availability of materials and delays in transport due to the rainy season present additional challenges. Significant investment in WASH infrastructure is needed, given the precarious health structures and WASH facilities in most refugee-hosting locations. The planned re-opening of schools that had been designated as quarantine or isolation centers requires the establishment of new structures with adequate WASH facilities. Movement restrictions have affected the delivery of protection services in most countries, in particular in critical sectors, such as SGBV and child protection. Advocacy to categorize protection staff and social workers as essential and exempt them from access restrictions alongside other humanitarian workers is being conducted through regional interagency working groups and regional bodies such as the East African Community (EAC) and Intergovernmental Authority on Development (IGAD).

## Response priorities and challenges

### Priorities and early achievements

Cases of local transmission have been reported in all countries of the region. Prevention and response activities are focusing on the most urgent priorities, such as strengthening primary and secondary health care and selected WASH services; ramping up cash assistance, reinforcing shelters, and providing core relief items in congested urban and camp settings; strengthening risk communication, community engagement and case management, including protection monitoring and registration; and supporting remote learning for out of school students. Construction of additional household shelters is ongoing and will facilitate relocation from reception centers to avoid congestion. Sites for additional isolation centers have been identified for use as emergency

<sup>37</sup> The original 2020 budget was 1.34 billion. The table indicates preliminary budget breakdown as full reprioritization and revision exercise is ongoing. COVID-19 requirements for the South Sudanese refugee response in the DRC, Ethiopia and Sudan are reflected in the DRC, Ethiopia and Sudan HRPs, respectively, and have therefore been subtracted from the calculation of the South Sudan RRP.

## South Sudan *Regional* RRP

health facilities in case of a major outbreak in the camps. Soap distributions are being increased for refugees in all locations. Efforts are underway to increase water production and distribution in camps where the supply continues to be inadequate.

### Challenges and impact to operations

The funding shortfall coupled with delayed delivery of international procurement orders for PPEs, medicines and medical supplies are among the key challenges hampering response efforts. Increases in the prices of basic and essential items for refugees, loss of income as a result of the general economic downturn and disruptions in educational activities, and lack of safety nets are affecting refugees in a disproportionate manner. Due to lack of livelihoods and basic needs, refugees have increasingly resorted to negative coping mechanisms. Refugees have reported skipping or reducing meals, taking loans on interest, selling assets, begging, engaging in child labour and in risky/harmful activities. The desperate conditions are also reflected by a rise in suicides, especially among the urban refugee population. Cash assistance programmes and remote protection counseling services have been significantly upscaled in the main urban centres in most of the asylum countries to address these critical gaps.

### Coordination

Some 97 RRP partners are engaged in the response and coordination structures are in place in all asylum countries, with dedicated Crisis Management Teams and Task Forces by sector. Partners are working closely with governments, UN Resident Coordinators and UN country teams, WHO and several national authorities on crisis management, business continuity arrangements, programme criticality, preparedness, and response planning, as well as to ensure the integration of refugees into national preparedness and response plans.

# Syria Regional RRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$758.3M**

### OF WHICH:

HEALTH: \$87.4M  
NON-HEALTH: \$670.9M

### People in need

Over 5.5 million Syrian refugees and 4.5 million host community population.

### Targeted population

Over 5.5 million Syrian refugees and 4.5 million host community population.

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$ 5.99B**

### OF WHICH:

COVID-19: \$758.3M  
NON-COVID-19: \$5.24B

### Countries covered

Turkey, Lebanon, Jordan, Iraq and Egypt.

## Impact of COVID-19

### Immediate health impacts on people and systems

Host countries undertook significant measures during the epidemic to prevent a public health catastrophe. The mobility restrictions and preventative measures have gradually eased in Turkey, Lebanon, Jordan and Egypt as the number of cases has stabilized. Meanwhile, there has been an increase in the number of confirmed COVID-19 cases in Iraq – through close liaison with the national authorities, the situation is being monitored and preventative and response measures have been taken in affected areas. Vulnerable groups of people such as persons with disabilities, older persons and persons with medical conditions still have increased difficulties in accessing healthcare services because of cost, transportation, and availability challenges.

### Indirect impacts on people and systems

While the poverty rates were already high in some countries among refugees and host communities, socio-economic conditions have significantly worsened due to the COVID-19 pandemic. According to the latest assessments, some 60 per cent of the households in some countries reported loss of job and entire income as a result of the pandemic. Refugee and host community informal workers, particularly women, don't have access to social security and are disproportionately affected.

As a result, there is an increased number of refugee and vulnerable host community households who are unable to meet their basic needs including food and nutrition, education, health and rent payment. This further puts girls, boys and women at heightened protection risks such as sexual and gender-based violence, child labour and resorting to other negative coping mechanisms.

The effects are also seen on access to quality education. Prior to COVID-19, around 35 per cent of refugee children were out of school across the region. The recent assessments show that over 20 per cent of children who were previously at school cannot continue education due to the change in learning modalities which requires additional

resources such as TV, internet connection and mobile devices.

Across the five countries, 95 per cent of Syrian refugees live in urban or peri-urban settings, oftentimes in densely populated areas or shelters, where physical distancing and/or limiting outdoor activities are extremely difficult to implement and overall health risks remain high.

## Response priorities and challenges

### Priorities and early achievements

As restrictions have started to ease, partners have gradually scaled up their response with physical presence. 3RP health partners have supported national efforts on assessing prioritized needs and providing immediate support related to COVID-19 prevention and response. This includes provision of personal protective equipment (PPE) for health workers and increasing testing of COVID-19 in selected settlements and collective shelters where they host refugees. Moreover, reopening of the primary healthcare clinics have enabled refugees to visit clinics to collect medications and receive consultations. 3RP health partners also continue the implementation of originally planned activities, including in some cases with an intensified focus on strengthening aspects of the national healthcare system, as requested by national authorities.

Concerning COVID-19 related activities, some adjustments were made based on the outcome of the various assessments conducted. One of the key priorities is to support vulnerable refugee households and host communities that faced difficulties in accessing livelihoods activities during the last months when the confinement measures were put in place, which hindered them from gaining income and meeting their basic needs. This support will be done through cash-based and in-kind interventions such as cash and food assistance, and through cash for work. Moreover, there are increased needs to support national and local institutions to enable them to provide expanded public services while still adhering to current COVID-19 measures. For instance, as distance learning

---

## Syria *Regional* RRP

continues for an extended period, the support for distance learning will be critical for schools and universities. In addition, capacity building of teachers to support children in the new learning modalities is essential for quality education. Furthermore, protection services continue to be crucial to respond to increased SGBV and child protection cases and provide mental health and psychosocial support not just to those impacted women and children, but also to larger populations affected by psychological trauma, stress and anxiety attributed to the impact of COVID-19.

### Challenges and impact to operations

While various measures to prevent the spread of the virus have been eased in most countries, such measures have been re-imposed in Iraq due to an increase in the number of cases which affects the overall protection environment and partners' capacity to deliver assistance. More broadly, full implementation of 3RP plans is subject to a range of technical, financial and capacity challenges.

### Coordination

While the exact modalities vary by country, the 3RP is aligned with government-led plans, WHO and other UN-led plans, and the work of development actors. It is also important to note that while the 3RP covers the needs of Syrian refugees and vulnerable host community members, 3RP partners also serve refugees, asylum-seekers and other vulnerable groups of many nationalities in a non-discriminatory manner.

---

**ANNEX 1**

# Country and regional plans: Refugee and Migrant Response Plan

**66** *Venezuela Regional Refugee and Migrant Response Plan*

# Venezuela Regional Refugee and Migrant Response Plan

RMRP

## COVID-19 REQUIREMENTS<sup>38</sup>

### REQUIREMENTS

**\$438.8M**

### OF WHICH:

HEALTH: \$132.4M  
NON-HEALTH: \$306.4M

### People in need

6.1 million people (refugees and migrants and affected host community members).

### Targeted population

4.1 million people (refugees and migrants and affected host community members).

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.41B**

### OF WHICH:

COVID-19: \$438.8M  
NON-COVID-19: \$968.8M

### Countries covered

Argentina, Aruba, Bolivia, Brazil, Chile, Colombia, Costa Rica, Curacao, Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay.

## Context

Of the approximately 5.1 million refugees and migrants from Venezuela displaced globally, some 4.3 million are hosted in Latin America and the Caribbean (LAC). Colombia alone hosts more than 1.8 million refugees and migrants, including over 1 million with irregular status, who are without proper documentation to facilitate access to basic rights and key services. The LAC region has responded to a situation of unprecedented human displacement with tremendous solidarity, hospitality, and has at large kept doors open for refugees and migrants from Venezuela. The arrival of the COVID-19 pandemic has presented additional challenges of unforeseeable magnitude, putting to the test the health and social welfare systems, and countries' ability to maintain an inclusive society. As Latin America has become the epicenter of the pandemic, the inability of refugees and migrants to access livelihoods, shelters, basic goods and services, or to move between countries, due to quarantine and movement restrictions has exposed Venezuelans to highly vulnerable and desperate situations.

## Impact of COVID-19

### Immediate health impacts on people and systems

Refugees and migrants, particularly those in irregular situations, are still at high risk of being left out of health and social welfare programs, and increasingly vulnerable to health and protection risks. Measures to contain the spread of the virus, including closed borders, movement restrictions and closed businesses, have left many without the means to provide for themselves and their families, or any alternative support. According to a recent impact survey 90 per cent of Venezuelans in Colombia are unable to cover basic needs such as shelter, food, hygiene and healthcare.

Without livelihoods, levels of evictions and homelessness have spiked, as have reports about increasing food insecurity, poor nutrition levels, discrimination, violence,

exploitation and abuse. As a result, many see no choice but to consider returning to their home country, leading to heightened risks of contracting the virus, and exposure to human trafficking and exploitation when using irregular border crossings.

While the pandemic is yet to reach its peak in the region, the already overstretched public health services are severely challenged throughout the region, while hygiene items and personal protective equipment remain elusive to people on the move and to re-sponse actors. In these conditions, unimpeded access for refugees and migrants to health and sanitary facilities, and their inclusion in social welfare programs, remain essential.

### Indirect impacts on people and systems

Ongoing movement restrictions have impacted tremendously the ability of refugees and migrants to sustain themselves. Unable to cover basic needs and unable to comply with quarantine measures and physical distancing, Venezuelans have not only lost livelihoods and accommodation, but recent impact surveys found that in several countries in the region over a quarter of the refugees and migrants can only afford eating once a day, further impacting their nutritional health and development. To avoid this situation from deteriorating, and indirectly contributing to a further spread of the pandemic, immediate assistance to the refugee and migrant populations is required.

Amongst those most at-risk are persons with pre-existing chronic illnesses and specific needs (children, older persons, persons with disabilities), single-headed households and women and girls at risk of GBV and trafficking and exploitation. Resulting from prolonged confinement and isolation, the prevalence of GBV continues to rise, impacting especially those in violent households. With schools and universities closed across the region, education is of increasing concern as many refugees and migrants have

<sup>38</sup> The table reflects full revision of the RMRP. As a result of the reprioritization and identification of additional requirements, the original total budget of USD 1.35 billion increased to USD 1.4 billion.

## Venezuela *Regional Refugee and Migrant Response Plan*

RMRP

limited capacities to access on-line and other forms of education available for nationals.

### Response priorities and challenges / Coordination

As COVID-19 is yet to peak in LAC, its consequences for refugees and migrants may be truly devastating. In response, the Regional Inter-Agency Coordination Platform (R4V), as a priority, advocates for full inclusion of refugees and migrants in the national COVID-19 responses of the 17 countries covered by the R4V response. The R4V Platforms are co-led by UNHCR and IOM, with different agencies and organizations co-leading sectors at regional and national levels. In the context of the COVID-19 response, in line with its global leadership, WHO/ PAHO leads the health-related aspects of the response plan. The objective of the Platform remains to complement governments' efforts in the region, through the Regional Refugee and Migrant Response Plan (RMRP) for Refugees and Migrants from Venezuela. In this respect, a comprehensive review of the RMRP was undertaken, highlighting the urgent COVID-19-related needs and priorities of host governments. The key focus of this exercise was responding to refugees' and migrants' needs in the areas of Health, Protection, Shelter, WASH, Nutrition, Food, and Livelihoods/Integration.

Reflective of the reprioritization of the 151 RMRP partners' activities, the COVID-19 review of the RMRP resulted in an increase of planned humanitarian interventions targeting 3.1 million refugees and migrants from Venezuela and almost 1 million affected community members. As per the revised RMRP of May 2020, many R4V partners are focusing on life-saving activities and COVID-19 prevention activities, with adapted and largely remote response modalities. Some of the specific COVID-19-related responses include: mobile health facilities for testing and referral of COVID-19 cases; upgrading of temporary accommodation solutions and shelters with adequate spacing and WASH arrangements; development of adapted GBV pathways; remote education mechanisms, and focused provision of technical support to authorities to enhance their response to the COVID-19 pandemic.

---

**ANNEX 1**

# Country and regional plans: Other Plans

- 69**   **Horn of Africa and Yemen** *Migrant Response Plan*
- 71**   **Rohingya Crisis** *Joint Response Plan*
- 73**   **Benin**
- 75**   **Democratic People's Republic of Korea**
- 77**   **Iran**
- 79**   **Lebanon**
- 81**   **Liberia**
- 83**   **Mozambique**
- 85**   **Pakistan**
- 87**   **Philippines**
- 89**   **Sierra Leone**
- 91**   **Togo**

# Horn of Africa and Yemen *Migrant Response Plan*

MRP

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$31.52M<sup>39</sup>**

### OF WHICH:

HEALTH: \$20.93M  
NON-HEALTH: \$10.59M

### People in need

235,000 people.

### Targeted population

235,000 individuals (The entire target population of the RMRP in 2020 will benefit from COVID 19 activities).

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$84.14M<sup>40</sup>**

### OF WHICH:

COVID-19: \$39.18M  
NON-COVID-19: \$44.96M

### Countries covered

Yemen, Somalia, Ethiopia and Djibouti

## Context

The Regional Migration Response Plan (RMRP) for the Horn of Africa and Yemen is a migrant-focused humanitarian strategy for vulnerable migrants who are part of the bi-directional movement between the Horn of Africa and Yemen, as well as host and transit communities in areas with significant numbers of returning migrants. The dire situation of the migrants affected by the humanitarian crisis includes severe economic decline, food insecurity, cholera, malaria and other diseases and massive displacements have been worsened by the outbreak of COVID-19.

Restriction of movements has been forcing migrants to use new routes where access to health and assistance is not available, further exposing them to humanitarian hardships and protection risks. Based on the assumptions that movements may gradually re-start towards the end of August, with an expected peak of returns from countries like KSA to Ethiopia and Somalia, and arrivals into Yemen, the RMRP 2020 Plan indicates that about 235,000 migrants are expected to be on the move along this route for 2020. This includes some 105,000 stranded and vulnerable migrants who will need assistance in Yemen, and 130,000 migrants returning to Ethiopia and Somalia, or in transit in Djibouti and Somalia. Response to the increased vulnerabilities of migrants stranded along the migratory routes, requires substantial resources and engagement by RMRP partners.

## Impact of COVID-19

### Immediate health impact on people and systems

The impact of the COVID-19 outbreak on the East and Horn of Africa is expected to be far reaching and more catastrophic given concurrent morbidity among the general population, the population size, and status of health systems and health workforce, which both have low

resilience to external shocks and have insufficient critical care capacities.

### Indirect impacts on people and systems

The COVID-19 has negatively affected the lives of millions of people escalating pre-existing financial burdens resulting in increased unemployment for youth. Migrant workers and other vulnerable populations in irregular situations face restricted access, decreased incomes and purchasing power to procure food and are no longer able to cross borders to trade or search for jobs and opportunities.

The RMRP countries are already experiencing the shocks of fluctuating commodity prices and reduced remittances compounded by floods, extreme weather conditions and invasion by locusts. This has resulted in growing food insecurities, threatening starvation and malnutrition, compounded by the disruptions in humanitarian assistance for the migrants and host communities.

COVID-19 has resulted in disruptions in health services for the treatment of TB, HIV, malaria and Sexual and Reproductive Health (SRH) for women as governments and partners focus on responding to COVID-19. People are also afraid to access health care facilities as they fear contracting the virus in the facilities.

Human rights abuses including physical and psychological abuse, xenophobia and stigmatization of migrants have been on the increase, as migrants are perceived as potential carriers of COVID-19. Protection concerns such as increased incidents of gender-based violence, human trafficking, family separation; and safety and dignity concerns for migrant women and girls are further compounded.

Among the migrants, women and girls, unaccompanied and separated children (UASC), older persons, persons with

39 This amount shows the total COVID-19 costs in the MRP, minus those included in plans for Somalia and Ethiopia (\$7.6 million). To avoid double-counting, this figure is used in the main financial table under Section 4.

40 This figure shows the total COVID-19 plus non-COVID-19 response for the MRP, including amounts for COVID-19 that are accounted for in the Somalia and Ethiopia plans. It differs from the total figure of the main financial table in Section 4 as the latter uses excludes amounts already covered in Somalia and Ethiopia to avoid double-counting.

# Horn of Africa and Yemen *Migrant Response Plan*

MRP

disabilities and are the most affected and they are also not included in most national response plans and social safety nets.

## Response priorities and challenges

### Priorities and achievements

Response priorities include support for quarantine facilities, and other systems to ensure migrants are able to access quality and culturally sensitive health services. Risk communication and community engagement (RCCE) to the affected communities; support to authorities with COVID-19 Infection, Prevention and Control (IPC) and the provision of personal protective equipment (PPE) are key priorities for the RMRP partners. Improved provision of mental health and psychosocial support (MHPSS); strengthening child protection structures, provision of humanitarian and protection assistance to the most vulnerable migrants even in hard to reach areas along the Eastern route remains key to the response.

The main achievements of the RMRP multi-agency responses include; provision of direct primary health care services delivery including MHPSS, HIV, TB and malaria detection and treatment as well as supporting governments both regional and national to strengthen IPC of the disease. The RMRP partners are coordinating advocacy efforts against xenophobia, discrimination, arrest and detention of migrants whilst strengthening existing referral mechanisms and service pathways for UASC among child protection service providers. RCCE on COVID-19 to promote access and referrals to specialized services remains one of the key activities to the response.

### Challenges and impact to operations

Lack of funding is resulting in limited testing capacity, tracing, isolating and care for the affected and at-risk populations is of concern. There are severe shortages of essential medical supplies and PPE to protect and support the frontline public health workers as a result of inadequate funding. Bureaucratic impediments including restricted access to the affected populations and breakdown of supply chains which increase transactions costs.

# Rohingya Crisis Joint Response Plan JRP

## COVID-19 REQUIREMENTS<sup>41</sup>

### REQUIREMENTS

**\$181.0M**

### OF WHICH:

HEALTH: \$86.4M  
NON-HEALTH: \$95.0M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$1.05B**

### OF WHICH:

COVID-19: \$181.0M  
NON-COVID-19: \$877.0M

### People in need

860,000 Rohingya refugees and 949,000 Bangladeshis in host communities.

### Targeted population

860,000 Rohingya refugees and 949,000 Bangladeshis in host communities.

## Impact of COVID-19

### Immediate health impacts on people and systems

Some 860,000 Rohingya refugees currently reside in 34 congested camps in Cox's Bazar District. The District is one of the poorest in the country, home to 2.65 million Bangladeshis. Cox's Bazar District is at extreme risk of severe impact from COVID-19, given the congested conditions in the refugee camps, high levels of vulnerabilities among the refugee and Bangladeshi populations, and the extremely limited public health capacity. People with chronic illnesses and older persons (approximately 4 per cent of the Rohingya population, or 31,500 individuals, are over age 59) are at particularly at high risk. The prevalence of respiratory illnesses combined with underlying factors such as malnutrition and other undiagnosed diseases could increase the impact of the COVID-19 outbreak in the camps. Planning is based on capacity, rather than on anticipated need; current modelling of the likely trajectory of the epidemic indicates that the requirement for beds will far exceed availability.

In close coordination with the Government of Bangladesh, humanitarian partners have been preparing for the outbreak since early in the year. Community transmission is now confirmed in the camps and wider District, with the number of cases increasing daily. To slow transmission of the virus, the Government has halted all but critical services in the camps; services such as health, nutrition, food and fuel distribution, hygiene, water and sanitation, construction of health facilities and additional WASH infrastructure, reception of new arrivals, quarantine and family tracing continue. Services that are temporarily closed include educational facilities, women and child friendly spaces, and markets.

### Indirect impacts on people and systems

949,000 Bangladeshis in Cox's Bazar are considered

vulnerable to loss of livelihoods and income as a result of COVID-19. Loss of livelihoods coupled with rising prices on some basic food items is stretching the coping capacities of vulnerable Bangladeshis. In addition, the social impact of the outbreak is deepening inequalities. Emergency provisions enacted to curtail the spread of COVID-19 must conform to human rights standards, to avoid discrimination and the potential for conflict. Women and girls are being disproportionately impacted due to restrictive gender norms, with reports of increased domestic violence in camps and host communities.

