



GLOBAL HUMANITARIAN RESPONSE PLAN COVID-19

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GHRP MAY UPDATE: ANNEXES





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KOINADUGU DISTRICT, SIERRA LEONE

A nurse working in the Kakoya health facility in the district of Koinadugu, Sierra Leone. She delivers babies, gives vaccinations, and is also a first point of contact for sick people in her community. *CARE/Shantelle Spencer*

Annex A

Response progress by strategic objective and specific priority

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 and Health clusters/sectors activated in 29 countries have scaled up their preparedness, planning, readiness and response through collaboration with over 900 health partners of which more than 600 are national and local partners. Risk Communication and Community Engagement (RCCE) actions are mobilizing communities to limit exposure, while integrating mental health and psychosocial support aspects. RCCE measures are also used for raising awareness on the need to protect healthcare workers from acts of both physical and psychological violence.

UNICEF is co-leading the RCCE pillar at the inter-agency level together with **WHO** and **IFRC** and a tight and effective coordination system is in place at the global, regional levels and country levels to align interventions' quality and ensure coherence. Currently, more than 100 countries have RCCE plans either a part of national plans or prepared by UNICEF and partners. Tools for qualitative assessments and perception surveys have been prepared and reach more than 9 million people through digital mechanisms including tracking misinformation and rumors.

In the three wild polio endemic countries of Afghanistan, Pakistan and Nigeria, UNICEF is using its existing social mobilization and community engagement polio networks and partnerships with community mobilizers, media, religious clerics, traditional leaders and civil society to promote hygiene and physical distancing practices, distribute soap and report cases to surveillance channels. In Afghanistan, over 3,700 polio social mobilizers are promoting hygiene

and physical distancing while 400 female mobilizers in health facilities have promoted hygiene practices and distributed soap to thousands of caregivers. In Pakistan, 1.2 million households are being tracked through community networks. Community mobilizers are promoting hygiene practices and physical distancing in more than 16,000 settlements, reaching over 22 million people, including 4.7 million under-five children across the 15 states of northern Nigeria.

IOM has set up Points of Entry Working Groups in collaboration with health and border authorities to enhance preparedness in more than ten countries, including Burundi, Guinea, Libya, South Sudan and Sudan. Public health measures have been strengthened by facilitating cross-border coordination and exchange of information, health screening, capacity building for disease surveillance and development of standard operating procedures. Building on Ebola preparedness and response in the Democratic Republic of the Congo and neighbouring countries, frontline health workers have been trained to screen signs and symptoms of COVID-19.

IOM is also undertaking daily monitoring, analysis and reporting on international travel restrictions, changes in visa, immigration and regularization schemes, and airline suspensions by governments. It has also enhanced its country-level primary data collection for points of entry covering most countries and territories. Coordination between neighbouring Displacement Tracking Matrix country operations has been increased to improve tracking of cross-border movements.

UNFPA and **UNICEF** are addressing the reduction of gender based violence services, including supporting providers to adapt their services to physical distancing requirements and ensuring infection and

prevention control measures. In places where the pandemic is spreading, remote modalities are being put in place to provide case management services and psycho-social support. New ways are also explored to continue regular assessments and service mapping modalities.

WFP is further supporting health preparedness by augmenting storage capacity of governments, supporting warehouse stock management and onforwarding of medical and non-medical supplies, establishing or reinforcing logistics sector working groups at the country level to identify bottlenecks and address supply corridor challenges, negotiating cross-border corridors and securing land/air bridges where required. This is in addition to the upstream services provided on behalf of governments and health partners to position essential health cargo in GHRP countries at the request of national governments and in line with national preparedness and response plans at country-level. For example, WFP and the Emergency Telecommunications Cluster partners are assisting health authorities in Central African Republic, Libya and Yemen, among others, to establish dedicated COVID-19 call centres and COVID-19 emergency hotlines to track cases, and disseminate health information and official guidelines.

UNRWA has provided personal protective equipment to all 3,000 health workers in the 141 primary health clinics it is running to ensure that essential services can be maintained. Triage systems have been set up in health centres to screen those with respiratory symptoms, whilst telemedicine services have been set up and house-to-house delivery of medicines to non-communicable disease patients is taking place in some fields. Mental health and psycho-social support services are also being provided remotely, through hotlines and other modalities.

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

IOM has supported screening in points of entry in South Sudan while also equipping frontline workers with personal protection equipment, health screening materials, and technical supervision in tracing. It is mapping population mobility to facilitate the implementation of preparedness measures in the Democratic Republic of Congo and utilizing event-based community surveillance in the Americas region. IOM has provided training on laboratory biosafety, appropriate use of personal protective equipment, and

operational support for packaging and transfer of clinical specimens for laboratory testing, including both national and cross-border support.