## Response priorities and challenges

### Priorities and early achievements

Priorities include sustaining critical, life-saving services and assistance, with contextualized public health measures to minimize transmission, such as physical distancing and hygiene; scaling up Risk Communication and Community Engagement on health, and increasing availability of water, sanitation and hygiene services for Rohingya refugees and Bangladeshis; establishing the health response to COVID-19 for Rohingya refugees and Bangladeshis – a multi-sector effort; protecting older and vulnerable Rohingya refugees; augmenting Government social safety nets for vulnerable Bangladeshis whose livelihoods have been impacted by the pandemic; and scaling up critical common services to enable the humanitarian operation.

Among the achievements to date, twelve new Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) for COVID-19 are being established, three of which are already operational and receiving patients. Support to Government facilities is being provided across the District, with 10 new intensive care beds recently operational in the District Hospital. In the camps, the distribution of re-usable masks to everyone and installation of handwashing stations outside all refugee shelters is underway. For Bangladeshis,

<sup>41</sup> ISCG partners have developed a COVID-19 Response Plan as an addendum to the JRP 2020. The plan defines additional needs arising from the COVID-19 pandemic totaling US\$181 million, as well as priority funding gap within the JRP 2020 of US\$389 million, required to sustain critical, life-saving activities until the end of the year.

# Rohingya Crisis *Joint Response Plan* JRP

food, cash or agricultural inputs are being provided to the most vulnerable. To support front-line humanitarians, a 50-bed facility is being established, which will be essential to the continuity of the operation.

## Challenges and impact to operations

The refugee population remains entirely reliant on humanitarian assistance. The reduced footprint in the camps to deliver critical services only has made the role of refugee and Bangladeshi volunteers even more critically important and requires remote management. An increase in criminal and protection incidents has been observed since April. Shifting policies on movement restrictions call for constant negotiation to sustain access. Restrictions to supply chain, travel and entry of surge staff is presenting major challenges. Communication and trust between communities is fragile and maintaining privacy and data-sharing protocols is presenting challenges. The continued restriction on mobile data networks in the camp areas is a major impediment to the operation. The monsoon season has begun, with heavy rains and high winds in June causing flooding and damaging shelters and infrastructure, and the second cyclone season is approaching in October.

## Coordination

The 2020 Joint Response Plan (JRP) remains the core strategy, planning and resource mobilization platform for the operation. Guided by the JRP 2020, and through the Inter-Sector Coordination Group (ISCG), the humanitarian community works closely with the Government of Bangladesh and district health authorities. A total of 117 partners contribute to the JRP. The ISCG partners have developed a COVID-19 Response Plan as an addendum to the JRP 2020. The plan defines additional needs arising from the COVID-19 pandemic totaling US\$182 million. The addendum also identifies priority activities and funding gaps within the JRP 2020: US\$389 million is required to sustain critical, life-saving activities within the JRP 2020 to the end of the year.

# Benin

OTHER

## COVID-19 REQUIREMENTS

REQUIREMENTS

\$17.9M

OF WHICH:

HEALTH: \$10.9M  
NON-HEALTH: \$7.0M

## TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$17.9M

OF WHICH:

COVID-19: \$17.9M  
NON-COVID-19: –

## PEOPLE

IN NEED: 3.0M  
TARGETED: 1.0M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of June 22, the call center monitoring the spread of COVID-19 had received a total of 20,332 calls from the Beninese population to announce suspected cases. Simultaneously, 18,128 laboratory tests (PCR) have been carried out. The total number of patients diagnosed with Covid-19 reached 807 since the first patient was confirmed on March 16, 2020. 13 patients have died, marking a fatality rate of 1.6 per cent. Males seem to be the most affected, constituting 57.1 per cent of cases, and people aged between 15 to 45 are the most infected age group, with 66.2 per cent of the confirmed cases. Local transmission of the infection is estimated at 73.1 per cent among those infected.

By triggering the COVID-19 Response Plan, some health services, personnel and resources, mainly preventative and routine, have been diverted or relegated to the background. Several immunization services were affected, namely logistics (disruption in vaccine and its related devices), service delivery (reduced supply and demand), support components (supervision and capacity building of agents, monitoring, planning) and communication.

These measures have an estimated total cost of 672,095,179 USD. Commitments have been obtained from certain PTFs including the Islamic Development Bank, World Bank, BADEA, WHO and UNICEF. The funding gap for this budget is (365,090,609,042) FCFA as of May 3.

### Indirect impacts on people and systems

The Government's response to counter the spread of COVID-19, in addition to the prolonged border closure with Nigeria, is affecting economic activities. As a result, economic growth is projected to decrease by 3.2 per cent in 2020, reversing the upward momentum recorded in recent years (6.4 per cent in 2019<sup>42</sup>). The global demand slump resulting from containment and lockdown policies, in addition to the disruption of supply chains, is affecting economic activity and may see a rise in job losses, underemployment and losses in revenues. Effects are felt across sectors such as agriculture and food security, WASH, production and consumption, transport and communication,

health, education and consequently employment, economy, human rights and gender.

School closures impact over 3.2 million children and the disruption of public transport impacts a large number of vulnerable people. This situation calls for adjustments to be made so as not to hinder SDG achievements.

Households suffer from food shortages and a rise in food and basic commodities prices. The risk of a decrease in agricultural production would amplify food insecurity and the nutritional crisis for the most vulnerable. Food insecurity, estimated at 8.32 per cent before COVID-19, is expected to rise due to local and international market disruption. The "Cadre Harmonisé" is foreseeing 14,578 persons in IPC 3 (June - August 2020).

Lack of WASH items and the increase of prices in local markets affect the continuity and quality of water and sanitation services. With regard to protection, the measures taken to counter COVID-19 risk putting adolescent girls and women in vulnerable situations. Adolescent girls are at risk of dropping out of school, increasing their exposure to child marriage, while women are at increased risk of GBV. There are increased threats for children to be victims of domestic violence and violence against children (VAC) including gender-based violence (GBV). VAC was already alarming in Benin with 91 per cent of children aged 1-14 years experiencing a form of violent discipline before the pandemic.

## Response priorities and challenges

### Priorities and early achievements

Constituting an integrated response to support the Government's efforts against COVID-19 in line with the National Response Plan, UN agencies played their roles in coordinating technical, material and financial support as well as resource mobilization for the country. This includes: the development of the health contingency plan; the development of the UN contingency plan; support for design and construction of COVID-19 treatment centers; support for surveillance at entry points; support on epidemiological monitoring; support with PPEs, reagents and laboratory equipment; and support in awareness and communication.

42 IMF Country Report No. 19/398.

## Benin OTHER

For Benin not to lose gains towards achieving the SDGs, the response plan was coordinated through a joint approach. It focused on supporting risk communication and community engagement through innovative digital engagement and rumors monitoring, supporting allocation of supplies, scaling up early detection, testing capacity and contact tracing, and personal protection equipment for health workers. It will provide tailored response based on multisectoral analysis to deliver adequate emergency food assistance targeting around 500,000 beneficiaries in the most affected communes and livelihoods response as well as providing WASH services and support for the informal sector and vulnerable population.

The key early achievements are:

- Establishment of a dedicated task force and humanitarian response coordination mechanism for Covid-19
- The set-up of COVID-19 testing laboratories in the 12 departments including the systematic screening of the most exposed personnel by the Government
- UNCT distributed nearly 7 000 handwashing devices in primary schools in Benin
- Establishment of teleworking for schools in final classes via radio
- Multisectoral assessment of socio-economic and humanitarian impacts is underway

### Challenges and impact to operations

Benin is not familiar with the management of large-scale emergency response operations. Health response and coordination capacity remains limited. Scaling up an adequate response mechanism requires specific investment and adequate resources to ensure timely and tailored multisectoral response in order to address to immediate needs.

COVID-19 response funding remains limited despite the needs to bring the country's response system to scale.

# Democratic People's Republic of Korea OTHER

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$39.7M</b>	HEALTH: \$19.7M NON-HEALTH: \$20.0M	<b>\$146.7M</b>	COVID-19: \$39.7M NON-COVID-19: \$107.0M	IN NEED: 10.4M TARGETED: 5.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 19 June, there were no confirmed cases of COVID-19 in DPRK. Some 922 people have been tested to date, returning negative results. Borders remain closed for travel, though an increase in shipments has been recorded. The Government continues its efforts to systematically detect, test, and implement measures to prevent the importation/transmission of COVID-19 cases and augment its health capacity.

Around nine million people are estimated to have limited access to quality health services, due to chronic shortages of essential medicines, supplies, equipment, and limited training of healthcare providers. Maternal health care, especially the needs of pregnant and lactating women, has been identified as a priority for intervention due to increased vulnerability toward and immediately after maternity. Ongoing travel restrictions and lack of supplies have also affected adequate needs assessments.

### Indirect impacts on people and systems

Preventative measures adopted by the Government, such as long quarantines that affected more than 25,500 people as well as cargo, the closure of borders and travel restrictions within the country will negatively affect the economy. A Finch Solutions analysis estimates that the DPRK economy may contract by six per cent in 2020. An FAO study on the impact of COVID-19 on food and agricultural systems worldwide, based on exposure of countries and regions, assessed DPRK's exposure to the share of agricultural imports as "intermediate high".

Though the planting for main staples season had been completed, the limits on internal mobility, lack of super-seeds and essential agricultural inputs may result in a low yield harvest season. With the prevailing challenges around food security for over 10 million people and the decline in food imports, a decline in food consumption and lack of access to diversified foods and quantities is expected.

After a four-month suspension, educational activities resumed on 3 June, following a disinfection campaign and adhering to hygiene protocols. The loss of nutritional support for children during these months and lack of supplies and access for nutritional support remains a

concern; for example, some 200,000 children and pregnant women and lactating mothers did not receive micronutrients and around 95,000 acutely malnourished children did not receive treatment.

## Response priorities and challenges

### Priorities and early achievements

Support for the implementation of the strategic operational plan to country preparedness and response for COVID-19 (CSPRP) is being provided by the Health Sector Working Group in dialogue with the Ministry of Public Health. Ongoing health sector humanitarian interventions were able to continue thanks to the pre-positioning of essential medicines, arrival of new supplies and those in the pipeline. No irregular growth in other common diseases has been reported, while the vaccination services across the country continued to be provided.

As part of the response, humanitarian capacities and supplies in-country were redirected, including protective gear, diagnostic capabilities for the treatment of other diseases and basic medication. Shipments of COVID-19 items and other humanitarian programs are now arriving at a growing pace. These include a WHO shipment of 1,000 diagnostic kits and reagents and another with PPE, partially thanks to a CERF \$900,000 COVID allocation. Some medicines, including for Tuberculosis (TB) and non-communicable diseases (NCD) and medical supplies have also begun to arrive in Pyongyang and are being disbursed to health facilities, along with additional PPEs from MSF and UNICEF, as well as remote thermometers from the latter. Two shipments of vaccines for children by UNICEF including Pentavalent and BCG arrived via land route in June, replenishing stocks till end of 2020. WHO has regularly provided guidance to the Government while the IFRC has helped train and organize volunteers in COVID-19 epidemic control. An IFRC shipment of rt-PCR probes, primers and testing kits along with 250 professional PPE kits, N95 Masks and infrared thermometers were to arrive in country early July. UNICEF distributed Critical WASH supplies to 41,573 people and 121 health facilities.

Amid constructive engagement and advocacy, the 1718 Sanctions Committee has been granting expedited humanitarian exemptions.

# Democratic People's Republic of Korea OTHER

## Challenges and impact to operations

Strict measures at port of entry for supplies remain, including a 14-day quarantine. A five-month gap in the humanitarian response, along with a significant backlog of containers, has developed. The inability to bring staff into the country and to move internally continues to significantly affect delivery of services. Areas of impact include:

- **Health:** International assistance programs, including those targeting the critical and life-saving health interventions, like surgical and anaesthesia care, emergency obstetric and newborn care, adolescent and maternal care, treatment of tuberculosis and other diseases are experiencing low levels of supplies.
- **Food Security:** Some 581,577 beneficiaries, including 306,365 females, may not receive timely agricultural inputs and technical support from FAO. Additional 560,000 people receiving food assistance, including 211,800 women, may not to receive timely fortified foods, and other inputs and technical support from WFP.
- **Nutrition:** Production of fortified foods may continue to be delayed, despite the arrival of raw material, due to lack of access to beneficiary communities. An estimated doubling of the current caseload may occur, rising to 460,000 pregnant and lactating women and over a million children requiring assistance.
- **WASH:** Regular programme implementation remains mostly on hold except ongoing/continuing water supply and sanitation projects from 2019 for which supplies were already delivered.

Efforts of the international humanitarian community to secure unimpeded humanitarian access, along the Secretary-General's global call, are ongoing. Funding availability is crucial for the implementation of this plan.

# Iran OTHER

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$117.3M</b>	HEALTH: \$17.7M NON-HEALTH: \$99.6M	<b>\$117.3M</b>	COVID-19: \$117.3M NON-COVID-19: –	IN NEED: 40.1M TARGETED: 25.0M

## Impact of COVID-19

### Immediate health impacts on people and systems

Iran is the most affected country by COVID-19 in the MENA region. Since the first case was detected on 19 February, there have been 220,180 confirmed cases and 10,364 deaths (as of 27 June), with a total of 1,583,542 laboratory tests conducted (currently 25,000 daily). In mid-April, the Government gradually lifted lockdown restrictions and increased testing capacities. This led to a rise in new cases since May. Restrictions could be re-imposed if the trend continues.

Iran has upscaled domestic production of PPE and COVID-19 test kits and began exporting COVID-19 health supplies to support other countries. Iran is producing ventilators and working on a COVID-19 vaccine and is among the first to successfully use plasma therapy for COVID-19 treatment.

### Indirect impacts on people and systems

The COVID-19 crisis is affecting over 50 per cent of Iran's 25 million workforce. Economic contraction may lead to a fall of up to 15 per cent of GDP with significant impact on the most vulnerable bottom 40 per cent of the population. The World Bank estimates a 29 per cent inflation, which together with continuing devaluation of the IRR can result in economic downturn and lowered purchasing power of families. For its response, the Government asked the IMF for a US\$5 billion loan and the IsDB for a EUR130 million loan, both still pending approval.

COVID-19 caused a considerable degree of stress and anxiety among the population and the country is facing difficulties in providing mental health services. An estimated 64 per cent of female headed households in rural areas are living near the poverty line; women's unpaid care work has increased due to school closures and the increased needs of older persons.

COVID-19 increased malnutrition due to food insecurity and decreased levels of health care and has negatively impacted children's health and nutrition programmes.

Refugees as well as undocumented populations have access to primary health care services. As of 20 June, there were 3,243 refugees reportedly infected by COVID-19,

most of them in refugee settlements. The response is being closely managed by the Government and UN agencies. There is also an increased threat of trafficking and smuggling of migrants left stranded due to travel restrictions.

## Response priorities and challenges

### Priorities and achievements

Increased testing capacities were achieved, and a mobile application provides follow-up steps for users. Other priorities and advancements:

- Psychological and consulting support through 4030 Call Centre (10,000 people daily); the national and subnational media; and Primary Health Care (PHC) centres.
- The Supply Chain Coordinator is supporting the efforts of the Government with WHO, UNICEF and WFP co-leading on the global procurement and supply chain. To date, UNICEF, UNHCR, UNDP and WFP have brought over 115.9 tons of PPE. WHO brought in medicines to enable Iran to contribute data to the Solidarity Trial.
- IOM has instructed implementing partners on how to train 20,000 Afghan families on COVID-19 while distributing hygiene packages.
- UNFPA supported the Midwifery Association and older persons care services through procurement of PPEs and medical equipment.
- UNICEF supports the Government on Infection Protection Control services.
- UNICEF and the Ministry of Interior launched a campaign for children and youth on COVID-19 within the framework of Child Friendly Cities Initiatives.
- UNICEF reached more than 6.5 million people on its social media channels.
- The UN has developed a COVID-19 recovery programme focusing on 1) employment generation 2) social protection 3) health system strengthening.

### Challenges and impact to operations

Iran continues to deal with ongoing floods, earthquakes, locust invasion and wildfires.

- Floods have affected 20,000 people in 18 provinces since

## Iran OTHER

January. Damage to the agricultural sector is estimated to exceed US\$120 million.

- Earthquakes are considered high risk in Iran. Over 1000 earthquakes occurred in May/June, three of them above 5.0 RS.
- Locust invasions have affected eight provinces, over 12 million people's food and nutrition security is at risk.
- In May, wildfires broke out across five provinces causing extensive damage.

Remaining critical gaps include:

- Continuing risk communication and community engagement due to lifting of measures, reopening of business and non-compliance to health protocols;
- Strengthening laboratory network to enhance diagnostic and early detection capacities, supporting PHC and clinical network in screening, isolation and treatment capacities remain high priority;
- Strengthening implementation of International Health Regulations at points of entries;
- Maintaining essential health services during response to the outbreak, coordinating mechanism of health sector; consolidation of demand under national action plans for COVID-19 response, coordination of procurement; agreement of allocation, and streamlined distribution and transport to ensure efficient delivery;
- Addressing increased protection concerns for refugees, and non-registered immigrants, stranded migrants, smuggled migrants, and victims of trafficking in need of humanitarian assistance.

# Lebanon

OTHER

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$136.5M**

### OF WHICH:

HEALTH: \$75.9M  
NON-HEALTH: \$60.6M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$473.5M**

### OF WHICH:

COVID-19: \$136.5M  
NON-COVID-19:  
CPRP - \$34.3M  
LCRP - \$302.7M<sup>43</sup>

## PEOPLE

IN NEED: 6.0M  
TARGETED:  
In progress

## Impact of COVID-19

### Immediate health impacts on people and systems

Since the first confirmed case in Lebanon on 21 February, 1,778 confirmed cases have been reported, with 1,183 recoveries and 34 deaths, as of 1 July. The trend of confirmed cases has now levelled at around thirty per day.

Rafik Hariri University Hospital remains the main hospital available to screen, test and admit COVID-19 patients. Eleven other government hospitals are being upgraded for testing and inpatient care of moderate and severe cases.

An estimated 6 million people in Lebanon need access to adequate health services, with an estimated 65 per cent of the population unable to pay for hospitalization costs.

On 22 June, 92 Syrian refugees and 13 Palestine refugees were reportedly confirmed infected with COVID-19. An additional 74 migrants tested positive for the virus.

Subsidized primary health care is available to Syrian refugees and vulnerable Lebanese through a network of NGO-supported primary health-care centres. Primary health care is also available to Palestine refugees at UNRWA health clinics. Affordability and access to primary health care is, however, difficult due to increasing needs in relation to the economic crisis. Secondary health care in Lebanon is expensive and mostly private. Health care and other services support for migrants remain a gap.

### Indirect impacts on people and systems

COVID-19 arrived as Lebanon faces a crippling socio-economic crisis. Lockdown and other measures further exacerbated existing difficulties. Pressure on the Lebanese pound and reduced imports at increased prices have led to growing inflation. An estimated 430,000 people, equivalent to 32 per cent of the workforce, have lost their jobs. Many more have joined the informal sector.

Despite high levels of human development in Lebanon, almost 30 per cent of the population was living below the national poverty line prior to the onset of the economic crisis, further worsened by COVID-19 lockdown measures. It is now estimated that approximately 1 million Lebanese

are below the food poverty line. Among the estimated 1.5 million refugees, the percentage of those living in extreme poverty has increased from 55 per cent pre-crisis to an estimated 75 per cent. Migrants stranded in Lebanon face increasing unemployment, poverty, abuse and violence.

Restrictions of movement, public administration and municipal measures during lockdown, and inability to pay for transport decreased access to essential services. With decreased access to health care, compromised livelihoods, and increasing food insecurity, concerns remain about child health and nutritional status and sexual and reproductive health. Evidence suggest increasing patterns of gender-based violence and unpaid care work.

## Response priorities and challenges

### Priorities and early achievements

In support of the Government of Lebanon, on 7 May, the UN Resident Coordinator and Humanitarian Coordinator ad interim released a Lebanon Emergency Appeal with humanitarian partners. The appeal, which has been extended until the end of 2020, highlights critical areas of humanitarian intervention to protect the lives of people in Lebanon who are most acutely at risk of the virus and its immediate socio-economic impact.

With support from the UN, INGOs and their partners, the Lebanese Government's response capacity has increased in recent months. An average of 1,500 tests are conducted daily, with the goal to reach 2,000 tests per day. As of 24 June, the national ICU bed and ventilator capacity has also increased to 432 (target of 600) and 428 (target of 700) respectively. Information campaigns to contain the spread of COVID-19 have reached over two-thirds of the population.

Additional preparations are required ahead of a possible second wave, particularly following the resumption of international commercial travel. Additional funding is required to maintain operations of isolation centres over a longer period.

In May, the clusters of COVID-19 cases detected among migrant workers revealed the gap in the response for migrant populations. Efforts to strengthen the integration

43 The total requirements for Lebanon include \$34.3 million from Country Preparedness and Response Plan (CPRP), \$302.7 million from the 2020 Lebanon Crisis Response Plan and \$136.5 million for the COVID-19 response.

## Lebanon

OTHER

of migrant workers in the response, as well as advocacy for more support, continue to be required.

Support is ongoing to vulnerable Lebanese and Palestine refugees who were not previously targeted through the LCRP. Currently, preparations are underway to distribute food to an estimated 50,000 Lebanese households. In parallel, technical support was provided to the Lebanese government to provide their emergency cash assistance to vulnerable groups.

### Challenges and impact to operations

Data gaps about Lebanese, Palestine refugee and migrant populations remain a primary challenge to reach the most vulnerable populations in a needs-based, prioritized and principled manner.