WHO and health cluster/sector teams have been working closely with national authorities to detect COVID-19 cases and support testing in often remote and high-security risk locations such as north-east Nigeria and north-west Syria by scaling-up and training of rapid response teams for outbreak investigation and surveillance. Interim guidance on operational considerations for COVID-19 surveillance using early warning, alert and response (EWAR) in humanitarian emergencies has been developed and widely disseminated to country teams to improve surveillance in low resource and humanitarian settings where healthcare capacity including isolation, treatment, and contact tracing for suspected COVID-19 cases is limited. This practical guidance informs the early detection of COVID-19 cases from primary health care facilities and from the emergency-affected community by guiding rapid risk assessment to identify site-specific risks for COVID-19 outbreak, EWAR includes minimum requirements for detection of a suspected COVID-19 case and practical considerations when adopting standard guidance for surveillance, contact tracing and isolation for humanitarian emergencies.

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.*

UNICEF is conducting infection, prevention and control activities and services with communities to reduce the burden on health care facilities, including increasing availability of water and handwashing points. Specific guidance for COVID-19 was developed to support interventions in households, public spaces and schools. Additional technical guidance notes are being prepared including on water, sanitation and hygiene interventions in densely populated urban areas and urban low-income communities in collaboration with UN-Habitat. The Global WASH cluster is currently developing advocacy materials to reinforce the importance of maintaining WASH services, particularly in humanitarian settings.

IOM has repurposed existing health facilities to become isolation and treatment facilities in displace-

ment sites and set up community surveillance and reporting mechanisms to promote early detection of cases and coordination of referrals to relevant responders. Staff has been seconded to support national health ministries in counselling, referral services and radiology issues. This includes repurposing existing health facilities to become isolation and treatment facilities in displacement sites, seeking supplies and equipment to establish two 200-bed isolation and treatment facilities in Cox's Bazar in Bangladesh, and the transportation of suspected or confirmed COVID-19 cases. For instance, 29 staff are working with the Public Health Emergency Operations Centre in Ethiopia in the COVID-19 response.

UNHCR has assessed and tracked preparedness in public health, water, sanitation and hygiene in 38 countries with large scale displacement. The overall preparedness score has progressed, with an average of 82% (an increase from 45% in March), with laboratory services and case management still to be strengthened. In countries such as Yemen existing population profiles data and multisectoral risk assessments in collective sites are used to develop indices to identify and prioritize particularly vulnerable sites for COVID-19 preparedness and mitigation measures. In camps and camp-like settings, alternative ways for community gatherings as well as modalities for various distributions to prevent large gatherings of persons are implemented.

WHO, IOM, UNHCR and **IFRC** have developed guidance for Scaling Up COVID-19 Outbreak Readiness Preparedness and Response Operations in Humanitarian Settings¹ including Camps and Camp-like Settings so that field partners are able to quarantine/isolate confirmed cases within the premises of camps, utilizing available resources in the best - and especially fastest - manner. The guidance is being applied for example in Bangladesh, Iraq, Syria and Yemen.

WHO continues to work with national ministries of Health joining forces to strengthen national and local capacities for epidemiological surveillance (Colombia), and development and implementation of national risk communication strategies (for example in Colombia and Iraq). Several technical guidelines have been developed to address laboratory testing. WHO also supports the roll-out of Go.Data to enhance contact tracing.

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.

Each Health Cluster/Sector has identified case management requirements within their COVID-19 risk assessment and response plans. Health facilities capable of screening and providing clinical care for suspect and confirmed cases of COVID-19 have been identified and services adapted to provide COVID-19 care and/or maintain essential services. Where necessary new treatment centers are being established in alternative spaces and staff trained to care for patients with or at risk of severe illness. Strong collaboration with other sectors has enabled rapid identification and adaption of isolation and treatment centers in high population density settings in Iraq, north-west Syria and Bangladesh.

Health partners have taken steps to ensure routine health services remain available to all camp populations and host communities within health facility catchment areas including emergency obstetric care and skilled birth attendance needs for all women and girls in need by separating people accessing routine services from suspect and confirmed COVID-19 cases. In addition, partners are implementing measures to limit potential exposure of patients with chronic conditions to COVID-19 infection by reducing the number of required visits to health facilities, for example, through provision of three months of treatment for stable patients with non communicable diseases and follow up at home by community health workers.

UNICEF is supporting safe clinical care in health care facilities by strengthening infection, prevention and control through increased water supply, sanitation and waste management. A total of 330,000 health care workers within health facilities and communities have received personal protective equipment. UNICEF has delivered training on infection, prevention and control to about 400,000 health care facilities staff and health workers in communities. The WASH-FIT tool has now been adjusted to evaluate COVID-19 critical elements within health care settings.

IOM has seconded staff to support national health ministries in counselling, referral services and radiology issues. For instance, 29 staff are working with the Public Health Emergency Operations Centre in Ethiopia in the COVID-19 response.

Specific objective 1.5 - *Learn, innovate and improve:*

¹ <https://interagencystandingcommittee.org/system/files/2020-04/IASC%20Interim%20Guidance%20on%20COVID-19%20for%20Outbreak%20Readiness%20and%20Response%20Operations%20-%20Camps%20and%20Camp-like%20Settings.pdf>

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.

UNICEF is utilizing Social Sciences Analysis Cells that were useful in the Ebola response to support governments and response actors in improving their COVID-19 response (including the mitigation of negative health and socio-economic impacts) by putting populations' insights at the center to improve strategies and interventions.

IOM has developed a Migration Health Evidence Portal for COVID-19,² providing a repository of research publications and high-yield evidence briefs on COVID-19 and its intersection with migration health.

Specific objective 1.6 - *Ensure essential health services and systems: secure the continuity of the essential health services and related supply chain for the direct public health response to the pandemic as well as other essential health services.*³

IOM has provided medical equipment and supplies in Libya and Somalia, and conducted assessments in Turkey to address the health needs of migrants at country border points of entry. IOM is working closely with WFP to develop measures to prevent contamination and ensure that aid staff only use specific means of transport and practice physical distancing constantly even onboard aircrafts.

UNDP has started to procure health equipment and is supporting containment efforts in 20 countries including health procurement, health policy, early warning systems, salary and payments to existing and new health workers.

UNFPA supply chain for essential emergency medical supplies and commodities, in particular interagency emergency reproductive health kits, has continued to operate with limited delays despite substantial transport bottlenecks. UNFPA and partners, using existing coordination systems in place, in particular SRH working groups and GBV sub-clusters, have reviewed their gender based violence and sexual and reproductive health services in order to prioritise life-saving services and assess their needs in terms of personal protective equipment to ensure continuity of those services.

UNICEF has intensified efforts to decentralize

treatment for severe acute malnutrition, including building the capacity of affected communities in early detection and referral, and prepositioning of essential commodities (e.g. Ready to Use Therapeutic Foods) at health facility level. It is working closely with national health authorities and health partners, in coordination with WHO, to ensure continuation of essential maternal, newborn, child and adolescent health services. Where diversion of health resources to COVID-19 is inevitable, countries are supported to make plans based on equity and the right to basic health care and life-saving needs. UNICEF has provided, in partnership with WHO, guidance to countries on safe delivery of Maternal, Newborn, Child and Adolescent Health (MNCAH) services especially the life-saving services, in addition to capacity development of health workers to deliver services.

UNICEF has mapped available digital health platforms to support the dissemination of information on the availability of routine health services, interventions and proper health seeking behaviours. In addition, these platforms are being used to engage with health workers for information sharing, training and feedback. UNICEF is working with manufacturers and freight carriers to safeguard supply and logistics chains for bundled vaccine supplies and essential supplies for MNCAH.

UNRWA has begun local procurement of medicines in Gaza, due to the risk of potential breaks in supply chains.

WFP has put in place the foundations and systems to deliver the upstream hub and supply chain system for the GHRP response. WFP and WHO co-lead the High-Level Supply Chain Task Force was established and WFP continues to support the Supply Chain Inter-Agency Coordination Cell. These coordination forums bring together the collective capabilities of partners to address bottlenecks and drive the global response in support of national governments, and consolidate and prioritise procurement and supply chain services.

WFP established consolidation hubs and started air cargo flights. Two new international consolidation hubs were set up in Liege and Ghanzhou in April, bringing the total to seven international consolidation hubs and regional staging areas now active. The eighth hub is expected to come online in early May. In addition, the UN Humanitarian Response Depot dispatched humanitarian and medical cargo to 86 countries to support governments and health partners in their response to COVID-19 since late

² <https://migrationhealthresearch.iom.int/migration-health-evidence-portal-covid-19>

³ Specific objective 1.6 and specific objective 2.3 overlap. Each is spelled out under their respective Strategic Priority due to the importance of maintaining the supply chain for both the direct health response and the response to urgent indirect humanitarian needs. The reporting is done against both objectives as one narrative.

January. The first UN solidarity flight departed WFP's recently established Regional Staging Hub in Addis Ababa on 14 April, carrying medical supplies and dispatching the cargo to 52 countries across the continent. On 30 April, the first free-to-user cargo flight under the GHRP took off from the newly established staging area in Liege. The air passenger service will begin in May considering the complexity around negotiating access and clearance for the movement of humanitarian personnel and ensuring necessary health mitigation measures are in place. Where WFP has UNHAS operations, dedicated Standard Operating Procedures and mitigation

measures have been put in place to ensure continued operations amidst disruptions to commercial air services, travel restrictions, and quarantine requirements for crews.