In recent years, humanitarian and stabilization efforts have successfully provided direct assistance and institutional support to refugees and vulnerable Lebanese. COVID-19 and its socio-economic consequences, in the backdrop of a major economic crisis in Lebanon, require expanded efforts and an adjusted approach to address the ongoing multifaceted crisis. It is vital to ensure that a needs-based and principled humanitarian approach is applied. Furthermore, balanced messaging and dialogue is needed to ensure COVID-19 patients and non-national communities are not stigmatized.

# Liberia

OTHER

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$57.0M**

### OF WHICH:

HEALTH: \$17.5M  
NON-HEALTH: \$39.9M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$57.0M**

### OF WHICH:

COVID-19: \$57.0M  
NON-COVID-19: –

## PEOPLE

IN NEED: 4.4M  
TARGETED: 2.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 6 July 2020, Liberia had recorded 917 confirmed cases of COVID-19, including 41 deaths (CFR=4.43 per cent). Five-hundred and five (65.8 per cent) cases were male, while 263 were female. Seventy-three cases (9.5 per cent) were children below 15 years, 3 cases were pregnant women while 65 (8.5 per cent) were health-care workers.

Thirteen (13) of the 15 counties have now reported cases. Montserrado County, the epicenter of the pandemic in Liberia, has reported 81.50 per cent (626 out of 768) of the total confirmed cases. Capacity for treatment in Montserrado county is at risk of becoming overstretched, with 132 (80.9 per cent) cases admitted into treatment units, while over 100 confirmed cases are still in the community.

The risk of local transmission remains high, accounting for nearly 90 per cent of confirmed cases amid difficulties in complying with preventive measures, including social distancing in hotspot communities.

COVID-19 is severely impacting the Liberian health-care system. As of April 2020, the health services utilization rate has declined by 36 per cent. Outpatient visits have reduced from 0.88 in January to 0.54 visits in April 2020. Health facilities where cases were reported have either had to close sections of the hospital or shut down entirely. Some services have been suspended and routine services like immunization have been scaled down, risking the re-emergence of childhood preventable diseases.

Increased efforts are required to curb the risk of rising maternal and neonatal mortality rates. Stigma and fear linger over COVID-19 and health services among communities, exacerbated by the diversion of staff and resources, service reduction and infection of health workers. Liberia is a net importer of medicinal and pharmaceutical products and lowest levels of physicians (0.037/1000 population) and hospital beds (0.8/1000 population). Reduced child immunization services in an already under-vaccinated population is of significant concern. Rural facilities lack sufficiently skilled staff to care for pregnant women and newborns and provide HIV-related and essential reproductive health services.

### Indirect impacts on people and systems

The pandemic will exacerbate pre-existing vulnerabilities. Half the population lives below the poverty line and the economic growth rate was a low 1.4 per cent in 2019. Liberia imports 81 per cent of its food requirements. Prices are expected to continue to rise as the country struggles with an inflation that increased to 25.8 per cent in February 2020, putting the most vulnerable at-risk. Chronic malnutrition remains widespread and at least 35.5 per cent of children under 5 are stunted.

With the heightened economic hardships, movement restrictions and closure of non-essential businesses, women and children are at heightened risks of sexual and gender-based violence (GBV) and other forms of violence. GBV cases are likely to increase, surpassing the 2,708 cases recorded in 2019. The closure of schools is affecting over 1.4 million students (including 650,000 girls).

The high proportion of the urban slum population (65.7 per cent) is posing additional challenges to the response due to the small number of WASH facilities and services available (less than 1 per cent have basic handwashing facilities at home).

Other high-risk groups include subsistence and small producers such as agriculture labourers (landless farmers), urban workers of the informal sector, refugees, migrants, older persons and persons with disabilities. COVID-19 is likely to have a significant impact on the ability of affected populations to earn a minimum income coupled with rising levels of food insecurity, especially for female and child-headed households.

## Response priorities and challenges

### Priorities and early achievements

The Government has developed a preparedness and response plan with support from partners and activated the Incident Management System (IMS). Liberia has made significant progress in testing and response with the establishment of the COVID-19 Laboratory, case tracking, a dedicated treatment unit and Precautionary Observation Centres (POCs). Risk communication and community engagement has been accelerated, including through a countrywide hand-washing campaign, data analysis and Infection Prevention and Control.

The humanitarian community is working with the

## Liberia

OTHER

Government, changing the modalities for intervention to reach those most in need and repurposing existing funding in response to the pandemic. Some activities in the response will include: emergency social safety net interventions through in-kind food and cash-based transfer modalities; provision of assets and tools to increase agriculture and livestock production; continuation of essential life-saving interventions; increased diagnostic capacity; capacity strengthening of health and social welfare personnel; and supply chain services.

### Challenges and impact to operations

The major challenges are inadequate funding for preparedness and response activities and challenges in supply and logistics. The disruption of global supply chains, border closures and restrictions on commercial transport further undermine the country's capacity to supply, store and transport goods to hard-to-access and remote counties. This will be exacerbated by Liberia's poor road infrastructure and an impending rainy season affecting perishable goods, extending supply times and resulting in price increases that could reduce the purchasing power of the most vulnerable households. The increasing rate of infection from 101 to 768 as of June 28 has led to an extended state of emergency until 21 July. Despite the challenges, the Government approved the reopening of airports on 28 June; businesses have been allowed to open adhering to a curfew and school for 12-graders will reopen on 29 June.

# Mozambique

OTHER

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$68.1M**

### OF WHICH:

HEALTH: \$16.0M  
NON-HEALTH: \$52.1M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$68.1M**

### OF WHICH:

COVID-19: \$16.0M  
NON-COVID-19: –

## PEOPLE

IN NEED: 7.8M  
TARGETED: 2.9M

## Impact of COVID-19

### Immediate health impacts on people and systems

By 28 June 2020, Mozambique had 859 confirmed COVID-19 cases and 5 deaths. Since May, the outbreak has transformed from clustered cases to community transmission, and cases have been reported in all 11 provinces of the country, with Nampula (277 cases), Cabo Delgado (261 cases) and Maputo (136 cases) provinces hardest-hit.

### Indirect impacts on people and systems

The most at-risk groups include children, older persons, women, persons with disabilities, people living with HIV (over 2.3 million people), internally displaced persons (IDPs) (over 211,400 in Cabo Delgado and nearly 100,000 living in resettlement sites following Cyclone Idai and recent flooding), refugees/asylum seekers (more than 26,200) and migrants.

Travel restrictions have impacted Mozambique's economy and the country's most vulnerable people. The Government has decreased its forecasted economic growth from 4 per cent to 2.2 per cent and indicated that it expects a deficit of more than 10 per cent of gross domestic product (GDP) in 2020. COVID-19 has forced thousands of Mozambicans previously working abroad to return home, significantly diminishing the vital life-line of remittances. In March alone, some 14,000 Mozambicans returned to the country. Communities dependent on informal cross-border trade between South Africa and Mozambique are out of business due to the border closure.

COVID-19 has compounded the consequences of climatic shocks across Mozambique, and rising violence in Cabo Delgado. Mozambique is facing a national staple cereal deficit of 24 per cent, especially for rice (54 per cent) and wheat (98 per cent). More than 40 per cent of households recently assessed reported high inadequacy of food intake, with the situation expected to be worst for women of reproductive age (18-49 years). There has been a reduction in income and purchasing power, especially among households dependent on the informal economy. These households are already resorting to emergency and food crisis strategies, such as spending savings, borrowing food, borrowing money, reducing non-food expenditures, and

negative coping mechanisms, such as child marriage and transactional sex.

Schools -which are due to soon reopen- have been closed since 23 March, impacting the education of more than 8 million children, especially displaced children and children with disabilities. Access to clean water and appropriate sanitation is a major challenge, with 80 per cent of urban dwellers living in informal settlements. Decrees introduced for the suspension of payment of water tariffs during COVID-19 are likely to impact private operators and the provision of water from centralized networks.

## Response priorities and challenges

### Priorities and early achievements

Priority actions include:

- Ramping up support to the Government-led COVID-19 health response in the three main areas of:
  - » Surveillance: partners have supported the Ministry of Health (MISAU) and National Institute of Health (INS) to establish an information management network that monitors the outbreak and shares information in real-time.
  - » Preparedness and prevention: All provincial capitals have established isolation centers (Maputo and Cabo Delgado province each have two) and Rapid Response Teams have been trained at provincial and district level. Efforts have been made to secure and preposition Personal Protective Equipment (PPE - including allocation criteria and distribution mechanism), sanitizers, oxygen and Infra-Red thermometers. Partners have supported MISAU to raise community awareness of COVID-19 and prevent transmission, including in schools.
  - » Response: Partners have supported testing of suspected cases and tracing of contacts, including supporting community surveillance and innovative approaches to early detection. Some 28,586 people have been tested, more than 1.1 million have been traced and 20,395 remain in quarantine. Partners have supported the development of Standard Operating Procedures for ground crossings and airports and a national operational plan for Points of Entry, as well as the development of a community

# Mozambique

OTHER

response strategy for COVID-19 and provincial response plans (e.g. Nampula and Cabo Delgado),

- Supporting continuity of essential health services, including supporting MISAU in the strategic reorganization of resources and procurement of life-saving essential medicines and supplies.
- Kick-starting the life-saving non-health response, including through: cash-based food assistance; distribution of agricultural and fisheries inputs (seeds, fertilizers, livestock feed, fishing gear/equipment for cold chain); promotion of food production in IDP resettlement camps and host communities to protect food availability; improvement of displacement sites to ensure site safety, hygiene and livelihoods; protection mainstreaming, monitoring and analysis; procurement of NFI kits for vulnerable COVID-19-affected households; and procurement of handwashing stations, disinfection materials, waste management materials, and soap for urban health facilities.
- Adaptation of the humanitarian response, including through: procuring and pre-positioning stocks to anticipate/mitigate potential supply chain disruptions; social distancing and hand-washing during distributions; and adaptation of protocols for the treatment of children with acute malnutrition.

## Challenges and impact to operations

Humanitarian partners are facing a number of challenges including: shortage of adequate PPE; lack of reagents for testing and overall limited testing capacity; security-related constraints that may limit physical, safe, inclusive and meaningful access, particularly in Cabo Delgado; and inadequate Mental and Psychosocial support, particularly for frontline health workers. critical services - such as sexual and reproductive healthcare, immunization activities and continuity of care for HIV, tuberculosis, malaria and cholera - are currently overstretched. Restrictions on international travel have largely prevented humanitarian partners from bringing additional human resources.

# Pakistan

OTHER

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$145.8M**

### OF WHICH:

HEALTH: \$37.4M  
NON-HEALTH: \$108.4M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$145.8M**

### OF WHICH:

COVID-19: \$145.8M  
NON-COVID-19: –

## PEOPLE

IN NEED: 6.7M  
TARGETED: 5.7M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 1 July, there were 209,337 confirmed COVID-19 cases in Pakistan, of which 2 per cent are health-care workers, and 4,304 people have died. According to WHO, Pakistan has become the sixth most-affected country in the world reporting new cases and the third riskiest country for COVID-19.

The updated prediction for COVID-19 confirmed cases is now approximately 800,000 cases, of which 15 per cent could require hospitalization. It is estimated that 5 per cent of cases will require critical ICU care, despite the Government of Pakistan and partners' efforts on awareness raising, while the health sector continues to struggle with the hike in infected cases.

COVID-19 has hampered the continuation of immunizations, preventive health care, pre- and post-natal care and care for other co-morbidities and polio vaccination campaigns. Nutrition programmes have suffered due to the outbreak, leaving over 200,000 pregnant and lactating women and 400,000 children among the most vulnerable and in need of regular nutrition support.

### Indirect impacts on people and systems

Containment measures and movement restrictions are devastating the economy with the damage estimated to be up to \$4.95 billion. Provisional estimates indicate Gross Domestic Product (GDP) at negative 0.38 per cent, jobs lost/disruption at 12.6 to 19.1 million, followed by a subsequent increase in the number people living below the poverty from 50-60 million to 125 million. The faltering economy is expected to have a significant impact on the most vulnerable groups, particularly women headed households and persons with disability, and may lead to an increase in child labour and child marriage, as well as an increase in domestic violence. Pakistan, which is ranked high globally in terms of intimate partner violence, is experiencing increased gender-based violence (GBV) issues under COVID-19. The reported number of GBV cases is up by 50-60 per cent compared to 34 per cent pre-COVID-19 among married women, along with high prevalence of child sexual abuse.

An estimated 40 to 62 million people are chronically vulnerable to food insecurity while also being exposed

to natural hazards. They risk falling into increased food insecurity requiring a scaled-up response by humanitarian partners through both in-kind and cash modalities. Currently, over 3 million people are in severe acute food security (IPC-3 and above) and the effect of desert locusts' swarms is increasing the risks to food security and livelihood resilience.

## Response priorities and challenges

### Priorities and early achievements

The Pakistan Global Humanitarian Response Plan (GHRP) for COVID-19 prioritizes the 6.7 million people expected to be disproportionately affected by the crisis. This includes Afghan refugees, IDPs and returnees, undocumented Afghans and people affected by natural disasters. Among the key response highlights are:

- Continued collaboration with the Polio Eradication Initiative to use thousands of polio health workers to maintain and strengthen routine immunization; advocating for specific quarantine arrangements and services for women and girls and inclusion of refugees in social protection programmes.
- The Government of Pakistan has provided emergency cash assistance of USD \$75 per family to approximately 12 million Pakistani families through the Pakistan Social Protection programme to help improve access to healthcare and support economic conditions. While the UN has provided 22,000 of 45,000 households with the planned cash response, additional assistance to support food needs and livelihoods remains a priority for the most vulnerable communities.
- Over 282 million people have been reached through TV and radio through the Government and other partners. Using WASH sector communication networks, 10.8 million people have been reached with COVID-19 hygiene promotion messages.
- Education actors in the country are supporting the Government in implementing remote learning solutions for children affected by the disruption of educational activities. According to the Federal Minister of Education, the tele-schooling program is reaching about 8 million children per week across the country.
- The ongoing response in the GBV sector is focused on a lifesaving integrated approach including establishment

# Pakistan

OTHER

and support to Government-run helplines, provision of telephone-based psycho-social support services to GBV survivors, referral pathways and legal and rights-oriented support to GBV survivors. The multi-sectoral aspects include shelters, helplines, police, judiciary, health, governance and coordination mechanisms.

- Nutrition sector response is active through coordination at federal and provincial levels through weekly meetings with programme delivery sustained through 3,000 Health facilities providing services for SAM children. More than 1 million caregivers have been reached with RCCE approved communication messages on breastfeeding, complementary feeding, health and hygiene.

## Challenges and impact to operations

Community outreach and risk communication interventions, along with prevention and control, should also focus on prevention of protection concerns associated with multiple vulnerabilities, abuse, stigma, discrimination and rights violations due to COVID-19. Current data and surveillance are missing on protection dimensions associated with COVID-19, which makes high level advocacy to policy makers a challenge.

Given the low access to TV and the internet among the most disadvantaged, efforts are still needed to identify offline solutions to reach as many children as possible with remote learning activities.

The vulnerabilities of economically active groups, especially women in the informal sector, are further exacerbated by the disruption of income generation and survival activities, due to social distancing and other attempts to reduce risk of disease.

# Philippines OTHER

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$121.8M</b>	HEALTH: \$28.9M NON-HEALTH: \$92.9M	<b>\$121.8M</b>	COVID-19: \$121.8M NON-COVID-19: –	IN NEED: 39.0M <sup>44</sup> TARGETED: 5.4M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 30 June, there were 37,514 laboratory-confirmed cases of COVID-19 in the Philippines with 10,233 recoveries and 1,266 deaths. Since the last GHRP revision, Central Visayas has become a new hotspot of COVID-19 cases, including having the largest increase of fatalities.

Almost 52 per cent of the cases continue to be reported from the National Capital Region (NCR), followed by Central Visayas (16.3 per cent), CALABARZON (7.5 per cent), and Central Luzon (2.8 per cent). Metro Manila remains the most affected urban area followed by Metro Cebu.

As a lower middle-income country, the Philippines exemplifies the challenges of a health system in transition. Initially, a lack of PPE, ventilators, intensive care units (ICU) and other critical equipment impeded the ability of health facilities to treat COVID-19 patients. Since May, critical health care capacity has ramped up, and currently the health system has a 36 per cent critical care utilization rate with sufficient current availability of intensive care facilities to handle severe cases. Nonetheless, facilities in Metro Cebu are presently at near full capacity and health facilities in Mindanao face a continuing shortage of PPE.

### Indirect impacts on people and systems

Movement restrictions have resulted in disruptions to domestic supply chains, markets and logistics and have impacted on the livelihoods of the mobile and commuting population, leading to decreased income and purchasing power due to loss of jobs and work opportunities. Many farmers are struggling due to local market saturation and challenges in transporting goods across checkpoints to more distant markets, despite having proper documentation. Restrictions on mobility have led to reduced productivity and disrupted the flow of essential goods for small and medium enterprises (SMEs) in the food manufacturing sector. This is especially a concern in the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM), where the current transition phase has led to limited manpower capacities in the government.

The COVID-19 epidemic puts additional strain on an already overwhelmed health system in a country with ongoing measles, dengue and polio outbreaks. Stringent social distancing measures and community quarantine measures had significant impact on polio outbreak response activities and led to vaccination campaigns being postponed. Authorities have since announced that the third round of the immunization campaign to the poliovirus (types 1 and 2) will resume in Mindanao starting July, but not in other affected areas that are still under movement restrictions.

Measures taken to contain the spread of the virus compound existing gender inequalities and vulnerabilities, increasing risks of abuse and gender-based violence.

Movement restrictions provide challenges to humanitarian organizations in reaching communities and delivering services. Conflict-affected and internally displaced population, in particular in Mindanao, remain as the most at-risk group, given the cramped living conditions in transitory sites and limited access to basic services. The risk of a widespread emergence of COVID-19 in Mindanao is of particular concern, given the region's fragile health system, limited number of testing centers, remote areas and IDP sites with little or no access to health services, compounded by travel bans from Mindanao to/from Manila.

There are challenges faced by refugees, asylum seekers, and stateless persons in accessing social amelioration programmes due to lack of uniform guidelines that will allow the group to be accommodated at the local level. As of mid-June, over 65,000 Overseas Filipino Workers (OFWs) have returned to the country since February, with the number expected to rise in the coming months. In addition, the migration of 5,300 Filipino returnees from Sabah, which commenced in July, may further aggravate an already complex humanitarian situation.

## Response priorities and challenges

### Priorities and early achievements

A total of 620,000 people have been supported by WASH cluster with hygiene kits, water containers, handwashing stations and other facilities. 5.7 Million people were reached with Risk Communication and Community Engagement

<sup>44</sup> People in Need encompasses population living in hotspot focus areas of the response plan, and People Targeted encompasses the poor and vulnerable population in these areas.

# Philippines

OTHER

(RCCE). Twenty-two thousand families in overcrowded urban settlements and displaced people in IDP sites received shelter assistance. Protection cluster support to BARMM government with creation of Mindanao Virtual Protection Coordination Platform for COVID-19 response in Mindanao. The Food Security and Agriculture cluster supported distribution of food aid and NFIs and FAO provided cash transfer assistance in BARMM. The Logistic cluster produced 60 daily snapshots on logistic related issues. Seventy-one trucks of various cargoes have been loaded and delivered by WFP. Equipment such as mobile storage units and generators issued from WFP's prepositioned stocks for set-up of medical facilities and warehouses. IOM provided assistance to OFWs and LSIs at points of entry and quarantine facilities. INGOs are working with authorities and affected communities, providing hygiene and water kits, medical supplies and PPEs to health workers and front liner workers, and cash transfer assistance and psychosocial support to patients and affected families.

## Challenges and impact to operations

While the Philippines is not an HRP country, a number of ongoing humanitarian response activities were affected by COVID-19. Activities under the North Cotabato earthquake response were slowed down or halted. Agencies partly reprogrammed their CERF rapid response funding to assist earthquake-affected communities. UNICEF used the funds to install handwashing stations in evacuation centres, to construct WASH facilities in evacuation sites and distribute hygiene kits for child-friendly spaces and women-friendly spaces. UNFPA used the funds to raise awareness about infection prevention and control and about stress management during the COVID-19 pandemic

Movement restrictions put in place as part of the quarantine measures present a challenge to humanitarian organizations in reaching communities and result in delayed operations and services.

# Sierra Leone

OTHER

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$62.9M</b>	HEALTH: \$18.3M NON-HEALTH: \$44.6M	<b>\$62.9M</b>	COVID-19: \$62.9M NON-COVID-19: –	IN NEED: – TARGETED: 1.8M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 29 June 2020, there were 1,450 confirmed COVID-19 cases, 60 deaths (Case Fatality Rate, 4.2 per cent), and 961 recoveries. All 16 districts were affected with most cases (58 per cent) coming from the Western Area Urban District, including Freetown. Sierra Leone has entered community transmission: 1.8 million people (23 per cent of the population) may contract the virus. With more than 47.7 per cent of the population food insecure, one-third of children chronically malnourished, and 57 per cent of the population living in poverty, urgent actions are needed to mitigate the negative ramifications of COVID-19.

The pandemic's impacts on essential health services are already apparent. Maternal health and family planning services including pre-/post-natal care and labour have decreased due to acute pressure on health systems. Pre-pandemic, Sierra Leone's maternal and child mortality rates are already among the highest in the world, with only 3 physicians and 50 nurses/midwives for every 100,000 persons. People living with non-communicable diseases and chronic communicable conditions, such as TB and HIV, have also been affected, increasing deaths in the communities or at isolation facilities. Reporting on TB case notification has declined. Failure to adequately address these challenges could result in an overall heightened death toll, as three-quarters of COVID-19 deaths had underlying health conditions.

### Indirect impacts on people and systems

GDP could plunge to -3.1 per cent in 2020. The loss of export earnings and foreign direct investment, and dependence on essential food and medical imports, would create a substantial balance of payments gap in 2020. Along with the dampening effect on revenues, additional spending to cushion the health and economic effects are projected to widen the fiscal deficit by almost 5 percentage points or more, compared to the pre-COVID estimate.

Trade disruption has reduced the supply of food and essential commodities and increased inflation, already at an annual rate of 15.5 per cent. Around 1.3 million people are exposed to acute food fragility and are unable to cope with socio-economic and environmental shocks such as

drought, floods, and fluctuating food prices. Heavy rainfall has started, potentially affecting 125,000 people residing in flood-prone areas. Moreover, women, who constitute more than 50 per cent of the population, are found in the informal sector economy with daily wage incomes that have deteriorated. Female petty traders have protested the inter-district lockdown, which has hampered their businesses. Migrant and mobile populations, persons with disabilities, and urban slum dwellers are also highly vulnerable to social impacts.

## Response priorities and challenges

### Priorities and early achievements

The first COVID-19 National Prevention and Response Plan, finalized on 31 March 2020, aimed to prevent or limit local transmission. Thus far, 85 per cent of recorded cases were asymptomatic at identification, implying a robust surveillance system that has identified positive cases through contact tracing. However, with the country having entered the community transmission phase, there is a need to focus on mitigating and slowing down the transmission to a level that does not overwhelm the healthcare system.

As such, the National Health Response Plan has been revised to refocus efforts on mitigating contagion, minimizing deaths and protecting wider health services. The plan calls for improved flow of information from health facilities to communities, shifting of services to increase home-based care support, adequate protection and training on IPC and ensuring uninterrupted supply of drugs and commodities at health facilities. A National Risk Communication and Social Mobilization (RCSM) Strategy was drafted to address behaviour changes necessary to complement the health plan.

A socio-economic plan was drawn up to assist vulnerable and affected populations, encompassing food security, livelihood, protection, education, and logistics. A national social safety net system was developed to provide income to extremely poor households. Food support is targeting severely food insecure people through either in-kind food distribution or cash-based transfers.

### Challenges and impact to operations

The overarching challenge to the COVID-19 response is the lack of funding. The Government and its partners drafted

## Sierra Leone

OTHER

and started the implementation of health and socio-economic plans even before the first positive COVID-19 case was detected in the country. Despite these efforts, capacity and equipment gaps, along with socio-economic considerations to the most vulnerable, have limited response.

As the response focus shifts due to community transmission, targeted efforts to support the absorption of COVID-19 impacts at the district level are imperative. District Health Management Teams need sustained coordination and technical support. Provision of health equipment, training, capacity building, and engagement need to accommodate a decentralized approach at district level and points of entry. WASH facilities, particularly in PHUs and hospitals, PPEs for health workers remain limited, along with equipment and beds for treatment facilities to accommodate the projected number of patients. Alternative and remote delivery systems will need expansion to maintain key social and health services, including sexual and reproductive health, gender-based violence support, and education.

Food distribution systems will need to be refined to accommodate the emergency context and provide food access to 300,000 food-insecure persons. Existing social protection measures that support basic needs, particularly those in the informal sector and agriculture should be adapted for rapid expansion. Cash transfer systems, an approach used during the Ebola outbreak, will need to be supplemented.

# Togo

OTHER

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$19.8M</b>	HEALTH: \$2.3M NON-HEALTH: \$17.4M	<b>\$19.8M</b>	COVID-19: \$19.8M NON-COVID-19: –	IN NEED: 3.5M TARGETED: 1.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 24 June 2020, 576 cases of COVID-19 were confirmed, including 24 health workers throughout the country with a total of 45 per cent local transmission. Despite a free call and care policy, the common nature of symptoms and poor access to the mobile network hamper reporting and monitoring. The redeployment of resources to COVID-19 negatively impact the access of vulnerable groups (pregnant women, homeless people, persons with disabilities, people living with HIV/AIDS, and populations with underlying health conditions) to adequate healthcare.

Even though the national response plan is under implementation, challenges remain with insufficient quantities of tests, secure transport of potential COVID-19 cases and proper management and referral of suspect cases, scarce necessary personal protection equipment (PPEs) and limited surveillance at the points of entry.

### Indirect impacts on people and systems

An estimated 3 per cent fall in GDP negatively impacts public finances and household consumption. Restrictive measures have hit the agricultural and informal sectors, reducing food availability and leaving vulnerable households (65,000) without livelihoods. Incidences of gender-based violence (GBV) and other protection concerns are increasing.

Critical vaccinations, malnutrition and malaria campaigns are hampered. Fear of infections jeopardizes maternal and child health as does misinformation. Media hype tends to increase stigmatization and human rights violations of marginalized groups.

Over 2.7 million children – 91,000 of whom received school meals – are out of school, eroding major educational gains. Chronic malnutrition (23.8 per cent in 2017) will be impacted by difficulties in accessing inputs. According to Cadre Harmonisé, 534,200 people are under 'pressure' (CH phase 2)<sup>45</sup>, with an expected 38 per cent increase in cases of acute malnutrition by the end of 2020.

Only 45.1 per cent of the population has access to potable water and 20 per cent have access to handwashing facilities

in rural areas. Most of health care facilities lack access to water, sanitation and hygiene to allow proper infection prevention and control (58 per cent and 25 per cent of health centers have access to clean water and sanitation facilities, respectively).

Refugees camps are at high risk, lacking adequate healthcare, food and WASH facilities. Togo hosts 12,336 refugees including 1,182 in Avépozo camp, facing challenges for social distancing and a significant number of people already suffering from chronic diseases and risk factors.

The plan will target 1.5 million people in acute need of humanitarian support out of 3.5 million people in needs, including those at risk of being left behind.

## Response priorities and challenges

### Priorities and early achievements

Numerous interventions remain necessary to address COVID-19's direct effects: reinforcing outreach to decrease risks; deterring and testing all suspected cases; preventing, suppressing and interrupting transmission; providing safe and effective clinical care and scale unessential health services and systems.

Actions on indirect effects of COVID-19 will help the most vulnerable and affected people to access food supplies, ensure the continuity of prevention, essential health services, and setting up the supply chain for emergency response. Meanwhile, partners are sensitizing local population and refugees on protection measures, installing handwashing facilities and distributing protection kits, including in prisons; providing gender-based violence-related psychosocial and medical services.

The Novissi programme, set up by the Government to provide a cash transfer to the poorest households and launched in May 2020, has shown its relevance and feasibility but remains too limited in time and in its group of beneficiaries.

In terms of resource mobilization, great efforts have been made since May 2020 and \$898,900 have been mobilized to start the response to COVID-19. But further efforts remain

45 Analysis of the Integrated Food Security Phase Classification (IFSPC) - Cadre Harmonisé.

# Togo

OTHER

essential to ensure an adequate response to increasing humanitarian needs in Togo.

## Challenges and impact to operations

Global stock management affects health and food supplies availability and distribution along with aid inputs. Delivery times reverse recent progress in maternal and child health and universal access to health, with detrimental impact on access to basic social services.

The number of people in a fragile situation is expected to increase due to the rainy season. Limited capacity of the country in emergency management can also hamper timely assistance.

---

**ANNEX 1**

# Country and regional plans: Intersectoral Plans

94	Bangladesh
96	Djibouti
98	Ecuador
100	Jordan
102	Kenya
104	Republic of the Congo
106	Tanzania
107	Uganda
109	Zambia

# Bangladesh

INTERSECTORAL

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$205.9M<sup>46</sup>**

### OF WHICH:

HEALTH: \$103.8M<sup>47</sup>  
NON-HEALTH: \$102.1M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$205.9M**

### OF WHICH:

COVID-19: \$205.9M  
NON-COVID-19: –

## PEOPLE

IN NEED: 20.18M<sup>48</sup>  
TARGETED: 7.45M<sup>49</sup>

## Impact of COVID-19

### Immediate health impacts on people and systems

Under the overall leadership of the Ministry of Health and Family Welfare, the COVID-19 Health Emergency Response is implemented through the Bangladesh Preparedness and Response Plan (BPRP). As of 9 July, there were 172,134 confirmed COVID-19 cases in Bangladesh and 2,197 deaths associated with the disease. Beyond the country's high population density, especially in urban and slum areas, the main challenges in Bangladesh to combat the pandemic are the economic conditions, the limited number of health facilities in semi-urban and rural settings, and the inability of low and middle-income families to refrain from work, which limits the ability of the Government to impose social distancing and closures. Doctors represent four per cent of the country's fatalities, making Bangladesh the country with the highest doctor mortality rate in the world.

### Indirect impacts on people and systems

The Anticipatory Multisectoral Impact and Needs Analysis undertaken has shown that Socio-economic shock and climate-related disasters will significantly increase humanitarian needs resulting from the health emergency. The report also reveals a strong geographical correlation between the negative impact of the COVID-19 pandemic and the exposure to risks of climate-related disasters (flood, cyclone and landslides), specifically for 20 districts.

People without a sustainable source of income and those marginally above the poverty level are likely to fall below the poverty line due to loss of income and employment, as well as direct losses from natural disasters. The negative impact on the production of food and the price of basic commodities will lead to a reduction of the availability of food. Cyclone and flooding are already resulting in high levels of internal displacement and loss of shelter and livelihoods.

Women, girls, and female-headed households and LGBTIQ+ groups are likely to face more severe impacts. Protection issues such as domestic and intimate partner violence and child exploitation will likely increase while access to regular protection and related support mechanisms will be limited. Maternal mortality will likely increase as mothers will opt for delivering at home due to safety concerns and lack of access to health services.

To specifically address the large number of people under threat from this compound disasters, under the overall leadership of the Ministry of Disaster Management and Relief, the humanitarian community developed a Humanitarian Preparedness and Response Plan (HPRP) covering floods, cyclones and landslides and related sectoral humanitarian response interventions based on average seasonal impacts. The response packages are fully adapted to the pandemic context to complement activities in the health response.

On 20 May 2020, Bangladesh was hit by Cyclone Amphan affecting 10 million people in 19 Districts, out of which 700,000 of the most vulnerable were targeted. Currently, a severe flooding situation is expected mid-July where a further 7.53 million people may be exposed to flooding with up to 3 million temporarily displaced.

## Response priorities and challenges

### Priorities and early achievements

The country has started screening at points of entry (PoE) and has 329 quarantine facilities identified having accommodation for 31,991 individuals all over the country. 5,054 nurses and 2,000 doctors have been recruited between May-June 2020 and another 4,000 nurses and 2,000 medical doctors' recruitments are forthcoming.

There are Rapid Response Committees along with Rapid Response Teams (RRT) from national to Upazila level responding to the outbreak and overseeing quarantine and

46 This amount is addition to the *Addendum to the 2020 Joint Response Plan for the Rohingya Humanitarian Crisis 2020 COVID-19 Response Plan*, for \$181 million (see the Rohingya JRP page for further information).

47 The COVID-19 health amount represents the total funding required for three months of life-saving activities which have not yet received funding and can be implemented immediately with locally available resources. The total budget for Bangladesh's health response as laid out in the BPRP is USD \$838 million.

48 Including 7.5 million targeted for non-health activities and 12.68 million for health.

49 Including 3 million vulnerable persons for non-health interventions and 4.45 million for health.

# Bangladesh

INTERSECTORAL

isolation at home, facilities or community. With established community transmission, health services and Intensive Care Units (ICU) facilities are being strengthened. Emphasis will be given to prevention of hospital-acquired infections and protection of the caregiver both at the health-care facility, at home and within the community. To date, IPC, including case management, training has been done for 2,000 newly recruited doctors and for staff at 60 district hospitals.

Strong efforts are being taken for communication and advocacy nationally and locally using all media. Already 15 organizations are covering more than 1,400 Risk Communication and Community Engagement activities with more than 20 topics covered, including prevention (e.g. mask wearing, physical distancing) and secondary impact (e.g. mental health, stigma and discrimination). All parts of Bangladesh have been reached through cell phone pre-message 76 million people), mosque-based communications (50 million people) and other mass media and social media platforms.

For Cyclone Amphan, the HPRP was activated and a dedicated response plan with 323,000 people already reached. For the floods, forecast-based Actions are being implemented by the members of the Bangladesh Red Crescent Society (BDRCS)-led Forecast-based action working group with support of CERF. Based on the impacts, the HPRP will be activated and a multi-sector response scaled-up as appropriate.

## Response gaps and challenges

- As lockdown is eased, COVID-19 is expected to spread more quickly. Appropriate measures, including better use of community-based prevention practices and physical distancing regulations will be needed to limit the spread so as to reduce the pressure on the national health systems.
- Returning migrants workers from abroad will put added strain on the quarantine and health systems, increasing number of people in high-risk areas and loss of remittances creating additional socio-economic and livelihood shocks.
- Access constraints due to COVID-19 limit the ability of humanitarian agencies to assess and reach people in natural disaster affected areas, requiring greater use of remote management and modalities such as electronic cash transfers.

# Djibouti

INTERSECTORAL

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$30.0M**

### OF WHICH:

HEALTH: \$11.1M  
NON-HEALTH: \$18.9M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$30.0M**

### OF WHICH:

COVID-19: \$30.0M  
NON-COVID-19: –

## PEOPLE

IN NEED: 1.15M  
TARGETED: 600K

## Impact of COVID-19

### Immediate health impacts on people and systems

The first case of COVID-19 was confirmed in Djibouti on 18 March, and as of 7 July 2020, the Ministry of Health reported 4,889 positive cases (4,644 cases cured and 55 deaths). A significant spike was observed since mid-May, with higher fatality rates, with a downturn trend a month later, which is peaking up again since early July.

### Indirect impact on people and systems

The Government estimates that 65,000 families (30 per cent of the population) will require humanitarian assistance in the coming months. The pandemic has added a significant burden on an already overstretched health-care system and threatens to derail progress on HIV and TB – which are among the main causes of death in Djibouti. Vaccination campaigns have been postponed and thousands of children are at risk of contracting vaccine preventable diseases. Nutrition services have also been affected. Attendance levels of Moderate Acute Malnutrition treatment programme has reportedly reduced, particularly in Djibouti city.

### Most affected and at-risk population groups

Workers engaged in the informal sector (70 per cent of jobs), people living in informal settlements and migrants and refugees living in urban areas are particularly vulnerable to COVID-19. Djibouti hosts more than 30,000 refugees and asylum-seekers, mostly from Ethiopia, Eritrea, Somalia and, more recently, Yemen. In addition, over 100,000 migrants, mostly Ethiopian, live in the country, and an additional 300-600 travel through Djibouti on daily basis, mostly on foot. Following the border closure in Ethiopia, and due to stricter border management policies in Yemen, more than 1,300 migrants (69 per cent male, 31 per cent female) who were transiting through Djibouti on their way to or from the Arabian Peninsula have become stranded in the country. These migrants – most of them Ethiopian nationals – are living in 20 spontaneous sites located along the migration corridors. More than one third of the capital city's population lives in rapidly growing slums, where over-crowding and lack of access to hygiene and sanitation expose them to higher risk of the spread of COVID-19 and other infectious diseases. In addition, the informal sectors of construction; small trade; domestic work and public transportation have been affected

by movement restrictions put in place to stop the spread of the pandemic. At the same time, overcrowding, poor shelter, water and sanitation conditions particularly in urban areas is likely to contribute to increased COVID-19 transmissions. The closure of schools could lead to an increase in child labor, protection risks, and school dropouts.

## Response priorities and challenges

### Priorities and early achievements

The UN and NGO partners are supporting Government efforts included in the 'National Solidarity Pact' focusing on support to health care, promotion of hygiene measures, including risk communication, food security through in kind and cash transfers focusing on particularly at-risk populations including refugees, asylum seekers and migrants. Protection, Water Sanitation and Hygiene (WASH) and education interventions are also ongoing. Some of the response highlights include:

- In-kind and cash food distribution has been completed for 45,000 people in urban areas and 30,000 refugees at the Markazi, Holl Holl and Ali Addeh settlements and in Djibouti town. In refugee settings a two-month food ration was provided to ensure social distancing during distributions and reduce COVID-19 propagation risk.
- Nearly 31,400 hygiene and protection items distributed to all regions in Arta, Ali Sabieh, Dikhil, Obock, Tadjourah and Djibouti City.
- More than 17,000 people were reached by mass sensitizations on safe physical behaviours (such as handwashing) through community engagement and door-to-door activities.
- Unaccompanied and/or separated street children and children on the move benefit from a basic package of social services, including food distribution, hygiene kits/ services, family reunification, health care and counselling.

### Challenges and impact to operations

Identified challenges and gaps in the response include: PPE and materials for health facilities; COVID test kits; IPC materials in health centres; and capacity building of health providers, especially for ICU; as well as cash-based transfers and WASH interventions, and multi-sectoral support for migrants. In addition, the increased safety measures introduced for cross-border transport may result

## Djibouti

INTERSECTORAL

in a slowdown of humanitarian operations and additional costs. Over-land transportation is a major part of the Djibouti service economy, especially to service Ethiopia with goods, services and fuel out of Djibouti ports.

# Ecuador

INTERSECTORAL

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$46.4M</b>	HEALTH: \$10.2M NON-HEALTH: \$36.2M	<b>\$46.4M</b>	COVID-19: \$46.4M NON-COVID-19: –	IN NEED: 9.0M TARGETED: 2.4M

## Impact of COVID-19

### Immediate health impacts on people and systems

As of 9 July, 65,018 cases of COVID-19 had been confirmed in Ecuador (8,221 confirmed and suspected deaths). The National Health System as well as the Private Health Network have reached maximum capacity in terms of intensive care units (ICU), ventilators and personal protective equipment (PPE). There is a waiting list for COVID-19 patients.

Quito has reported an increase in the number of COVID-19 cases since the “yellow light” was implemented in the city. In June, the number of cases increased by 71 per cent. COVID-19–related deaths increased from 305 on 2 June 2 to 464 deaths on 30 June, a 50.8 per cent rise. Under this scenario, other vital health services such as treatment for chronic conditions, sexual and reproductive health care services and efforts to control other outbreaks such as malaria, measles and diphtheria have been restricted.

There is limited diagnostic capacity to detect, isolate and treat. The National Influenza Center and National Reference Laboratory is certified by WHO in Guayaquil to collect and process COVID-19 samples using polymerase chain reaction (PCR) tests. The laboratory has expanded its capacities to Azuay and Quito; however, there are limitations in the collection and transport of samples to designated labs with the demand for tests surpassing capacity.

There is limited prevention and control of infections and a lack of PPE for health-care workers from contracting COVID-19. Estimates indicate that at least 10 per cent of all cases of COVID-19 correspond to health-care workers.

Due to the weakening of health-care services, a reduction in human resources, medicines and medical supplies has made it challenging to sustain essential health services programmes and community-based healthcare.

### Indirect impacts on people and systems

COVID-19 and its impact present additional challenges in an economic and political climate that was difficult even before the pandemic. At the beginning of the year, GDP growth for 2020 was projected at around 0 per cent, along with an increasing fiscal deficit, limited access to international financial markets and worrying levels of debt. In 2020

Ecuador’s economy is envisaged to contract by 7.4 per cent.

Before the crisis, socioeconomic indicators already showed precarious conditions, especially for the most vulnerable population groups. Income-based poverty reached 25 per cent and extreme poverty 8.9 per cent. The level of formal employment was only 38.8 per cent at the end of 2019. Access to social security remained below 30 per cent, with lower inclusion for youth, women and rural populations. Women also account for the highest proportion of underemployed people (72 per cent) and without social security (80 per cent).

Ecuador is the fourth highest recipient country of Venezuelan migrants and refugees, in addition to the historic migration from Colombia. These people – residents or in transit – are equally exposed to income losses, increased risks of gender-based violence, and a lack of access to food and hygiene products, in addition to greater levels of risk due to possible evictions, overcrowding, difficulty in accessing basic social services, xenophobia, exploitation and human trafficking. Poverty and extreme poverty among indigenous peoples, in addition to their relative geographic isolation, makes these groups and rural communities particularly vulnerable to the impact of COVID-19.

## Response priorities and challenges

### Priorities and early achievements

Currently 27 hospitals and 2,100 medical centres are dedicated to COVID-19 treatment.

Some 55,600 PPEs have been provided to the Ministry of Health and Ecuadorian Institute of Social Welfare (IESS) and distributed to the national health-care system and health partners. In addition, 865 tonnes of medical supplies are being provided to support the health system. The first shipment of 400 tonnes arrived on 23 June and will be strengthening the capacities of front-line workers. The procurement and delivery of the supplies was made through the WHO supply system.

Risk communications and community engagement activities have been promoted. About 34 radio podcasts were launched by the radio of the National Assembly and the Educa Contigo Program with the support of the UN communications group. Information capsules were also communicated through social media, including messages in

# Ecuador

## INTERSECTORAL

quechua, reaching 118,043 people.