Contracting is underway with the first two medical evacuation hubs established. Thanks to the research of the UNHRD Brindisi (Italy), WFP in collaboration with WHO quickly designed modular COVID-19 field hospitals. The first two field hospitals were procured to be set up in early May, linked to the two medical evacuation hubs. Road ambulances have been procured for all medical evacuation hubs.

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.*

FAO has fast-tracked the procurement of and pre-positioned agriculture inputs to meet planting season needs and compensate for the limited purchasing power of farmers and access further aggravated by COVID-19 lockdowns. Ongoing responses are supporting the local production of fresh foods to sustain local income and nutrition, ensuring the emergency provision of animal health services as well as fodder/feed distributions particularly to pastoralists affected by movement restrictions, and expanding 'cash plus' and social protection programmes to take into account the additional needs of the most vulnerable rural population groups such as informal workers, landless, and female-headed households.

IOM has adapted distributions and livelihood activities in displacement sites to comply with physical distancing measures. Support services, personal assistance, physical and communication accessibility for people with disabilities have been preserved in those sites, including during quarantine.

UNDP has mobilised its core resources to 22 countries (21 of which prioritised in the GHRP) (Bangladesh, Cameroon, Central African Republic,

Chad, Colombia, Democratic Republic of Congo, Egypt, Iran, Iraq, Liberia, Mali, Nigeria, Palestinian territory, Pakistan, Somalia, Sudan, Syria, Uganda, Ukraine, Venezuela and Yemen) to support emergency employment, public employment services, as well as basic livelihood and start-up grants including cash transfers. Support is also provided to deliver essential services and enhance the protection of fundamental human rights, justice and security needs of those groups. Rapid needs and impact assessments are being conducted to identify the most affected populations and to inform livelihood assistance and recovery efforts. UNDP is also analysing the impact of containment measures on vulnerable populations, and proposing alternative measures to limit transmission to national governments.

UNHCR has, in line with the Global Compact on Refugees, advocated for the inclusion of refugees in national social assistance schemes (as non-citizens are normally excluded from them), provided short term cash grants in order to save lives and ensured refugees and IDPs can meet their basic needs, feed their families and respond to threats of eviction.⁴ In the reporting period, an additional US\$30 million has been paid by UNHCR through cash assistance, including advanced payments.

UNICEF has put systems in place to collect information on social protection system scale up and adjustments in humanitarian operations. Information

⁴ UNHCR emerging CVA best practices in COVID-19 contexts: <http://reporting.unhcr.org/sites/default/files/CashCOVID19.pdf>

collected includes disbursement of humanitarian cash transfers through the government system and design and delivery of humanitarian cash transfers through a parallel system which helps meet multiple needs of affected populations.

UNRWA is ensuring that food and cash distributions are maintained in all its fields of operation, reaching an estimated 1.8 million Palestine refugees, including 1 million in Gaza and 418,000 in Syria. In Gaza, food is being delivered directly to beneficiaries' homes, to avoid the risk of transmission in overcrowded distribution centres. Additional cash distributions are planned or underway for another 400,000 Palestine refugees in Jordan, Lebanon and West Bank who fall outside of government assistance programmes

WFP leveraged its extensive experience in managing the safe and continued delivery of food assistance in health emergencies (in particular Ebola) to develop safe delivery and distribution protocols adapted to COVID-19; these were shared with food security partners to benefit all NGOs. In GHRP countries WFP has used its resources to shift from cooked meals to take-home pre-kitted food packages (such as in Colombia for Venezuela migrants and indigenous children) and partnered with more retail outlets to reduce congestion at shops and shifted between cash/vouchers to secure inventory. It also leveraged its deep field footprint to transmit health sensitization messaging for governments, put in place tailored delivery mechanisms to reach at-risk groups and/or persons in isolation, and is working with government social protection partners to update targeting and top-up transfers to cover residual food and minimum essential needs gap of migrants, refugees, and urban poor. WFP is undertaking real-time remote monitoring in 17 countries to collect continuous data food security, market and health-related indicators to support coordinated analysis and informed decision making for governments and partners⁵. Real time monitoring is complemented by country-level impact projections as well as global economic analysis, political, security and social unrest analysis to model changes in acute hunger as a result of COVID-19.

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.

FAO is mobilizing communities and raising awareness on COVID-19 risk transmission through Farmer Field Schools, Livestock Field Schools, Animal Health Clubs and other networks. Sensitization trainings are conducted with actors along the food supply chain on best practices to mitigate the risk of infection. For example, in Afghanistan, physical distancing and hygiene-related practices are promoted in seven main markets for agriculture produce/inputs, livestock and live animals in most affected provinces. More than 27,000 individuals including landless labourers, migrant Kuchi herders and vulnerable farmer households (representing approximately 194,000 people) will receive awareness messages and information, education on appropriate preventive practices pertaining to minimizing the transmission of COVID-19. As in several other humanitarian operations, food security partners in Iraq are planning to introduce "cash plus" schemes, among other agriculture and livestock interventions in support of household livelihoods and resilience.