Over 441,690 people have benefited from food assistance and nutritional supplements targeting vulnerable populations such as pregnant and lactating women, female heads of household, homelessness and displaced people. Moreover, 170 initiatives to promote child protection have reached some 23,500 people. This includes the identification and referral of more than 600 cases to the local protection systems.

### Challenges and impact to operations



PCR testing needs to be scaled up. Moreover, there is concern about the circulation of counterfeit testing supplies, which may distort the real number of affected people.

Allocation of resources for vulnerable populations such as indigenous communities is needed. Logistical issues, including reaching remote areas, must be solved to provide these groups with PPE and other essential supplies. Cultural aspects also represent additional challenges to humanitarian access.

International and national travel restrictions have affected the capacity to evaluate humanitarian needs and the continuity of operations of the humanitarian partners. At present, municipal governments have the authority to decide whether to maintain the quarantine or relax the mobility restrictions. The humanitarian community has re-oriented its strategies to continue operating.

# Jordan

INTERSECTORAL

COVID-19 REQUIREMENTS <sup>50</sup>		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
	HEALTH: – NON-HEALTH: –		COVID-19: – NON-COVID-19: –	IN NEED: 1.4M TARGETED: 980,000

## Impact of COVID-19

### Immediate health impact on people and systems

As of 7 July, Jordan had recorded 1,169 cumulative COVID-19 cases, with 10 deaths. Through timely and extraordinary lockdown measures, Jordan has, so far, prevented large-scale spread of the virus. Following the relaxation of movement restrictions in last April, a slow increase in cases reinforced the need to remain prepared, particularly given underlying national and regional risks, including potential spread of the virus to crowded refugee camps, migrant and poor Jordanian communities.

With only selective health personnel exempted from movement restrictions and efforts focused on strengthening capacity to respond to COVID-19, gaps in essential health services quickly emerged. Routine vaccinations were postponed, and sexual and reproductive health services interrupted. Management of chronic diseases and mental health was limited to distribution of medication and on-line consultations. Reduced access to essential health services and medications increased other health vulnerabilities, including for older persons people, those with pre-conditions and persons with disabilities.

### Indirect impacts on people and systems

The already high unemployment (19 per cent pre-crisis) increased, particularly in the informal sector – which accounts for 44 per cent of Jordan's labor force. Low wage workers and women have been disproportionately impacted. In addition to reports of vulnerable Jordanian, refugees and migrants not having enough food to eat, impacts of income loss include higher levels of anxiety, increases in domestic violence and recourse to negative coping mechanisms. While domestic and gender-based violence risks rose, access to safe spaces became harder due to closed shelters and suspended transportation services.

Expanded government social benefits have reached an estimated 200,000 households but did not include certain at-risk groups such as Jordanian women in shelters, Jordanian households with foreign fathers, women dependent on revenues from informal sector work and home-based

businesses, as well as migrants and refugees more broadly.

Following the suspension of education facilities in mid-March, over half of Jordan's 4 million students were unable to access Government's alternative remote educational platform due to connectivity, equipment and other challenges. Students from vulnerable communities, also lost associated support such as meals and safe spaces provided in schools, impacting their psycho-social well-being.

The crisis has also brought new environmental challenges including management of increased medical waste and increased water consumption, in one of the world's most water scare countries. The stark, uneven access to safe water and sanitation, and associated risks of COVID-19 transmission became more evident in Informal Tented Settlements and poor urban settings.

The urban poor in Jordan and refugees in densely populated camps are amongst the most at risk groups in Jordan. Of the 744,795 refugees of concern to UNHCR, 83 per cent live in impoverished urban areas, with the remainder in camps. Some 415,000 people live in the ten official Palestine refugee camps, all overcrowded. Extended movement restrictions for camp inhabitants continues to limit their access to livelihood opportunities. In the Jerash camp, home to 'ex-Gazans', poverty has reportedly risen to 53 per cent.

## Response priorities and challenges

### Priorities and early achievements

The UN is working with the Ministry of Health to revise the National COVID-19 Preparedness and Response Plan. Technical advice along with material support is provided in all areas of the public health response, including ensuring health service continuation even during periods of lockdown. UN and partners are providing safe and effective clinical care in refugee camps and partner-supported health centers in urban areas, including sexual and reproductive health, mental health and subsidized medications. Targeted support for triage, sanitation and medical waste management is also being providing in key hospitals. Risk communication is provided to increase public awareness on prevention, symptoms, reporting and required actions.

<sup>50</sup> COVID-related activities for existing and newly vulnerable people in Jordan are detailed with costing in the Jordan Covid-19 Response Framework, to be published in mid-July 2020. Figures will be reflected through hpc.tools and FTS when available.

# Jordan

## INTERSECTORAL

Support is also being provided to strengthen and extend Jordan's social protection system, informed by vulnerability-based targeting criteria. Cash and in-kind assistance are provided to address the basic needs of hundreds of thousands of newly vulnerable populations not eligible for government assistance (ex-Gazans, Syria and Iraq Palestine refugees, and other non-Syrian refugees, stranded migrants, etc.). Remote cash programming includes support for education, medication, rent and food for vulnerable groups, including persons with limited mobility.

Organizations are working with the Ministry of Education to provide ICT support, devices, and specially printed materials to facilitate children's access remote education. Targeted support for vulnerable students to address challenges of re-entry into regular classes during the upcoming education recovery phase is also a priority.

The protection and gender-specific needs of GBV survivors, including through counselling services, virtual trainings, awareness raising and material support for women and girls in shelter is provided through a range of in-person and remote mechanisms.

Partners are ensuring access to water, hygienic supplies and PPEs for front-line partners, municipalities and impoverished camp and urban areas.

### Challenges and impact to operations

Movement restrictions impacted humanitarian services during curfew and movement restrictions, cutting off lifesaving/life-sustaining support. Putting in place measure to ensure uninterrupted access to essential health and basic services as well as to continue cash and in-kind assistance is a priority, even during future lockdowns. Mobility of camp inhabitants to facilitate access to livelihood opportunities is also needed. Reducing the funding gaps for cash assistance to address basic needs and other core programs is needed.

# Kenya

INTERSECTORAL

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$259.9M**

### OF WHICH:

HEALTH: \$56.5M  
NON-HEALTH: \$203.4M

## TOTAL HUMANITARIAN REQUIREMENTS<sup>51</sup>

### REQUIREMENTS

**\$259.9M**

### OF WHICH:

COVID-19: \$259.9M  
NON-COVID-19: –

## PEOPLE

IN NEED: 14.3M  
TARGETED: 10.1M

## Impact of COVID-19

### Immediate health impact on people and systems

Kenya reported its first case of COVID-19 on 12 March 2020 and, as of 7 July, 8,067 cases had been confirmed and 164 deaths reported. The number of cases is rising rapidly and more than tripled from the beginning (1,962) to the end (6,190) of June. Of the confirmed cases, six were reported among refugees and asylum-seekers, bringing the total to 16: 14 in Dadaab and 2 in Kakuma; with 1 death and 2 recoveries. The Government attributes the spike in the number of COVID-19 cases to increased testing capacity and community transmission. As of 30 June, only 6 out of the country's 47 counties had no reported COVID-19 infections.

### Indirect impacts on people and systems

The COVID-19 pandemic—which is occurring against a backdrop of increased humanitarian needs due to drought, floods, and a locust upsurge—is worsening existing vulnerabilities across Kenya, including due to measures put in place to curb the outbreak's spread. At least 130,000 jobs in Kenya have been lost in the formal sector, while at least 84 per cent of people living in Nairobi's informal settlements have lost all or part of their income due to COVID-19. In July, 980,000 people were expected to face Crisis (IPC Phase 3) or worse food insecurity, with 112,500 people in the counties of Kwale, Turkana and Marsabit estimated to be in Emergency (IPC Phase 4). However, this projection is based on analysis carried out prior to COVID-19 and will soon be updated. Approximately 370,000 children with acute malnutrition, 66,000 pregnant and lactating women and 84,000 older persons need services related to acute malnutrition. There was a 775 per cent increase in calls to the national gender-based violence (GBV) hotline in Kenya from pre-COVID containment measures to post-COVID containment measures. About 20 million children have been affected by the nationwide closure of schools due to the COVID-19 pandemic, according to the Ministry of Education. In addition to the COVID-19 outbreak, multiple diseases still threaten communities, including: cholera in Marsabit County; measles in Kilifi, Garissa, Tana River and West Pokot

counties; and kala-azar in five counties.

### Most affected and at-risk population groups

In Kenya, the urban poor, migrants, refugees, asylum seekers and people living with HIV are among those most vulnerable to COVID-19. Some 56 per cent of Kenya's urban population live in informal settlements and are at risk of high infection rates due to inadequate access to water and sanitation and cramped living conditions. Female-headed households, who constitute 30.2 per cent of the poor population, are at particularly high risk. Nearly 500,000 refugees live in camps in Kenya and there are fears that crowded living conditions and poor access to health, water and sanitation services in the refugee camps could lead to high infection rates. At least 1.4 million adults live with HIV in Kenya, of whom 910,000 (65 per cent) are women. Other at-risk groups include health-care workers, truck drivers (especially those crossing international boundaries), and health and non-health staff working at airports, seaports, ground crossings and check points.

## Response priorities and challenges

### Priorities and early achievements

In April 2020, humanitarian partners launched an Emergency Appeal for Kenya in support of the Government-led response to COVID-19, prioritizing the most urgent and life-saving interventions to be carried in the next six months (April to September 2020). The Appeal addresses both the immediate public health crisis and the secondary impacts of the pandemic on vulnerable Kenyans, including children, older persons, women, persons with disabilities, people living with HIV, refugees, migrants, and those displaced by natural disasters.

Under the Appeal, partners have scaled-up their coordinated response:

- At least 2.5 million people have been reached with messages on GBV and 700,000 with information on Sexual and Reproductive Health.
- At least 600,000 people have access to safe water from 62 newly constructed boreholes in Nairobi informal

<sup>51</sup> The total requirements for the Kenya COVID-19 response are \$259.9 million, including nearly \$5 million for refugee multi-sector. Since these requirements overlap with the South Sudan RRP, the requirements for Kenya are shown as \$254.9 million in the main financial table of section 4.3 to avoid double-counting.

# Kenya

## INTERSECTORAL

settlements.

- At least 37,700 children (19,219 boys, 18,523 girls) have received learning materials, while 373 children (225 boys and 147 girls) with disabilities/special needs have received psychosocial assistance.
- At least 8,300 out of 13,500 people were reached with integrated services in 15 Nairobi informal settlements including: child immunization, nutrition services, curative services, ante-natal care, family planning, COVID-19 screening among other Primary Health Care (PHC) services.
- More than 6,220 children, parents and caregivers (3,349 F/ 2,745 M/ 130 undisclosed) have received mental health and psychosocial support since March 2020.
- Partners are scaling up cash transfers to over 100,000 vulnerable households in informal settlements as COVID-19 restrictions impact access to informal employment, food and essential services.
- In the refugee camps, over 274,000 refugees and asylum-seekers have been provided with additional soap and 63,620 have been reached with messages on COVID-19, and 977 additional hand washing facilities have been established.

### Challenges and impact to operations

There are multiple challenges related to the public health response: many health facilities have sub-optimal infection prevention and control measures due in part to lack of water and sanitation facilities; there is a lack of sufficient personal protective equipment; there are not sufficient testing kits and equipment for mass testing; and there is insufficient bed capacity for isolation and treatment. At the same time, response capacity is stretched, as the Government and partners have had to respond simultaneously to COVID-19, the locust upsurge and floods.

# Republic of the Congo

INTERSECTORAL

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$12.0M</b>	HEALTH: \$2.75M NON-HEALTH: \$9.25M	<b>\$12.0M</b>	COVID-19: \$12.0M NON-COVID-19: –	IN NEED: 1.7M TARGETED: 400,000

## Impact of COVID-19

### Immediate health impacts on people and systems

According to the Ministry of Health of Republic of Congo, as of 6 July 2020, 1,662 COVID-19 cases were confirmed, including 500 recovered and 42 deaths. Brazzaville and Pointe Noire are the most affected with regards to their population density. The other departments of concern are Bouenza, Cuvette, Cuvette Ouest, Kouilou, Lekoumou, Niari, Pool and Sangha. The first positive case was reported on 14 March 2020. Consequently, the Government developed a national response plan which includes actions to strengthen epidemiological surveillance, risk communication, measures to prevent and control infection and the management of cases along with a basket fund of CFA 100 billion. The UN, local institutions, national and international organizations are jointly working with the Government to implement this response plan.

Despite considerable investments, the health system in Congo remains extremely weak. With the appearance of COVID-19 in the country, the main health activities are now oriented to the management of cases. The resources planned for other pathologies have been shifted to the COVID-19 response, including health centers, health personal, financial resources and equipment which is putting additional pressure on the already fragile health infrastructures and resources notably on sexual and reproductive health.

At the early stage of the pandemic, the Government decided to impose total lockdown measures including the closure of national and international borders, movement restrictions and a curfew.

### Indirect impacts on people and systems

Because of pandemic related nosedive of the value of crude oil on the international market, the national budget has been slashed by more than 1 billion USD. This situation negatively impacts the delivery of essential services. The impact of the cuts is felt across sectors such as agriculture, food security, WASH, production and consumption, transport and communication, health, education and consequently employment and economy in general.

In early April, the price of the food basket monitored by the food sector increased by 16 per cent in Brazzaville

compared to the previous month. The price of the basic consumption needs for a Congolese household rose by 15.5 per cent over the month of May. This trend may continue and cause disruption of economic activity, problems with market access and loss of community purchasing power and livelihoods. As of now, the number of people most affected by food insecurity in the peri-urban area can be estimated at 300,000.

Lack of WASH facilities drastically affects the continuity and quality of water and sanitation services in rural and urban centers, and has a negative impact on the capacity of vulnerable population to observe hygiene measures.

For education, schools have been closed for a long period. It is estimated that out of school children will be higher in the coming months.

With lockdown measures, the situation of vulnerable children, already fragile in normal times, has worsened. Confinement has led to an increase in domestic violence, with a remarkable impact on women and girls, as well as persons with disabilities and those with special needs.

Regarding early recovery measures, actors of the sector are working to strengthen the capacity of authorities at regional and local levels through training and institutional support to enable them take full leadership of emergency interventions.

On the basis of Multiple Indicator Cluster Surveys (MICS) data, it is estimated that for malnutrition prevention, it will be necessary to support, in priority urban areas, 12,000 pregnant women, 13,200 lactating women, as well as 19,400 children under 2 years of age and 54,000 children under 5 years of age.

## Response priorities and challenges

### Priorities and early achievements

The humanitarian joint multi-sectoral response strategy is aligned with the national response plan. The strategy aims to mobilize resources and foster coordinated support for the country response to the pandemic. Community and media awareness-raising activities, with the technology of broadcasting messages by drones and computer innovations to avoid all physical contact, have been initiated, to strengthen COVID-19 prevention measures and combat GBV.

# Republic of the Congo

INTERSECTORAL

The particularity of the COVID-19 pandemic is that it simultaneously affects the productive sectors of the economy and the livelihoods of the populations and could undermine the achievement of SDGs.

In addition to health priorities, humanitarian support is highly needed for the WASH, Nutrition, Food Security, Protection and Education sectors to urgently assist the most vulnerable populations affected by impacts of COVID-19 as well as their access to basic social services.

## Challenges and impact to operations

The national budget has been reduced and access to basic social services will be increasingly limited. A National Emergency Operations Center has been put in place for the management of the response but with limited resources and centralized at Brazzaville level.

Logistic and transportation are a major challenge in Republic of the Congo; the road network is faulty and it is challenging to transport items to remote areas. In most cases, transportation is only possible by river.

Finally, resource mobilization is a serious challenge in Congo, humanitarian projects receive insufficient funds and all previous HRPs were underfunded.

# Tanzania

INTERSECTORAL

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$158.9M**

### OF WHICH:

HEALTH: \$46.1M  
NON-HEALTH: \$112.8M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$158.9M**

### OF WHICH:

COVID-19: \$158.9M  
NON-COVID-19: –

## PEOPLE

IN NEED: 11.1M  
TARGETED: 7.5M

## Impact of COVID-19

### Immediate health impacts on people and systems

The confirmed number of people who tested positive for COVID-19 until 8 May was 509, including 21 who died from the disease. No public update has been provided since 8 May. Nine regions are considered to be high-risk due to their proximity to border points of entry, connection to international flights and the location of initial COVID-19 cases.

### Indirect impacts on people and systems

An estimated 15 million people in Tanzania live under the national poverty line. The socioeconomic impact of the virus is likely to hit these people the hardest. The COVID-19 pandemic will also put pressure on an already stretched healthcare system, which faces a shortage of qualified health workers and high neonatal and maternal mortality. An estimated 320 children die daily and only 63.7 per cent of births are delivered by skilled health personnel. Many health facilities lack adequate water and sanitation facilities, with only 68 per cent having access to safe water and only 44 per cent having latrines for patients, increasing the health risks and potential for disease transmission. An estimated 4.3 million people who are employed in the informal economy risk losing their livelihoods due to restrictive measures put in place to stop the spread of the pandemic. Protection risks are also very high as school closures affecting 14.4 million children puts schoolgirls particularly at risk to harmful social practices such as female genital mutilation and child marriages, which may consequently increase the number of out of school children once schools reopen, undermining progress. The school environment more generally offers a protective environment for children and an important referral pathway to access other essential services.

### Most affected and at-risk population groups

Vulnerable groups in Tanzania include those living in urban informal settlements, people living with HIV, older persons and refugees and asylum seekers. An estimated 8 million people – more than 50 per cent of the urban population – live in informal settlements. These areas are densely populated, lack adequate water and sanitation facilities and are overcrowded. Poverty, poor sanitation and pollution mean that residents often suffer from high rates

of undiagnosed respiratory infections, including asthma and tuberculosis, which places older residents in informal settlements at higher risk during COVID-19. There are over 1.6 million people in Tanzania living with HIV, including 92,000 children. Over 253,000 people have tuberculosis, 28 per cent of whom are also HIV positive. People living with HIV often face stigma and discrimination when accessing services and their access to anti-retroviral therapy (ARVs) may be compromised during the pandemic. Only 4 per cent of older people in Tanzania receive a pension, leaving many to work into old age. As a result, while older people are more at risk of COVID-19, many poorer older persons may be unable to self-quarantine as they seek an income for survival. There are 242,000 refugees and asylum seekers living in three camps in Tanzania, who face movement restrictions and are reliant on humanitarian assistance.

### Ongoing response

The Government put in place several measures to prevent the spread of the outbreak, including closing schools and enforcing quarantine and restrictions on travel and bans on large public gatherings. However, no lockdown was imposed and the Government began lifting its containment measures by mid-May, including removing the requirement of quarantine for international arrivals. All schools had fully reopened by 29 June. The UN and NGOs have developed an Emergency Appeal that identifies the most pressing, immediate and critical needs that have come with COVID-19. It presents the response of the UN and its civil society partners in one coherent, coordinated and costed framework, enabling donors to ascertain where they can best assist. Bringing together 38 partners, the Appeal spans urgent interventions between July-December 2020, targeting 7.4 million people across the country. Food assistance is provided to approximately 238,000 Congolese and Burundian refugees hosted in Nyarugusu, Nduta and Mtendeli Refugee Camps, which is the main source of food for refugees, and has taken steps to adapt its distributions to minimize risks. An immediate focus of the response has been on increasing access to appropriate water, hygiene and sanitation: 1,085 handwash points have been established and maintained and 421,653 kilograms of soap has been distributed to 62,099 households.

# Uganda

INTERSECTORAL

COVID-19 REQUIREMENTS		TOTAL HUMANITARIAN REQUIREMENTS <sup>52</sup>		PEOPLE
REQUIREMENTS	OF WHICH:	REQUIREMENTS	OF WHICH:	
<b>\$271.3M</b>	HEALTH: \$71.2M NON-HEALTH: \$200.1M	<b>\$271.3M</b>	COVID-19: \$271.3M NON-COVID-19: –	IN NEED: 15.0M TARGETED: 12.7M

## Impact of COVID-19

### Immediate health impacts on people and systems

Uganda registered its first case of COVID-19 on 21 March 2020. As of 9 July, 1,006 cases are registered, including 52 refugees and 55 children. No related death have been registered to date. Districts with high-volume points of entry from South Sudan, Tanzania and Kenya, as well as Kampala, were identified as hotspots.

### Indirect impact on people and systems

Wide-ranging pandemic containment measures impacted livelihoods and employment opportunities, particularly for women, who make up 86 per cent of the informal sector and essential health services disruption. Child mortality could increase by 22 per cent and maternal mortality by 21 per cent over the next year, gains made on TB and HIV control can also be negatively impacted. Government estimated the number of poor people would increase by 2.6 million and a loss of UGX 116.26 billion in customs revenue is anticipated.

Urban slums residents make up over 60 per cent of Kampala's population and have suffered the most. Over 6 million urban poor living in Kampala and other urban areas nationwide will need an exceptional amount of food assistance. Sixty per cent of people observed an increase in acts of sexual violence against children by peers, caregivers and community members, leading to an increase in teenage pregnancies and girls drawn into commercial sexual exploitation<sup>53</sup>. Primary and secondary school age refugee children missed 60 per cent of 840 hours of school since March.