IOM is supporting government efforts to ensure the continuity of essential health services to stranded migrants, regardless of legal status, and to IDPs through the provision of life-saving primary health care, including mental health and psychosocial support referrals, sexual and reproductive health, and gender-based violence services, HIV and tuberculosis services, the procurement of essential medicines and medical supplies, distribution of hygiene and disinfection products, and the improvement/ construction of infrastructure to enhance infection prevention and control water, sanitation and hygiene measures, particularly in countries with compounding pre-COVID-19 humanitarian needs such as Bangladesh, Djibouti, Ethiopia, Nigeria, South Sudan and Venezuela.

IOM is also continuing its protection mainstreaming efforts including gender based violence risk mitigation in all sectors of response. IOM revised its strategies and approaches to ensure that essential water sanitation and hygiene services, such as the provision of safe drinking water and desludging of latrines, are sustained in displacement camps, such as Bangladesh, Nigeria, South Sudan and Yemen. Capacity building and empowerment of community-led management committees have been fast-tracked to take greater responsibilities in

⁵ Live data is available to partners and decision makers at <https://hungermap.wfp.org>

the management of water, sanitation and hygiene services and operate more independently. Similarly, IOM country programs have adjusted their hygiene promotion approaches, such in the case of Ethiopia to ensure that the activities planned in hygiene promotion adhere to social distancing guidelines and integrate COVID-19 messages.

UNFPA is supporting governments and partners in prioritizing the needs of women and girls and ensuring the continuity and adaptation of sexual and reproductive health and gender-based violence services, including prevention, mitigation, risk communication, and community engagement, and the provision of supplies including modern contraceptives and personal protective equipment. Amid the movement restrictions, alternative solutions are employed to deliver services including virtual outreach, mobile clinics, hotlines for survivors of gender based violence, and provision of dignity kits in isolation centers. UNFPA is also training health and social workers to provide mental health and psychosocial support.

UN-Habitat has been ensuring that in Iraq contractors and partners can return to work safely, based on the “Managing COVID-19 risks on UN-Habitat construction and field sites” guidelines based on WHO health instructions and UNOPS guidelines. This has permitted the resumption of much needed water and sanitation projects and housing/shelter rehabilitation, particularly in conflict-affected areas, with a particular emphasis on job creation. Pilot mobile hand-washing trailers will be installed in critical public locations, such as busy markets places.

In Syria, UN-Habitat will support rapid municipal responses (decontamination, solid waste management, water supply and sanitation) aimed at preventing the spread of COVID-19 in densely populated, high risk urban areas. In Lebanon, UN-Habitat is complementing the work undertaken by UNICEF with regards to water and sanitation, by providing critical lifesaving hygiene protection gear to the most vulnerable urban populations in two communities in Beirut, specifically targeting women, women headed households, refugees, vulnerable Lebanese, the elderly and chronically ill. This effort will be further complemented by implementing hand-washing stations in critical locations across three vulnerable communities, enabling enhanced hygiene practices and protection against COVID-19. These interventions are complemented by rigorous awareness raising around protection to and responding to COV-

ID-19, including awareness on available resources to respond to domestic violence.

In Yemen, UN-Habitat is raising awareness on COVID-19 symptoms, prevention and means of transmission through improvement of Shelters and upgrading of the WASH facilities inside the houses.

UNICEF continues to provide maternal, newborn, child and adolescent health (including immunization), nutrition, education, child protection, HIV prevention and treatment, water, sanitation and hygiene, and gender-based violence services across humanitarian operations. For instance, in Iraq and Afghanistan classes are delivered through television, radio e-learning and self-learning mediums, among others. Water, sanitation and hygiene infrastructures are also being upgraded in schools to facilitate schools’ reopening once mobility restrictions are lifted. In health facilities, UNICEF is supporting triage capacities and management of patient flow, adherence to infection, prevention and control protocols through training and provision of personal protective equipment to ensure safe delivery of health care to all. Support and guidance are also provided to maintain and adapt gender based violence services and mitigate risks of gender-based violence through other sector interventions, and collaborating with local women’s groups to identify digital service provision options for low-resource and low-tech settings. In sub-Saharan Africa where the burden of HIV is high, UNICEF has supported planning for and dispensing of multi-month prescriptions of antiretrovirals for women, children and adolescents living with HIV.