Furthermore, Uganda has been experiencing heavy rains causing devastating floods, landslides, and windstorms affecting a total of 470,825 people.

### Most affected and at-risk population groups

For vulnerable groups, including refugees, IDPs and their hosts, children, older persons, widows, persons with disabilities, female-headed households, youth, market women, street vendors, and people living with HIV and TB

who rely on daily income-generating activities for their survival, the COVID-19 outbreak could have a devastating long-term impact. There are 1.4 million people living with HIV, with 73,000 acquiring the virus annually; 80,000 new TB infections reported annually.

Uganda hosts 1.4 million refugees (82 per cent are women and children). The refugee response was already facing funding shortfalls, with WFP being forced to introduce a 30 per cent ration cut from April, weakening refugees' food security. Movement and market restrictions affected economic opportunities of refugees who are mostly reliant on food assistance. The humanitarian situation is exacerbated by recent devastating floods causing significant population displacement.

Border travel restrictions halted the admission of new asylum-seekers. However, the Government temporarily re-opened border with DRC on allowing 3,056 people (65 per cent are children) to enter Uganda (July).

## Response priorities and challenges

### Priorities and early achievements

Modelling data, new evidence to reduce importation, transmission, morbidity and mortality are part of the Government's National COVID-19 Preparedness and Response Plan. In April, the UN in Uganda and NGO partners launched an Emergency Appeal to support the Government's response.

Key response highlights include:

- More than 7.6 million people reached with COVID-19 prevention messages, and 2,126 children, parents and primary caregivers received community-based mental health psychosocial support.
- 402 individuals including 2,000 indirect beneficiaries attained increased access to justice and peaceful co-existence through legal aid services and police follow ups.
- More than 769,000 women and children reached with essential health services and nearly 78,400 primary caregivers of children received counselling on infant and

52 The overall requirements for the Uganda Emergency Appeal are \$271m but they are shown as \$200.2 million in the main financial table in section 4 due to the overlap of the refugee multi-sector portion already accounted for through regional refugee response plans.

53 Survey in refugee hosting districts.

# Uganda

INTERSECTORAL

young child feeding.

- Critical WASH supplies and services reached more than 190,000 people.
- Mobile money provided to 4,950 refugee families in Kampala (13,618 individuals) (over UGX 1 billion).
- 1,844 children, including children with disabilities, received child protection case management services and 1,466 women supported with GBV services. 2,333 mothers received emergency obstetric care, 12,839 women supported with safe birth deliveries and 24,871 women with family planning services.
- 60 families with disabilities received food and non-food items (NFIs).
- Treatment centers established with 904 patients successfully managed. Data management teams, e-data sharing platforms, contact tracing were set up. Surveillance mechanisms allowed to analyze over 150,000 samples.
- UN Emergency Appeal coordination mechanism established, and UN Uganda MPTF Emergency window activated.

## Challenges and impact to operations

There is a stock out of Infection Prevention and Control supplies with an understaffing of hospitals. There is a need to increase psychosocial support, support to GBV survivors, women of childbearing age and pregnant and lactating women to access essential GBV and sexual, reproductive, and maternal health services; nutrition of children, capital and economic recovery packages.

Isolation units lack funds to support meals and NFIs. Limited public quarantine spaces including areas hosting South Sudanese refugees, is a major concern. Community based organizations and women's rights organizations lack financial assistance. People living with disabilities also disproportionately work in insecure and informal employment, with no social protection.

Decentralization of laboratory testing services received limited support. Efficient investigations, contact tracing, management of alerts remains a big challenge with coordination mechanisms lacking personnel. Therefore, shaping continuity of essential services is critical. Comprehensive information on multi-sectoral needs among the affected population from floods and landslides is critical.

# Zambia

INTERSECTORAL

## COVID-19 REQUIREMENTS

### REQUIREMENTS

**\$125.6M**

### OF WHICH:

HEALTH: \$20.1M  
NON-HEALTH: \$105.5M

## TOTAL HUMANITARIAN REQUIREMENTS

### REQUIREMENTS

**\$125.6M**

### OF WHICH:

COVID-19: \$125.6M  
NON-COVID-19: –

## PEOPLE

IN NEED: 9.78M  
TARGETED: 6.1M

## Impact of COVID-19

### Immediate health impacts on people and systems

Zambia recorded its first case of COVID-19 on 18 March 2020. As of 7 July, a total 1,895 confirmed cases had been confirmed out of which 42 had died. Of the 42 deaths, 24 were brought in dead, highlighting the likelihood of wider prevalence in the community. Out of the country's 119 districts, 35 have reported COVID-19 cases.

### Indirect impacts on people and systems

The COVID-19 pandemic is unfolding at a time when Zambia is struggling to recover from consecutive drought and flood disasters which have resulted in increased food insecurity in more than 58 districts for the past two seasons. While there has been an improvement in food security conditions following a good harvest during the 2019/2020 season, many communities are now being impacted by COVID-19. The nutritional status of children and women is expected to deteriorate because of limited access to basic commodities and services, while availability of food could be affected by disruptions in the market, including a slowdown of imports due to movement restrictions. The disruption of school feeding programs that 97,000 children depended on could lead to further deterioration of nutrition conditions of the most vulnerable. Since 20 March 2020, all schools have been closed as part of the Government of Zambia's measures to stop the spread of the virus, disrupting the learning of more than 4.4 million children. Prolonged school closure puts children, especially girls, at risk of protection violations, including sexual abuse, child marriage and other harms. Zambia has one of the highest child marriage (31 per cent) and teenage pregnancy rates globally, according to the most recent ZDHS: 32 per cent of girls aged 15-19 years have already given birth or were pregnant with their first child and over 45.9 per cent of adolescence girls and women are exposed to GBV.

### Most affected and at-risk population groups

About 70 per cent of the urban population reside in informal settlements that are highly dense, with inadequate basic services, such as water supply, sanitation and no proper solid waste disposal facilities. Further, overcrowded areas including refugee camps are at risk and require specific interventions. Zambia hosts 88,064 refugee population in

five refugee settlement areas in Lusaka, Luapula, North, North Western and Western province. Prevalence of HIV/AIDS in Zambia among females aged 15-49 years is 11.3 per cent, which could be exacerbated with increased protection risks.

## Response priorities and challenges

### Priorities and early achievements

Immediately after the first confirmed case, the Government of the Republic of Zambia introduced measures to mitigate against the spread of the virus including closure of international airports, restrictions of public gatherings of more than 50 people, closures of religious institutions, bars and restaurants. In May, the Government launched its COVID-19 Multi-sectoral Contingency and Response Plan together with the UN and partners' COVID-19 Emergency Appeal, which complements the Government Plan. The Emergency Appeal targets 6.2 million most at-risk and vulnerable people with urgent assistance. Under the Appeal, partners have scaled-up their response:

- Over 4,505,347 people have been reached with COVID-19 messaging on prevention and access to services; with 400,000 at-risk people have been sensitized on COVID-19 in a door-to-door campaign in Lusaka
- Approximately 656,000 vulnerable and food insecure people residing in high-density, low-income urban and peri-urban compounds of Lusaka, Kafue, Livingstone and Kitwe will receive cash-transfers from July to December 2020 to meet their basic food needs.
- Approximately 100,000 households in urban and peri-urban COVID-19 hotspot areas will receive social protection emergency cash transfers by December 2020
- 7,389 schools supported with provision of PPE and sanitary-hygiene supplies, building capacity of teachers, sensitization of parents/ caregivers to support children's distance learning and back-to-school when operation of schools resume, targeting 550,000 children and adolescents.
- 307 health care facilities and isolation centres benefitted from WASH and infection prevention and control (IPC) improvement measures while 2,579 healthcare facility staff were trained on IPC.
- Over 28,000 people were provided access to safe water

# Zambia

## INTERSECTORAL

while 106,66 people and over 96 schools were provided with WASH supplies including soap and/or hygiene kits.

- 169,546 children & women have received essential healthcare services, including immunization, prenatal, postnatal, HIV & GBV care nutrition sites in 17 districts received PPE supplies to be used to prevent and mitigate COVID-19 at nutrition services delivered through facilities and outreach sites.
- 14,318 children and adults accessed safe channels to report sexual exploitation and abuse; 12,969 children, parents and primary caregivers have been provided with community based mental health and psychosocial support during the COVID-19 response; 732 children without parental or family care provided with appropriate alternative care arrangement.

### Challenges and impact to operations

On 26 May, the Government withdrew some of its initial containment measures and recommended the opening of schools for student examination years and of restaurants and gyms subject to adherence to public health measures and social distancing. Partners are concerned that there is a noted relaxation of people's adherence to proven recommended public health measures including wearing masks, hand hygiene and social distancing. Continuity of learning is a challenge to many vulnerable children who cannot access TV, Radio and on-line learning and other platforms that have been established by the Ministry of General Education. Many schools in the rural area are under-resourced and poor-equipped to provide support to the students learning at home and parents are unable to support children's learning, widening the equity gap between the well-off and worse-off in learning, potentially leading to life-long negative impact. The lack of data around the re-opening of schools and links to caseloads hinders the ability to plan and respond appropriately. An increase in the caseload and the number of brought-in-dead points to the potential of wider community transmission, alongside lack of healthcare-seeking behaviour. There is insufficient testing and supplies to accurately determine the prevalence and trends of COVID-19 in Zambia. PPEs supplies are insufficient to equip, capacitate and protect all front-line workers and provide appropriate monitoring and support to POEs and health facilities. The lack of adequate health, water and sanitation services will be a challenge for effective Infection Prevention and Control (IPC) of COVID-19 and further increase vulnerabilities, particularly of women, children, persons with disabilities, older persons and people living with HIV.

## Annex II

# Summary of Response Progress by Specific Objectives and by Agency

## Strategic priority 1

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

**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.*

**WHO** worked with government stakeholders and Health, WASH, Protection and Shelter/NFI sectors to reduce risk of COVID-19 transmission and enable appropriate physical distancing among vulnerable populations living in camp and camp-like settings through multi-sector decongestion plans. WHO, UNICEF, and IFRC launched the Collective Service which aims to formalize a coordinated approach at global, regional and national level by bringing together all partner organizations and service providers to develop and scale-up risk communications and community engagement systems. It enables communities to receive timely context appropriate information and be active participants in decision-making that affects their lives. WHO rolled out tools using artificial intelligence methods to gather insights on behaviors, respond to COVID-19 questions and refer individuals to national hotlines and educational materials.

**IOM** continues to support Ministries of Health and border authorities to enhance preparedness and response efforts of prioritized points of entry (POEs). As the lead/co-lead of COVID-19 POE task forces in several countries and regions, IOM has supported implementation of sound public health measures at POEs, including exchange of information through cross-border coordination; assessment of about 3,470 POEs across 169 countries; health screening; capacity building for disease surveillance as well as preventive measures for POE workers, reaching more than 1,900 front-line workers globally. At POEs, IOM is also assisting governments in the implementation of Infection, Preven-

tion and Control (IPC) measures through enhanced hand washing and disinfection practices in several countries including DRC, Libya, Mali and South Sudan.

IOM also contributed to the capacity enhancement in several countries through webinars and virtual training on the POEs, the International Health Regulations, and cross-border coordination. These efforts resulted in a strategy “Cross-Border Management of COVID-19 Outbreak in East and Southern Africa” outlining a harmonized approach to POE surveillance, testing of transnational truck drivers and their assistants, timely operational, strategic cross-border information sharing and the use of mobility and surveillance data to guide the investment of public health actions along major transport corridors<sup>54</sup>.

As of 26 June, IOM has assessed 3,524 PoEs (including 762 airports, 2,147 land border crossing points and 6,158 blue border crossing points) in 169 countries, territories and areas and 1,406 other Key Locations of Internal Mobility (internal transit points, areas of interest and sites with populations of interest) in 139 countries, territories and areas. Of the total number of locations of internal mobility assessed, 373 were internal transit points, and 1,033 comprised other areas and sites of interest.

**UNICEF** recognizes the importance and relevance of promotion of handwashing, hygiene and access to essential WASH supplies and services to protect vulnerable groups and reduce the risk of disease transmission. Since the outbreak of the pandemic, 58 countries where UNICEF operates have developed costed WASH plans and are providing essential WASH supplies, including hygiene items and services to promote hygiene and handwashing in response to COVID-19. UNICEF and partners are also working globally to ensure that all

54 For example, all 43 cases detected recently in Uganda in one single day were truck drivers from neighboring countries.

WASH facilities and interventions are gender sensitive and inclusive of persons with disabilities.

**NGO partners** have been leading in RCCE as well as providing leadership in development of global guidance for humanitarian operations. For example, SCHR members have reached over 57 million people with information on stopping the spread of COVID-19. SCHR members have also mobilized over 80,000 faith leaders worldwide to disseminate preventive measures for COVID-19. SCHR members have delivered tens of thousands of public health messages via media including Social media and radio broadcasts worldwide. This includes more than 1,000 radio broadcasts and social media links to COVID prevention messages in local languages in Mozambique, Zambia and more across Africa, South and Latin America and Asia. SCHR members have also provided preventative WASH services and supplies, including hygiene kits to over 5 million people.

SCHR members have conducted multiple advocacy initiatives including responding to the UN Secretary General's brief on food security, supporting advocacy to the EU and European Ministers of health calling for a need to stick to a global response for Covid-19, particularly on the development, manufacturing and allocation of COVID-19 vaccines.

The **Norwegian Refugee Council (NRC)**, an ICVA member, has contributed and provided some form of preventive assistance to at least 1.7 million people across 25 humanitarian contexts by end May, either by helping reduce the spread of Covid-19 and improving displacement-affected people's access to health services. NRC also contributed to IASC interim guidance on public health and social preparedness and prevention measures in low-capacity and humanitarian settings.

**CARE** reached 19.3 million people with health, risk or hygiene messaging through one way communications or mass media while 6.1 million people were reached with health, risk or hygiene messaging through communications involving a 2-way dialogue, such as community workshops, door-to-door, or government or other service providers.

**A consortia of NGOs** (NRC, LSHTM, DRC, ACF Spain, MSF Spain, and SCI) has formed to support the design and piloting of innovative approaches to shielding high-risk populations at a family level, with an increasing focus on Yemen as the main case study working through the WASH Cluster and Site Management Task Force. Work is underway on engagement with coordination bodies and humanitarian communities at different

levels for a broader roll out of a shielding strategy.

**UNHCR** is advocating for the inclusion of refugees within national response plans and is providing support to those plans when needed with a focus on districts hosting large numbers of refugees. For example, UNHCR has supported referral facilities with equipment including oxygen concentrators, ambulance transport, medicine and medical supplies including personal protective equipment, refurbishment, expanding clinical capacity through infrastructure improvements and human resource support in a number of countries such as Bangladesh, Lebanon, Egypt, Ethiopia, Uganda, Kenya, Cameroon, Chad, Brazil and Colombia. Extensive work has been done on training of community health workers and health staff on COVID-19.

---

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

**WHO** surveillance guidance, case definitions and reporting requirements were modified and simplified to improve data collection and reporting to better understand the epidemic and guide response efforts.

**IOM** has continued to strengthen the existing national-level disease surveillance systems through active health screening and surveillance for COVID-19 at, for example, POEs in Bangladesh, Democratic Republic of the Congo, Libya, Somalia and South Sudan, among other countries. IOM is currently supporting 31 health screening points in the DRC, screening over 2.7 million people in May while simultaneously contributing to enhanced national capacity for detection of COVID-19 in Cox's Bazar, among others, by supporting the WHO-led contact tracing, testing, provision of trainings on laboratory biosafety and appropriate use of PPE and operational support for packaging and transfer of clinical specimens for laboratory testing. IOM has seconded laboratory technicians and information management personnel to increase capacity in government-led facilities in Afghanistan and Ethiopia.

IOM has also provided frontline workers with personal protective equipment, health screening materials and other equipment. IOM is making preparations towards the First Line of Defense for United Nations staff. In particular, IOM has secured over 10,000 GeneXpert cartridges to provide COVID-19 testing to the UN staff in Kenya.

**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.*

**WHO** has continued to develop and update technical guidance intended to support Member States to prevent, suppress and interrupt transmission and save lives. Since May 2020, WHO has focused on updating critical preparedness, readiness and response actions for Member States for COVID-19. This guidance provides an overview of needed actions to increase the level of preparedness, alert and response to identify, manage, and care for new cases of COVID-19 and trace and quarantine contacts across the health system, according to the transmission scenario.

WHO developed operational guidance for maintaining essential health services. This guides Member States as to how to balance the demands of responding directly to COVID-19 while simultaneously engaging in strategic planning and coordinated action to maintain essential health service delivery, mitigating the risk of overwhelming the health system. WHO has published guidance on immunization in the context of COVID-19 and strategies for delivering vaccine preventable diseases immunization services during the pandemic. WHO continues to provide technical support to national and local health personnel to strengthen epidemiological surveillance, clinical management and laboratory testing.

WHO also collaborated with IASC members to develop guidance on the adaptation of key public health and social measures needed to reduce the risk of COVID-19 spread and the impact of the disease in low capacity and humanitarian settings. This provides adapted guidance for testing, isolating and treating those who develop the disease, tracing and quarantining contacts in recognition that these capacities may be lacking locally owing to weaker health systems.

**IOM** continues to work with health actors and authorities to facilitate isolation, physical distancing and, where appropriate, quarantine. This includes repurposing existing health facilities to become isolation and treatment facilities in displacement sites, for example in Cox's Bazar, Bangladesh and Iraq, as well as the transportation of individuals with suspected or confirmed COVID-19 in those countries. Responding to needs identified by health partners, IOM is currently finalizing purpose-built shelters to be used as quarantine facilities in Nigeria. These shelters are designed to house those that have either a history of travel from an area with confirmed cases or those that have a contact history with a confirmed case.

**UNICEF and partners** have reached over 1 billion people across 56 countries with COVID-19 prevention, risk communication and community engagement activities since the onset of the COVID-19 pandemic. UN agencies and NGOs have leveraged various communication platforms including traditional media (television and radio) as well as social and digital media. For instance, WHO is utilizing mobile technology, and broadcast media to effectively to disseminate messages regarding GBV risk and available services<sup>555657</sup> while UNICEF has developed key community-based messages on available GBV services for integration in RCCE through different culturally appropriate communication channels. UNICEF translated messages, adjusted content and used various channels to disseminate information to migrant and displaced children (at least 1,409,082 in 41 countries).

**IOM** has provided a variety of support to POEs in East and Horn of Africa and Central America. These include multi-sectoral COVID-19 assessments of POEs and quarantine facilities as well as simulation exercises for migrant returns in Ethiopia, rehabilitation and installation of temporary safe waiting areas in Burundi, development of protocols for management, triage, and isolation of possible COVID-19 cases in border areas in Costa Rica.

55 United Nations Population Fund. (2020, May). Arab States Region COVID-19 Situation Report No. 3. UNFPA. [https://reliefweb.int/sites/reliefweb.int/files/resources/ASRO\\_COVID-19\\_Regional%20Sitrep%20%233\\_May%202020.pdf](https://reliefweb.int/sites/reliefweb.int/files/resources/ASRO_COVID-19_Regional%20Sitrep%20%233_May%202020.pdf)

56 Ibid

57 Needs Assessment Working Group. (2020). Covid-19: Bangladesh, Multi-Sectoral Anticipatory Impact and Needs Analysis. Government of Bangladesh. <https://reliefweb.int/report/bangladesh/covid-19-bangladesh-multi-sectoral-anticipatory-impact-and-needs-analysis>

**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.*

**WHO** as part of the joint UN Global Supply Chain system is working to accelerate availability of oxygen to countries in need via the distribution of 4,000 concentrators in rapid surge to 41 vulnerable countries. 10,000 more concentrators are soon to be distributed, alongside with technical support directly to countries to identify more sustainable oxygen solutions based on in-country surveys and technical specifications. WHO also provided support to design and architecture of facilities so that they are built or repurposed in a manner that reduces the risks of nosocomial infections and facilitates the provision of quality safe care.

Likewise, WHO updated Clinical Care for COVID-19 patients guidance as well as associated training modules that have been made available to frontline healthcare workers. The Emergency Medical Teams Network has been supporting the training and knowledge transfer through access to qualified and experience emergency health workforce capacity. Finally, the WHO Clinical research working group prioritized the study of corticosteroids in COVID-19 patients at the beginning of the pandemic encouraging randomized clinical trials to be pursued. The largest of these trials, RECOVERY, has just released preliminary results that dexamethasone is associated with reduction in mortality in patients with COVID-19 on oxygen and/or ventilation.

**SCHR members** trained over 71,000 community health workers to provide community-based services, such as home support and contact tracing while also providing personal protective equipment to more than 160,000 medical personnel in health facilities.

**IOM** continues to provide safe care, prioritizing those most vulnerable, including remote counselling and referral services relating to COVID-19, including by telephone or online, in countries like Bangladesh, Ecuador, Sudan, Syria, Turkey, Ukraine, and Uruguay. IOM has also provided the secondment or remote support of health experts (medical officers, radiologists, radiographers, among others) to health facilities. As of 3 July, 128 IOM health staff have been called upon to contribute to national COVID-19

response activities in some locations and support the national Ministry of Health COVID-19 responses.