UNHCR is supporting national health services in areas where displaced populations reside. For example, In Myanmar, UNHCR has funded and secured a pipeline, in partnership with other UN agencies, comprising 75 different medicines, medical supplies and equipment to support an outbreak for 40,000 people including up to 2,000 people in intensive care units. In Lebanon, UNHCR has trained more than 400 frontline workers and more than 6,000 community volunteers on hygiene promotion and awareness of COVID-19 symptoms while also expanding existing medical wards with 800 additional beds and 100 additional intensive care unit beds. In most of the major refugee-hosting states in Africa, UNHCR activities include, among others, procuring medication, medical supplies and medical equipment (including personal protective equipment) in coordination with WHO; establishing isolation/quarantine facilities

through refugee housing units and shelters; capacity development and trainings of health workers and volunteers in camps and urban reception centers; and disease surveillance and referral mechanisms at border areas; and establishment of additional wards and Intensive Care Units; and procuring generators and fuel to power health facilities.

UNHCR also continues to provide education services building around national approaches to ensure they reach refugee populations. In Niger, UNHCR has been distributing radios to ensure access to government education broadcasts and programmes tailored to refugees. Operations in Uganda and Jordan have focused on access to e-learning. In refugee-hosting areas (Kenya, Uganda, Chad, Burkina Faso and others) UNHCR is preparing for a complementary back-to-school approach that aims to strengthen WASH, teacher capacity, and accelerated and connected education for students to catch up.

WFP worked with partners including **UNICEF**, the Global Nutrition Cluster and the Global Technical Assistance Mechanism for Nutrition to develop guidance on Protecting Maternal Diets and Nutrition Services and Practices in the Context of COVID-19.⁶ WFP is partnering with governments and health partners to top-up food assistance to severely vulnerable groups (including refugees and migrants) with a cash top-up or in-kind delivery of essential hygiene needs. In Latin America, the Middle East, Africa, and Asia, WFP is working with governments to adapt health and nutrition sensitization messaging for a COVID-19 context, and leveraging WFP's complaints and feedback mechanisms, partner call centres, and hotlines to transmit health and nutrition messages and enable two-way communication.

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.*⁷

FAO is maintaining and scaling-up humanitarian livelihood interventions focusing on boosting food production and reducing the impact of lean seasons through inputs distribution and technical support in food crisis countries with ongoing humanitarian response. Local production of fresh foods (vegetables and animal products) is supported to sustain local income and improved nutrition; emergency animal health support is provided and fodder/feed distributed particularly to pastoralists affected by movement

restrictions. **FAO** is also 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. It is supporting food processing, transport, marketing, storing with a specific focus on vulnerable small-holder farmers food workers; and strengthening local producer groups to maintain negotiation power and access to markets.

WFP is providing governments with logistics augmentation, technical assistance, and coordination and information management services at points of entry to mitigate congestion and ensure the continued flow of prioritized humanitarian cargo, in addition to the upstream services appealed for under the GHRP outlined under specific objective 1.6. WFP has recruited dedicated health advisors and leveraged its experience in delivery in the Ebola response to develop detailed SOPs and health mitigation measures along the supply chain. See also specific objective 1.6 above, as many interventions for this specific objective are combined for health and non-health commodities and staff-related supply chain responses.

IOM has been actively involved in Chad, Libya, Somalia and South Sudan to secure the procurement, storage and distribution of critical medical, water, sanitation and hygiene, and infection prevention and control supplies, to ensure the continuation of operations while maintaining the highest level of security for staff and affected populations. It also continues to invest in the global and national prepositioned stock capacity of various essential items and equipment, under established inter-agency coordination mechanisms at global and country levels.

UNFPA has procured 4,812 reproductive health kits for 24 countries, 75% of which were already shipped to their destinations. The kits provide commodities to 2,195,100 pregnant women and for 1,636, 200 deliveries in the next 6 months. Reproductive health interventions are ongoing in several GHRP prioritised countries such as Afghanistan, Bangladesh, Central African Republic, Democratic Republic of Congo, Haiti, Myanmar, Pakistan, Palestine, and Sudan.

UNHCR continues to ensure the supply chain and distribution of core non-food items as well as, where feasible, cash assistance for essential needs to mitigate the spread and impact of COVID-19 (see below strategic priority 3 for details).

UNICEF continues interagency supply chain coordi-

⁶ www.nutritioncluster.net/node/11091

⁷ 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.

nation efforts in the context of COVID-19 to address education, nutrition, and water, sanitation and hygiene supply issues. Education related supply response is being scaled up including education kits and additional warehouse storage space. Ready-to-Use Therapeutic Food is being procured to ensure a continuous supply while efforts are underway to facilitate logistic partner shipments of vaccines translating into a volume of 16.5 million doses of vaccines for preventive immunization campaigns. UNICEF is exploring different charter options to expedite vaccine shipment deliveries with reduction in planned shipments impacting shelf life for delayed shipments.

UNICEF is working in close collaboration with UN agencies and partners, including **WHO, GAVI, PAHO**

and **BMGF** to mitigate risks. Priority shipments focusing on outbreak response and countries where there are critical stock levels will be identified, and production will be facilitated in the anticipation of a scale up of operations when COVID-19 has stabilized. UNICEF also continues to facilitate water, sanitation and hygiene commodities and services facilitating COVID-19 preventative measures in communities and health care facilities.

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.*

IOM along with other partners have liaised with local authorities in several locations to guide and address issues arising from quarantine measures taken hastily that violate fundamental rights of displaced populations and highly vulnerable groups such as migrants. Work is ongoing with governments in the Americas (Bolivia, Peru, Mexico, among others) where many migrants' reception centers, managed by civil societies, and faith-based groups, are being transformed into quarantine centres.

UNHCR is working closely with national authorities, partners, clusters, and people of concern—refugees, asylum seekers, returnees, internally displaced people and stateless persons— to analyze changes in the protection and operational environment and maintain essential protection and assistance activities and to advocate for the inclusion of people of concern into national health services and response plans and strategies.

Activities include protection monitoring, inter alia in border and remote areas, support to governments in establishing health prevention and response mechanisms in border zones, and critical protection case management focusing on registration, issuance of documentation, status determination interviews, legal and psychosocial counselling, response to gender-based violence and child protection.

In refugee and IDP camps, **UNHCR** supported the scale up of infection prevention and control, and healthcare responses through the provision of personal protective equipment, medical equipment and supplies, and training of frontline health personnel, including to produce protective equipment locally. UNHCR procured and delivered a total of 6.4 million masks, 850,000 gowns, 3,600 oxygen concentrators and 640 ventilators to 25 high priority countries. Together with local authorities, health, water, sanitation and hygiene, and shelter partners, treatment, isolation and quarantine centres were set up in locations with high numbers of people of concern at risk, for example in Bangladesh and Ethiopia, among many others. In addition, US\$30 million were disbursed in cash grant payments in several countries targeting populations with existing and new vulnerabilities including through piloting contactless biometrics and digital cash delivery modalities.

UNICEF has made the care and protection of rights of migrant and displaced children in this pandemic a key focus of its work as per its agenda for action.⁸ In particular, UNICEF has been advocating with national authorities on ending deportations, push-backs and return, as well as has called for ending child immigration detention. UNICEF has insisted on equal treatment of all populations, no matter their migration or displacement status. Vulnerable, displaced and migrant populations have also been targeted by COVID-19 messaging in Myanmar and national hotlines supported for migrants in Libya, for example.

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.*

IOM has stepped up risk communication and community engagement at global, regional and national levels to ensure that public health messaging considers mobility, information reaches migrants and mobile populations, and that xenophobia and discrimination in areas with a high influx of migrants, such as in Colombia and Djibouti, is prevented. IOM has also led comprehensive preparedness and awareness-raising communication efforts in countries such as Afghanistan, Bangladesh and Nigeria. In Chad, travelers have been trained and equipped to pass on COVID-19 related vital information in remote locations. In the Americas, IOM and UNHCR collaborate successfully to encourage migrants and refugees with a health sector background to join local health responses. Life-saving minimum protection programming is also maintained and adapted in remote settings.

UNDP is supporting local governments to plan and deliver vital basic services rapidly in an inclusive manner to mitigate sources of tension while mainstreaming social cohesion and conflict sensitivity in countries with a humanitarian response plan. Using the “Leave No One Behind” approach, UNDP is addressing issues of stigma and discrimination stemming from COVID-19.

UN-Habitat has launched an online portal in Iraq capturing key information on COVID-19 and response measures with a specific focus on informal settlements was launched in both Arabic and English to disseminate accurate information to wider

public. A ‘Housing, Land and Property COVID-19 Response Guidance’ was produced for HLP actors. A Critical Protection Issues) Note was prepared to bring to attention the increased risk of evictions of IDPs and vulnerable households due to the socio-economic impact during COVID-19. Field teams have been distributing and displaying WHO-approved COVID-19 messages and providing the number to the Iraq Information Centre hotline which Iraqis can phone to ask for information on COVID or where they can obtain help if they have lost their jobs. UN-Habitat is sending regular messages and advice to project beneficiaries using various phone/data platforms on how to ensure personal protection and avoid spread of COVID-19 virus in their communities.

In Syria, UN-Habitat mobilized support for enhanced preparedness and response operations at the municipal level and strengthened local community engagement in COVID-19 response, and improved hygiene and sanitation conditions. In Yemen, UN-Habitat is focusing on innovating in community engagement to identify best practices and successes in provision of hand washing facilities and behavioral change, applying lessons learnt of water, sanitation and hygiene practices, Ebola, cholera and HIV responses to enhance effectiveness, avoid stigma and focus on most vulnerable groups.