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

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

**IOM** has developed a policy paper on Cross-border Mobility Amid and Post COVID-19 in order to provide further knowledge on the short and medium-term challenges and selected solutions for human mobility, possible and preferred scenarios for promoting coordinated and healthy reopening of borders and lifting of travel restrictions, and longer-term recommendations for migration and health policies in this regard. IOM is also undertaking applied research studies, for example, through secondary analysis of international migrant workers and returnees in relation to COVID-19 in Mozambique in order to analyze disease burden and patterns.

**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<sup>58</sup>*

**WFP** has supported 375 organisations with common services: 55 per cent NGOs, 11 per cent UN, 14 per cent donor and government representatives, 5 per cent other international organisations and civil societies, and 15 per cent other (including private sector, academia etc.) since the launch of the GHRP. This includes organisations that have signed up for and used both passenger and free-to-user cargo transport, as well as organisations that

58 Specific objective 1.6 and specific objective 2.3 overlap. Each is spelled out under their respective Strategic Priority due to the importance of maintaining the supply chain for both the direct health response and the response to urgent indirect humanitarian needs. It is fine to report against 1.6 only.

have attended the Global Logistics Cluster calls.

WFP's passenger transport service was launched on 1 May and has now opened routes serving 43 destinations throughout Africa, Asia, the Middle East and Central Asia. As of 29 June, 338 flights were carried out transporting 5,267 passengers from 174 organisations, fulfilling 94 per cent of received requests. The remaining 6 per cent was not fulfilled due to varying challenges such as lack of clearances and permits. No flights have been cancelled or delayed due to technical issues. Additional destinations throughout Africa, Asia, the Middle East as well as Latin America are expected to be reached in coming weeks as necessary government and civil aviation clearances are received.

**WFP** started use of the eight humanitarian response hubs to facilitate cargo movement on a free-to-user basis on behalf of all humanitarian organizations, leveraging existing WFP facilities (UNHRD) and assets where possible. The first free-to-user airlift took place on 30 April. As of 29 June, 13,031 m3 of critical COVID-19 response items and other humanitarian cargo have been moved as part of the free-to-user services provided by WFP, reaching 90 destinations on behalf of 23 organizations through 233 flights. WFP also provides sea transport where possible, and the first shipment took place from Antwerp to Yemen on 31 May. Road transport from the Accra hub to destinations in West Africa and from the China hub to destinations in Central Asia is also provided.

In conflict zones of Central African Republic, Libya and Yemen, as well as in the Pacific islands, WFP and the Emergency Telecommunications Cluster are supporting health partners to establish dedicated COVID-19 call centers, emergency hotlines and chatbots to disseminate health information, and providing connectivity in health facilities and emergency operations centers.

As of 29 June, 86 per cent of the cargo movement requests received through the Emergency Service Marketplace have already been addressed by WFP, with the corresponding cargo either already delivered at destination, or on track to be so. Of the remaining requests, 8 per cent were received through the Marketplace and are currently being analysed by WFP in terms of feasibility, while 6 per cent were rejected by WFP as they fell outside the scope of the GHRP.

Under the framework of the UN System-Wide MEDEVAC Task Force in response to COVID-19, a UN

MEDEVAC Cell has been set up to approve, manage and coordinate all COVID-19 MEDEVAC requests for UN and INGO personnel. WFP has access to a global network of contracted air ambulances which have so far carried out 18 medevacs of UN staff, with measures underway to extend these services in line with growing needs. Five strategic regional treatment locations are being established and formalized by the UN to be able to receive those eligible personnel or dependents who require COVID-19 related medical evacuation.

WFP also finalised the construction of a 68-bed COVID 19 field hospital in Accra. The hospital, which is equipped with essential infrastructure including beds and two road ambulances, is being handed over to WHO, which is in the process of contracting the logistics support and medical team to operate the hospital. As advanced preparedness, WFP has also completed construction of a 92-bed COVID-19 field hospital in Addis Ababa, with two road ambulances in place.

Following the strain experienced on supply chains and increased common humanitarian logistics needs due to the COVID-19 pandemic, logistics clusters have been activated in Ethiopia, Somalia and Sudan and the Pacific. The Global Logistics Cluster increased surge capacity to provide in-country and remote support and it has supported logistics gaps and needs analyses in Afghanistan, Burundi, Ecuador, Honduras, Libya and Sudan. Partners in the Global Emergency and Telecommunication Cluster led by WFP and the Global Food Security Cluster co-led by FAO and WFP continue to engage with partners to monitor the evolving situation and needs, and to provide support to field operations as needed.

WFP publishes and regularly updates the online platform on World Travel Restrictions<sup>59</sup>, where airline and quarantine information continues to support the global humanitarian and diplomatic communities. It collects real-time data, blending information on 234 countries and territories worldwide, with over 300,000 views since the launch of GHRP

**UNICEF and partners** trained 151,058 health workers in infection prevention and control and provided 463,929 health workers with personal protective equipment (PPE) in order to protect frontline workers and beneficiaries against disease transmission. UNICEF produced clear guidelines on the use of PPE and clear IPC practices in various service delivery situations including at the community level, at health facilities and during outreach and campaigns.

59 Available at: <https://unwfp.maps.arcgis.com/apps/opsdashboard/index.html#/db5b5df309ac4f10bfd36145a6f8880e>

Efforts to maintain and re-build community trust in health services is also ongoing to reverse the drop in both availability and utilization of services. At least, 18,482,477 children and women have been reached with essential healthcare services including antenatal, delivery and postnatal care, essential newborn care, immunization and support for common childhood illnesses, while national communication campaigns have been rolled out reaching 6,773,237 caregivers of children under 2 years old with key messages on the importance of breastfeeding, advice on young child feeding and healthy diets.

The increased vulnerability of women and children in the context of the pandemic exacerbates the risk of sexual exploitation and abuse by aid workers. The scaling up of safe and accessible reporting channels is a priority for the Inter-Agency Standing Committee, and since the onset of the pandemic, 3,627,018 children and adults have been provided with a safe place and accessible channels to report sexual exploitation and abuse. UNICEF has focused efforts on field support and recently established a technical field support function to support Humanitarian Coordinators/Humanitarian Country Teams to deliver on PSEA as part of the COVID response.

**UNICEF** supported the establishment of 22 complaint mechanisms that include community-level PSEA focal points and has reached more than 160,000 children with messages on PSEA in the DRC. In Myanmar, UNICEF translated PSEA messages and information on how to report into local languages and provided online PSEA training for local NGOs and frontline workers while in Colombia UNICEF worked with the inter-agency PSEA Network members to develop dedicated guidance on PSEA and COVID.

**WHO** focused its efforts on ensuring continuity of health services and systems including maternal, sexual and reproductive health services and provision of essential health items including test kits. Available data on facility births<sup>60</sup> from country systems in the Africa region shows an average 12 per cent decline in the number of facility births during February-April 2020, as compared to the same period in 2019. The range of decline in five countries changes between 9-31 per cent while no decline (3 per cent increase) is seen in one country. Data from other countries will become

available over the next 3 months. It is expected that the above average figure of 12 per cent decline for February-April 2020 period will be higher in the following quarter, better reflecting the effects of COVID-19.

Health partners in many countries are reinforcing the health sector response to GBV by regularly assessing and updating GBV referral pathways to reflect changes to formal or informal services or access points as a result of the COVID-19 pandemic. In addition, health partners are engaging virtual platforms to offer trainings on the provision of first-line support for sexual violence and intimate partner violence and introducing telemedicine approaches. In north-eastern Syria, for example, over 2,000 health service providers have been trained. Reports suggest, however, that use of such technologies may place survivors experiencing violence in the home at further risk. Innovations in health service provision should appropriately incorporate considerations for ensuring the privacy and confidentiality of patients. Multiple stressors of COVID-19 underscore the need to maintain and provide mental health and psychosocial support (MHPSS) services as part of the CMR/IPV<sup>61</sup>.

**WHO**, at the request of the SG, established a Supply Chain Task Force in mid-April 2020. As part of this effort, three purchasing consortia were established in an attempt to secure volumes of supplies from a heavily disrupted market for diagnostics, PPE and biomedical equipment for oxygen provision. Since being established the consortia have managed to secure over US\$ 500 million US of supplies to support the global COVID-19 response. The consortia have delivered 123,436 tests to 18 HRP countries, with 428,476 being shipped and an additional 1.06 million being planned for all 23. 32,880 tests have been delivered to an additional 4 RRP countries with 55,000 under shipping and a remaining 578,842 tests to 8 RRP countries not part of HRP. Some of the other key achievements of consortia members include the following;

- 4.7 million pieces of PPE have been delivered to 16 HRP countries, 1.2 million pieces to 11 RRP countries. 87 million pieces are planned for 23 HRP countries, 7.4 million pieces for 8 additional RRP countries and 45 million pieces for Venezuela RMRP in 13 additional countries.
- 4,845 oxygen concentrators, accessories and

60 Data on facility births from country routine systems is not usually available on a frequent basis at global level. Efforts are being made to strengthen collection of standardized data from country routine information systems to assess changes in service continuation during COVID context.

61 UN Women. (2020). COVID-19 and ending violence against women and girls. UN Women <https://www.unwomen.org/en/digital-library/publications/2020/04/issue-brief-covid-19-and-ending-violence-against-women-and-girls#view>

consumables are in planning for delivery across all HRP countries with 264 delivered or shipped to 10 countries. 582 units are planned for an additional 5 countries not in HRP with 100 shipped or delivered.

- Following the initial procurement of 4,000 oxygen concentrators, WHO has purchased an additional 10,000 oxygen concentrators, 9,800 pulse oximeters and consumables (estimated total value: \$10 million), which will be distributed to more than 120 countries.

**UNFPA** has supported continuity of sexual and reproductive health interventions including protection of health workforce by:

- Procuring personal protective equipment (PPE) for frontline healthcare workers delivering both COVID-19 and non-COVID-19 related SRH and GBV services (medical masks, gloves, goggles);
- Training of frontline healthcare workers, including provision of infection prevention and control (IPC) measures in health facilities, rolling-out standard operating procedures and guidance for COVID-19, with regard to pregnant women/delivery, and adaptation of training packages including on normal deliveries and C-sections;
- Disseminating relevant GBV information, education and communication materials in line with WHO guidelines;
- Establishing alternative delivery modalities (e.g. mobile outreach and home visits) where SRH services have been shut down or severely curtailed

**UNFPA**, lead of the GBV sub-cluster coordination in 43 humanitarian settings, is coordinating the procurement and logistics of humanitarian relief supplies as they relate to UNFPA's mandate and COVID-19 response. UNFPA has also scaled up safe, accessible and high-quality GBV response services, but also to adapt services to respond within COVID-19; notably with creation or expansion of national toll-free 24/7 hotlines for women and girls at risk of/ experiencing GBV, and address immediate needs of GBV survivors, in particular for clinical management of rape, and offering the essential package of services to address various GBV prevention and response needs at UNFPA-supported safe spaces.

**UNHCR**, noting that the risks of gender-based violence against refugee, internally displaced, stateless and returnee women and girls have been exacerbated by the pandemic, updated and adapted existing programming based on priorities outlined by forcibly displaced wom-

en and girls. UNHCR created or expanded the capacity of 24/7 emergency hotlines and other communication channels and broadened the engagement with trained community outreach volunteers, who serve as a safe and trusted means for information sharing and to refer survivors to GBV services where requested. In Rwanda and Kenya for example, radio shows are conducted to sensitize refugee communities on prevention and response to GBV. After the shows, refugee women and girls reported an increased confidence to approach GBV service providers. In Uganda, a helpline is operated by a call centre with agents speaking 15 different languages. GBV survivors who call the helpline are provided with counselling by trained protection staff. UNHCR also provides emergency cash assistance, remote individual case management and psycho-social counselling over the phone for women and girls, men and boys including persons with diverse sexual orientation and gender identities and other persons with specific needs. Remote modalities also include GBV prevention group sessions for women via digital platforms used by local community networks. A coaching program for GBV case managers is conducted through tailored online sessions adapted to the context of the pandemic.

**IOM** supported in bridging the gap between the need and availability of essential health services and supplies through a responsive supply chain. Large quantities of PPE, thermometers, hand sanitizers, surgical masks, sterile gloves and other protective equipment have been sent to countries such as Burundi, South Sudan, Mauritania, Venezuela, Sri Lanka, Somalia, Egypt, Myanmar and Turkey. 18,940 pieces of coveralls for South Sudan, 8,352 pieces of PPE for Mozambique and 200,000 pieces of surgical masks for Yemen were delivered. Various equipment such as solar panels and IT equipment were sent in order to help the health officials in Burundi to screen travelers for COVID-19. IOM has also supported the development and operation of health clinics including through technical assistance to the Brazilian authorities to establish a field hospital to assist Venezuelan migrants in the border area. In Yemen, IOM is working with WHO to ensure public health services to migrants by equipping and supporting migrant clinics, as well as deployment of mobile medical teams that provide health assistance and referrals. IOM has also released mobile storage units and multi-purpose tents for assistance to vulnerable populations in Djibouti, Panama and Philippines.

Through IOM's Displacement Tracking Matrix, IOM has continued to gather weekly multi-sectoral updates, types of measures imposed, population movements,

affected population categories, ongoing responses and needs at Points of Entry, key transit points, areas and sites, to feed into ongoing COVID-19 response. For example, in Mozambique, IOM is collecting data on types of preparedness and precautionary meas-

ures that are available in IDP hosting resettlement sites, supporting decision makers plan interventions as well as recommend health and site preparation measures for outbreak prevention and containment.

## Strategic priority 2

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

**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.*

**IOM** has provided support to those vulnerable populations affected by the impact that COVID-19 is having on the mobility of migrants, IDPs and other populations of concern whose situation has been affected by the pandemic in countries like Ukraine and Iraq. IOM provided financial assistance to micro-enterprises run by former victims of trafficking to cover essential needs such as food, medicine, hygiene and rent during the crisis in Ukraine. In Ecuador, IOM is delivering financial support to migrants who have lost their jobs and are at risk of eviction and homelessness. Following a survey on the socio-economic impacts of COVID in areas of IDP returns in Iraq, IOM has also provided support to small businesses to create job opportunities including through the manufacture of disinfectant and PPE using the Enterprise Development Fund. IOM is also supporting displaced women in Yemen to sew face masks to be distributed to vulnerable populations in IDP sites as part of the livelihood programme in the country.

**FAO** has set up a data facility in acute food security areas to monitor risk factors in local food supply chains and indicate emerging trends through regular data collection, assessments and analyses. The facility will contribute to inform the humanitarian community to guide anticipatory actions, response

and recovery programmes. FAO is currently collecting primary data on impacts of COVID-19 on food security and livelihoods in 14 priority food crisis countries.

**FAO** is continuing and scaling-up distributions of agricultural inputs (seeds, tools, livestock feed) and provision of animal health support to ensure continuous food production and income generation in the most vulnerable areas. These activities are particularly linked to the agricultural seasons and timeliness is essential. Some examples include distribution of 7,222 tons of imported seeds to assist 4.8 million in South Sudan while 9,900 vulnerable farming households received agricultural inputs to boost their agricultural production and resilience in Haiti.

**FAO** has also scaled up its cash programming and in some instances established social safety nets. Over 4 million dollars in mobile money has been transferred to help 200 000 Somalis access food and other basic needs in the most remote, hard-to-reach and insecure areas. Mobile payment procedures are adapted to avoid health risks during COVID. Likewise, in Myanmar's Rakhine State an unconditional cash transfer mechanism has been designed for pregnant and lactating women as complementary to the Government Maternal and Child Cash Transfer (MCCT) national social protection system. FAO is establishing a safety net for 4,200 vulnerable urban households confined in the areas most affected by Covid-19 in Burkina Faso. All targeted households will receive unconditional cash transfers, 1 500 households will receive

agricultural support (inputs and support) while another 1,000 households will receive livestock support.

**UNRWA** provided additional cash and food assistance to 687,369 Palestine refugees affected by the impact of COVID-19 in Jordan, Syria, Lebanon, and the West Bank. In addition, considering Gaza's population density, UNRWA started delivering food baskets to homes reaching one million refugees by the end of June.

**SCHR members** have provided at least 18.5 million people with cash and voucher assistance both independently and in partnership with UN agencies, in particular WFP. World Vision has provided 3.7 million people with food assistance and distributed over US\$14 million in cash and vouchers. Meanwhile, CARE supported almost 725,000 people with food assistance and another 247,000 people with cash and voucher assistance. NRC provided food assistance to almost 745,00 people in 18 countries<sup>62</sup>.

**WFP** diversified its supplier base, is using alternative commodities and procuring locally and regionally where possible to help minimize any transport risks and ensure continuity of operations. WFP seeks to extend coverage to people already in IPC 3 and 4 but not yet receiving assistance to prevent them from falling into hunger risk in fragile contexts such as Central African Republic, Democratic Republic of Congo, Haiti, north-east Nigeria, Somalia and South Sudan. In addition, in at least 14 countries WFP is asked by governments, food security and protection partners to scale-up coverage of food assistance to persons of concern – covering a gap until these groups can be transitioned to existing social protection programmes. This includes: extending support to Venezuelan migrants in Colombia, Peru, Ecuador; and temporarily renewing support to refugees in the Middle East and East Africa.

Governments in some countries have requested WFP support to deliver punctual one-time temporary assistance to vulnerable and at-risk groups who are unable to meet their food needs during the peak period where COVID-19 restrictions, including large-scale lockdowns and disrupted access to food. This type of request is captured in some of the larger scale-up plans in Afghanistan, Liberia, Nigeria and Sudan – and this form of assistance in these four countries alone contributes to nearly 10 million of the total 38 million additional beneficiaries WFP aims to scale-up to globally in the next six months. Likewise, WFP is also providing short term food assistance in isolation/quarantine centers in Asia, Latin America and East Africa where returning migrant populations are being asked to quarantine upon return.

Finally, more than half of WFP's operations are scaling up direct assistance in urban areas – some for the first time. WFP is working with governments and partners to quickly identify populations – with particular attention to households with groups at higher risk of COVID-19 impacts including households relying on informal livelihoods, with nutritionally vulnerable members and older persons, and persons with disability or chronic illness.

**WFP** has also scaled up remote tools for market monitoring and is adapting programmes based on the evolving situation. Of WFP's additional requirements for direct food assistance, more than half are in the form of cash-based transfers. In 20 per cent of operations WFP is already having to adjust its transfer value to adapt to the market context and/or top-up to cover additional basic needs due to COVID-19. To enable the cash-based scale-up, WFP is supporting local market actors to ensure up to three months of requirements are available in stock and has signed contracts with at least 11 new financial service providers to diversify transfer mechanism options, and maximize WFP's digital payment system.

**UNICEF** distributed to 14,107 households in 28 countries, providing funds that will help families access life-saving commodities, services and support. In addition, UNICEF has reached 5.7 million households in 18 countries through social assistance programs provided by governments to help families cope and respond to the impacts of COVID-19.

**UNHCR** is working with WFP on the prepositioning of food rations and adequate supplies of food commodities for nutrition programs. Where school feeding programs exist in refugee camps and settlements, such as in Rwanda, take-home rations are being provided. In the East and Horn of Africa and Great Lakes region, UNHCR is also working with UNICEF to preposition supplies for therapeutic treatment of severe acute malnutrition in refugee sites. UNHCR also provided cash based assistance for over 1 million people worldwide.

---

**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.*

**WHO** reported that as of 22 June 2020, 38 countries (60 per cent of GHRP countries) have reported having

62 Please note that this data is preliminary and is based on available data.

to postpone at least one vaccination campaign for any preventable disease vaccine due to COVID, for a total of 86 campaigns. Several countries are facing concomitant outbreaks of vaccine preventable diseases and COVID-19. For example, out of the 17 countries that have reported postponing measles campaigns due to COVID-19, six are currently experiencing ongoing measles outbreaks WHO recently published a framework to support decision making for implementing campaigns<sup>63</sup>. The framework recommends countries undertake a risk assessment, consider epidemiological data and weigh public health consequences vis-a-vis the potential aggravation of COVID-19 transmission resulting from a vaccination campaign.

**WHO** will support programme adaptations and transition towards resumption of immunization services and campaigns through working with the regions, countries and partners. These include training and building capacity on safe delivery of immunization services using appropriate infection prevention and control measures, continuity of essential health services, and forecasting vaccines and supplies, among others.

**WHO and partners** have made progress in roll out of MHPSS guidance and providing support to field operations. WHO<sup>64</sup> and IASC partners have developed a wide range of mental health and psychosocial support materials providing guidance to agencies, governments, responders and the general public. MHPSS actors disseminated, translated (in 110 languages) and used these materials widely in all humanitarian settings including a book to support children aged 6 to 11 to cope with COVID-19 stressors and an illustrated guide entitled Basic Psychosocial Skills: Guide for COVID-19 responders to integrate a set of basic psychosocial skills as a core skills for all COVID-19 responders from all sectors. Since May, seven additional MHPSS Technical Working Groups were established. WHO is currently assessing whether an MHPSS plan in the context of COVID-19 was developed and budgeted in 194 countries. Other country support actions include deployments from the newly established interagency MHPSS surge deployment mechanism<sup>65</sup> to Burkina Faso, South Sudan and Yemen, and to support integra-

tion within needs assessments and response plans.

**CARE** provided access to safe water to more than 1.9 million people while also reaching more than 873,000 people with hygiene kits to enable good household and personal hygiene and COVID-19 prevention while also installing 6,470 handwashing stations with provision of soap and water<sup>66</sup>. **NRC** also provided almost 1.95 million people with critical WASH supplies including hygiene kits and services in 22 countries which include four non-GHRP countries<sup>67</sup>.

**SCHR members** have provided at least one million children, parents, and caregivers with education support or training. **World Vision** has reached over 730,000 children with child protection programming and services, including gender and age-appropriate psychosocial support.

**UNRWA** procured PPE supplies for all frontline health workers (some 4,000 staff) to ensure health services could be provided safely for staff and refugees. A triage system was established in UNRWA health centres to separate patients with non-COVID-19 respiratory symptoms from those collecting medicines or requiring urgent medical care to mitigate community transmission. In addition, UNRWA carried out home deliveries of 2-3 months supplies of NCD medications for patients with non-communicable diseases (NCD) to reduce foot traffic at clinics. Hotline services (telemedicine) provided refugees with an important link to health staff and doctors carried out home visits for emergency cases. Hotlines were also used for provision of mental health and psycho-social support services.

Sanitation and solid waste management services continue in all 58 UNRWA camps. Daily spraying of diluted chlorine was undertaken to disinfect UNRWA facilities that remained open, such as health centres and sanitation offices, and food distribution trucks, compactors and other equipment were also disinfected as were areas surrounding solid waste containers.

**UNRWA** continued its efforts to provide access to education to more than 540,000 students affected by the closure of schools and vocational training centres. The Agency also focused on ensuring that

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

64 WHO and IFRC co-Chair the IASC MHPSS Reference Group which has 57 member organizations.

65 Dutch Surge Support MHPSS is a programme of the Dutch Ministry of Foreign Affairs, implemented by the Netherlands Enterprise and Development Agency in cooperation with the Inter-Agency Standing Committee (IASC) Reference Group on MHPSS in Emergency Settings. More details are available at: <https://www.drrteam-dsswater.nl/mhpss/>

66 This covers the March to June 2020 reporting period and consists of CARE's work in 41 GHRP countries. CARE is also adapting and responding to COVID-19 in 28 non-GHRP countries.

67 Based on available data and preliminary results.

psycho-social support remained available, considering the additional trauma and stress that the COVID-19 crisis is causing to both parents and students.

**UNICEF and WHO** are collaborating to launch a new global initiative for scaling up hand hygiene. This global effort calls for countries to lay out comprehensive roadmaps that bridge together the national COVID-19 response plans with mid-term and long-term national development plans to ensure hand hygiene is a mainstay in government programmes throughout and beyond this pandemic.

**UNICEF** supported access to essential services, which include healthcare, clean water, hygiene items, sanitation facilities, nutrition and child protection services and education support. Critical WASH supplies, including personal hygiene items and services have benefited 31,209,120 people, while 93,610,033 children and youth have been supported with distance/home-based learning in 55 countries. Since the start of the pandemic, and through strengthened capacity of frontline workers and paraprofessionals working with children and caregivers in mental health and psychosocial support, 9,446,290 children, parents and primary caregivers have been reached with community-based mental health and psychosocial support and messages.

Currently 57 countries included in the GHRP report that minimum child protection services have been operational throughout the COVID-19 crisis while the continuity of GBV services for survivors as well as mitigation of GBV risks for women, girls and other vulnerable groups is critical during the pandemic. As basic services have decreased and economies have slowed, families are finding it more difficult to meet their basic needs, including having available nutritious food. UNICEF also supported 748,957 children aged 6-59 months with treatment of severe acute malnutrition.

**IOM** is supporting health care and infection prevention and control (IPC) in camp and camp-like settings globally. IOM has supported the Rohingya response through the installation of over 300 handsfree handwashing stations throughout Cox's Bazar. At the IOM-supported primary health care facilities in Cox's Bazar, Bangladesh, COVID-19 testing, referral, MHPSS, GBV, HIV and tuberculosis services, as well as maternal health care including delivery are also being provided. IOM is working with the National Tuberculosis (TB) Control Programme and National AIDS Control Programme to ensure proper disease surveillance and reporting for both TB and HIV and any associated co-morbidity related to COVID-19 in Lebanon. IOM is also supporting the continuity of care for persons living HIV/AIDS in the cross-border communities in Uganda. Through the use

of mobile technologies (including SMS), IOM is linking health facilities to community peer networks to ensure that people with HIV are still able to get their antiretrovirals refilled. IOM has also adapted its MHPSS services in all countries to ensure continuity of care in countries like Turkey, Bangladesh, and South Sudan.

**IOM's** efforts to mitigate GBV risks across all types of assistance prior to the pandemic has served as a key lesson learned on the importance of continuity and consistent mainstreaming and capacity building efforts in achieving better safeguarding outcomes for women in emergencies. In many contexts including South Sudan and Turkey, IOM has ensured GBV risk mitigation efforts have been incorporated into their COVID-19 response interventions in a meaningful manner, including gender considerations in shelter relocations conducted for physical distancing purposes. As well as risk mitigation efforts, IOM's specialized GBV teams in Nigeria, South Sudan and Bangladesh have had to adapt modalities used to support survivors including further reliance on technology to provide information and support the revision of referral pathways where necessary.

**UNHCR-led** country level Shelter/NFI clusters focused on scaling up NFI procurement and distribution, decongesting and reducing human density in shelters and settlements, identifying and establishing places of treatment, isolation and quarantine, and supporting shelter repair and upgrades through cash assistance. As part of these efforts, UNHCR has distributed 6,000 refugee housing units (with an additional 700 on order) and 10,160 tents (47,800 currently being ordered) reaching approximately 80,800 individuals with emergency shelter support. Emphasis has been placed on decongesting collective centers and settlements to improve physical distancing, reduce transmission and provide dignified shelter options while also disseminating guidance for high density settlement conditions to facilitate health response.

Country level shelter clusters have engaged with health clusters and authorities to mitigate health risks through activities such as donating resources for emergency hospitals, quarantine, isolation and the expansion of medical facilities for additional spaces for triage and testing. Material support has also been provided for the expansion of shelters of vulnerable households to reduce overcrowding and upgrade inadequate shelter conditions including hygiene facilities. More than 482,000 individuals have been assisted with NFIs in Burkina Faso, CAR, Sudan and Venezuela while cash for shelter assistance was provided to 700 households in the DRC.

**UN-Habitat** supported manufacturing of more than 20

handwashing stations for densely populated urban areas with poor WASH infrastructure serving up to 30,000 people in Lebanon and Iraq while almost 4.500 people were provided hygiene protection gear. In Yemen, UN-Habitat distributed hygiene kits to 3,000 individuals while 6,000 people were served with sensitization and awareness activities. Finally, UN-Habitat worked with local authorities in Palestine to encourage home-gardening to support mental health of affected populations and support self-sufficiency of households.

**FAO** is making efforts to provide accurate information and guidance to contain risk transmission that is more adapted to the context of rural farming, fishing and pastoral communities. Furthermore, there is a need to raise awareness of actors along the food supply chain about health regulations, including rights, roles and responsibilities of workers.

**FAO** has been mobilizing its own resources to support national authorities in the containment of the virus transmission within the agriculture sector and across the food value chain; targeted activities are ongoing in eighteen priority countries with high levels of food insecurity and high risk of transmission. In Afghanistan, guidelines have been produced for sensitization and training of market managers, functionaries, vendors, consumers on adoption of COVID-safety measures for key agriculture produce, inputs and livestock. **FAO** Colombia broadcast on “Radio Nacional de Colombia”, four radio spots targeting the rural population with key messages on healthy eating (consumption and safety), production of food for self-consumption, recommendations for productive agricultural activity and access to food (local purchases and supplies). **FAO** is collaborating with the Emergency Centre for Transboundary Animal Diseases (ECTAD) and the Emergency Management Centre for Animal Health (EMC-AH) to design and deploy control strategies in response to epidemics and support laboratory biosafety.

**CARE** provided additional food assistance to approximately 725,000 people to reduce the negative effects of COVID-19 and support resilience of households<sup>68</sup>.

**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.**<sup>69</sup>

Please note that there is some overlap between Specific Objective 1.6 and Specific Objective 2.3. The below should be read in conjunction with Specific Objective 1.6.

**UNFPA** procured 4,812 Reproductive Health Kits for 24 countries between 7 January and 22 April 2020, 75 per cent of which were already shipped to their destinations and 25% are released for shipment. Commodities included in the kits target care for 2.195.100 pregnant women and care for 1,636.200 deliveries in the next 6 months.

**FAO** is exploring appropriate technology options to enhance local capacities for conservation, storage, drying, and processing of grains, fresh fruits and vegetables combining local traditions and ag new techniques of food processing and construction of cold storage, zero energy storages and warehouses in Afghanistan. Across countries **FAO** is advocating for key food item corridors to remain open as much as possible while safeguarding the health of farmers and food workers across the whole value chain in compliance with national public health mitigation measures. Risk of transport restrictions is high, **FAO** has been advocating in these countries and neighboring countries to ensure that agricultural inputs are exempt from transport and import restrictions.

**FAO** is launching a “household basket” initiative in West Africa with UN Women and UNFPA, which aims to be a bridge between producers who cannot sell their food products because of restrictions related to COVID-19 and households that are facing food and nutritional insecurity. In Sierra Leone, **FAO** is training women farmers and youth on processing and preservation of vegetable and fruits and marketing; and negotiating market corridors for women during COVID-19 lockdowns. In Bangladesh, support is being provided to farmers’ associations (reaching 75, 000 farmers) in Hoar area for transport, procurement of machinery and storage to ensure the crops reach markets and to avoid food losses; this includes providing vouchers for transport and storage while facilitating commercial relationships inside the different value chains.

68 This covers the March to June 2020 reporting period and consists of CARE’s work in 41 GHRP countries. CARE is also adapting and responding to COVID-19 in 28 non-GHRP countries.

69 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.

In nearly half of its countries of operation, **WFP** is providing tangible logistics assets and services including the donation of mobile storage units to governments or health partners, in some cases being repurposed with health partners as isolation units for COVID-19 patients or screening areas (Bangladesh, Ethiopia, Malawi, and South Sudan among others); the establishment of

tracking systems for health cargo and supporting the onforwarding of critical health items; and transport services of health cargo and testing kits. Through bilateral service provision, WFP is supporting governments with the procurement of food such as in Sudan and Guatemala, and exceptionally for health items (Iran).

---

## Strategic priority 3

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

---

**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.*

**UNHCR** has had some success working with governments to ensure that public health measures and protection are not seen as mutually exclusive. As of 15 June, 164 countries had fully or partially closed their borders to contain the spread of COVID-19 at some point of the pandemic, and at least 99 States have made no exception for people seeking international

protection. at least 19 countries are still not providing adequate reception for arriving asylum-seekers. This has serious protection and health implications.

In public health responses, in addition to advocacy for inclusion of the displaced, UNHCR provided specific programmatic support to large numbers of refugees and host communities. For example, UNHCR supported referral facilities with equipment including oxygen concentrators, ambulance transport, medicine and medical supplies including personal protective equipment, refurbishment, expanding clinical capacity through infrastructure improvements and human resource support in countries including Bangladesh, Lebanon, Egypt, Iraq, Ethiopia, Jordan,

Uganda, Kenya, Cameroon, Chad, Brazil and Colombia benefiting both refugees and host populations. Extensive training of community health workers and health staff on COVID-19 has also been undertaken.

UNHCR has stayed and delivered essential protection services with its partners in 135 countries. These lifesaving activities include protection monitoring; registration and documentation; status determination interviews; individual case management; legal aid; psychosocial counselling; response to gender-based violence and child protection; risk communication; engagement with diverse communities and strengthening of accountability to affected people mechanisms. Examples of UNHCR's response efforts in several sectors including Protection, Shelter/NFI, Education, CCCM, Health and basic needs areas can be found in respective HRPs and RRP.

The strength of collaboration under the UN Common Cash Statement for accelerating responses has been evident in the surge of collaborative procurement and shared delivery mechanisms. UNHCR is advocating with States and development actors for the inclusion of refugees and IDPs in social protection responses, while providing cash as emergency response, which is proving to be a critical tool in the immediate response to COVID-19. More than 65 UNHCR operations had expanded existing cash assistance and/or initiated new cash assistance to support immediate needs, and mitigate socio-economic impact. 80 per cent of UNHCR's cash is now delivered digitally. Since mid-March, new cash assistance initiatives have helped 996,700 people in GHRP countries, and over 1.1 million globally. As part of the COVID-19 reprogramming, cash approaches range from increasing the transfer value, establishing required hygiene measures at cash distributions, linking cash to social protection, front-loading of payments and an increased use of digital payments and monitoring - to testing of new technology such as contactless biometrics and a move from cash to in-kind when markets are not functioning.

To respond to the increase of gender-based violence, country operations updated and adapted existing referral pathways and bolstered community-based protection to meet this challenge. Many countries created or expanded 24/7 emergency hotlines and other communication channels for survivors. Others broadened their network of community outreach volunteers, who serve as a safe and trusted means to refer cases to UNHCR and partner organizations for care.

UNHCR continued to offer practical solutions to ensure the continuity of learning and ensure children and youth access learning opportunities even if they do

not have access to online learning platforms/technologies. UNHCR will also provide tablets to refugee students who were preparing for end-of-school exams in Uganda while supporting government efforts for distance learning in Jordan by increasing availability of electricity available to camps. Likewise, UNHCR is working with national governments and NGO partners to support teachers, parents and students through incentive payments while also distributing self-study packs and radios so that displaced children can follow lessons through broadcasts. Finally, UNHCR is assisting authorities and schools for reopening by cleaning infrastructure and raising awareness on preventive measures in the short-term while investing in building back better opportunities including WASH interventions in schools in the long-term.

Field-level protection clusters have stepped up their work in 33 operations focusing in particular on five areas. The GPC supported the adherence to a "minimum protection service package" focusing on (i) supporting for effective, safe, dignified, and inclusive health response, (ii) adapting protection monitoring and protection analysis, (iii) substantially step up protection advocacy, (iv) scale up protection awareness raising activities and campaigns including risk communication and community engagement, and (v) adapting protection service delivery particularly for child protection, GBV survivors, persons with disabilities, and psychosocial support.

The UNHCR-led Global Protection Cluster (GPC) also adapted its modalities of field support through tele-deployment of staff to operations and utilization of existing regional expertise and help desks. Spaces of exchange and field to field support were systematically activated. Global guidance, standards and minimum operational footprint were issued by GPC members and put at the service of the wider protection community. GPC members stepped up their advocacy work to ensure that protection is central to the pandemic response through collective advocacy messages, webinars, dialogue with donors, regular situation reports and live dashboard. Finally, the GPC and the WHO-led Global Health Cluster adapted their Joint Operational Framework, which is under development, and rolled out parts of it relevant for the pandemic response.

The Camp Coordination and Camp Management (CCCM) cluster co-lead by UNHCR and IOM produced guidance and facilitated knowledge exchange on good practice including on collaboration with Health, Protection, Shelter and WASH sectors in displacement sites. Among several other examples, the CCCM/Shelter sectors worked to scale up COVID-19

prevention and preparedness efforts in the Central African Republic while also conducting simulation exercises for dealing with suspected and confirmed cases of COVID-19 in displacement sites in Nigeria.

The UNHCR co-led Global Shelter Cluster coordination role has issued guidance and information to cluster coordinators, supporting development and exchange of guidance and Standard Operating Procedures among national cluster peers as well as supported partners in the field to be able to operate despite confinement measures and other challenges. A dedicated COVID live page and dashboard was created on the Global Shelter Cluster website compiling IASC and shelter-related guidance from different countries and organizations in multiple languages including guidance on key issues as they arise, such as key considerations on tenure security and an advocacy paper containing 5 ways shelter and settlements programs can help mitigate the spread of COVID-19. Throughout the crisis, The Global Shelter Cluster has maintained support to country level clusters including through regular webinars on how to mitigate COVID-19 through shelter activities and advocacy.

A coalition of 39 international, national, and refugee-led organizations in the Horn, East and Central Africa called on governments in the region to reopen borders for asylum seekers and put in place measures that manage the current health emergency while ensuring asylum seekers can seek protection during the COVID-19 pandemic<sup>70</sup>.

**World Vision** led or significantly contributed to 152 policy measures to improve international and country-level COVID-19 response, advocating for policies, protocols and local measures to improve access to populations for health and humanitarian workers, duty of care and safety standards for frontline staff, enhancement of common services, and specific measures to protect girls and boys from different forms of violence, including GBV, as an indirect impacts of the pandemic.

**NRC** provided COVID-19 assistance to 3.8 million people including IDPs, refugees and migrants in 30 countries where it operates<sup>71</sup>.

**CARE** provided 679,409 people with adjusted GBV services.

**IOM** continued to provide technical support to country-level, cross-border and regional coordination mechanisms and advocate for inclusion of migrants, displaced persons, returnees and other vulnerable

populations in regional and national preparedness and public health planning as well as national health systems and other basic services. For example, IOM provided guidance on migrant health programming to support the development of a government preparedness and response plan in Agadez, Niger.

IOM also continued its advocacy efforts with authorities to address fundamental rights of affected populations. IOM prepared a COVID-19 Gender and Protection Analysis in South Sudan while putting in place monitoring mechanisms to identify, mitigate and respond to protection risks and violations of human rights perpetrated within the context of COVID-19. IOM is currently in discussions with the Government of Sudan on how to safely repatriate the estimated 11,000 Sudanese nationals who are stranded abroad.

IOM's DTM is producing regular updates on the situation of migrants and IDPs and the impact COVID-19 is having to gather better situational awareness of the spread and impact of COVID-19 among IDPs and migrants and mobile populations globally, with a view to ensuring better public health responses and accountability for provision of care to vulnerable populations and in addressing specific needs faced by migrants and mobile populations during the COVID-19 crisis.

**UNICEF** has provided refugees, IDPs, migrants, host community members and people of concern with key COVID-19 related assistance including access to education, nutrition, health and children protection services, social protection support, access to clean water, hygiene items, sanitation facilities, and essential supplies, among others.

---

**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.*

**UNHCR** bolstered call centers with integrated voice response in target languages and established 24/7 protection hotlines to take calls, followed by interventions aimed at safeguarding access to rights and services; and built capacity to staff helplines remotely as needed.

**UNHCR** reached millions of refugees and internally displaced through bulk SMS texts, audio and text WhatsApp messages. Chatbots were developed to automatically respond to common questions, and

<sup>70</sup> <https://reliefweb.int/report/burundi/thirty-nine-organisations-call-governments-ensure-access-asylum-seekers-during-covid>

<sup>71</sup> Please note that this figure includes host communities and returnee populations. Work is underway to further disaggregate data. Figures will be updated in future reporting.

communication trees deployed to propagate accurate information across community networks. Two-way communication via social media increased on Twitter, Instagram, Trello as well as dedicated Facebook, Kobo, and UNHCR Helpline pages in multiple languages, including sign language. For persons of concern without access to such technology, UNHCR used radio and TV to broadcast COVID-19 public service announcements.

All platforms enabled UNHCR to share timely and accurate health information and to receive information from persons of concern to support efforts in countering myths, misinformation, stigma, and xenophobia. Persons of concern also received information on protection risks related to COVID-19, including evictions, SGBV, child protection, and protection from sexual exploitation and abuse.

**IOM** works with risk communication and community engagement (RCCE) counterparts to ensure that mobility is taken into account in public health messaging, and to ensure that information is contextualized and communicated effectively to migrants and mobile populations, as well as aiming at preventing panic, xenophobia and/or discrimination. IOM has also led RCCE campaigns in Afghanistan, Bangladesh, Burkina Faso, Djibouti, Egypt, Ethiopia, Iraq, Malaysia, Mozambique, Nigeria, Somalia, South Sudan, Sudan, Yemen, and Zimbabwe, among others, where interventions including awareness-raising public sessions, door-to-door visits, and peer discussions, took place to increase understanding of the risks of COVID-19. RCCE efforts have also been made on COVID-19

prevention measures that have been strengthened along the entire mobility continuum including at Points of Entry (PoEs), through collaborative efforts between communities, national and local authorities, UN agencies and other partner organizations.

Awareness raising materials to promote well-being during quarantine have also been produced. IOM Ethiopia developed a coloring book for children to understand the pandemic, while in Cox's Bazar, IOM helped develop awareness facilitation guidelines on COVID-19 for children and adolescents, as well as guidelines for case workers and caregivers on how to take care for children in alternative care systems. In South Sudan and Somalia, IOM undertook community consultations with organizations of persons with disabilities to understand levels of exclusion within the COVID response. The findings will be used to programme more inclusive responses for persons with disabilities.

**UNICEF** reached 1 billion people in 56 countries with COVID-19 messaging on prevention and access to services.

**UNRWA** established phone hotlines across its operations to enable refugees to phone in for information on its services. Hotline operators were trained by social workers (in Gaza and Syria) on how to manage distress calls and offer basic information and the Palestinian Counselling Centre provided hotline training to social workers and counsellors in the West Bank and Gaza. In Lebanon, training was provided by the School of Social Work at St Joseph University.

**“COVID-19 is reversing decades of progress on poverty and hunger. We must accelerate coordinated global action to ensure that we recover better from this crisis and deliver together on the Global Goals for a better world for all.”**

---

**António Guterres,**  
Secretary-General, United Nations