UNHCR has issued guidance and tools to strengthen COVID-19 preparedness and response in health, water, sanitation and hygiene, and shelter areas, management of camps and camp-like settings, COVID-19 surveillance, sustenance and adaptation of essential services in health care, nutrition and mental health, and quarantine, isolation and treatment infrastructure solution. A Joint Operational Framework is being piloted by the global Protection and Health clusters to improve the integration and coordination of interventions for better health, protection and holistic responses, identification of critical shelter and camp management and coordination activities to mitigate health risks, and provision of guidance on COVID-19 readiness and response. UNHCR also adapted its gender-based violence programming. In West and Central Africa, field teams utilize remote gender-based violence case management and interventions, including integrating urgent cash assistance for women at risk and gender-based violence survivors. In the East and Horn of Africa and Great Lakes, UNHCR established a committee to ensure continuity in the case management of gender-based violence.

⁸ www.unicef.org/coronavirus/agenda-for-action

UNICEF is working globally on risk communication and community engagement and collaborating with universities to collect information and disseminate messages, such as the Harvard Humanitarian Initiative to collect timely data on migrants and refugees including measuring specific stigma and discrimination sentiments. Videos targeting IDPs and refugees in settings with low internet connections are being prepared with Stanford University. Other communication materials are under development as well to capture the effects of COVID-19 in the post response phase on migrants and refugees. On xenophobia and discrimination in particular, UNICEF has activated its global campaigning assets, and has focused the attention of the #Uprooted Campaign on preventing xenophobia and discrimination, with positive engagement on global social media channels as well as national level-campaign activation. In Lebanon and Guatemala, UNICEF teams have crafted campaigns to challenge myths, fears and stereotypes against returnee and refugee populations promoting tolerance.

UNFPA and partners are providing risk communications and community engagement activities adapted to local contexts and languages. This includes developing quality key messages and health education materials, raising awareness and supporting a range of communication channels to reach targeted groups (pregnant women, women of reproductive age, youth, the elderly, health workers, and internally displaced populations). UNFPA is supporting toll-free hotlines and offering services for mental health and psychosocial support. In Afghanistan, 7,377 calls from young people were received in the first two weeks of operation while youth networks have been mobilized to reach out communities and disseminate messages on COVID-19 symptoms and risks in Iraq, Libya, Somalia and Sudan.

Annex B

Response progress by IASC organizations and partners

AGENCY	OVERVIEW OF RESPONSES
FAO	<p>Strategic Priority 2 - SO 2.1 - SO 2.2</p> <p>FAO's approach is to: (i) stabilize access to food by supporting rural incomes and preserving ongoing critical livelihood assistance to vulnerable households; (ii) ensure continuity of the critical food supply chain; and (iii) ensure people along the food chain are not agents of COVID-19 transmission. Progress and plans include:</p> <ul style="list-style-type: none"> • Setting up a global data facility in close collaboration with the Global Network Against Food Crises Partnership Programme to support analysis and inform assessments and programming in contexts already experiencing humanitarian crises. • Stabilizing incomes and access to food as well as preserving ongoing livelihood and food production assistance for the most acutely food-insecure populations highlight impacted COVID 19 pandemic. • Ensuring continuity of the critical food supply chain for the most vulnerable populations, including between rural, peri-urban and urban areas through support to the sustained functioning of local food markets, value chains and systems, focusing on vulnerable smallholder farmers and food workers as well as areas that are critical to the food supply for vulnerable urban areas. • Ensuring people along the food supply chain are not at risk of COVID-19 transmission by raising awareness about food safety and health regulations, including rights, roles and responsibilities of workers, together with national authorities and the World Health Organization (WHO).
IOM	<p>Strategic Priority 1 – SO 1.1 - SO 1.2 - SO 1.3 - SO 1.4 - SO 1.5 - SO1.6</p> <p>IOM will scale up its support to local governments to enhance existing capacities by:</p> <ul style="list-style-type: none"> • Providing life-saving primary health-care services, mental health and psychosocial support services, procurement of critical medical supplies and infrastructure support. • Supporting governments with enhanced technical and operational capacity at Points of Entry related to surveillance, infection prevention and control, risk communication and community engagement and coordination. • Providing WASH services in health-care facilities and Points of Entry. • Enhancing national capacity for detection through trainings and operations support for laboratory testing, including through cross-border. • Strengthening Community Event-Based Surveillance by linking mobility information to surveillance data, particularly among border communities, strengthen data collection and conduct Participatory Mapping Exercises to identify high-risk transmission mobility corridors/areas. • Support to augment UN clinics services through the provision of staff and medicines, equipment and supplies <p>Strategic Priority 2 – SO 2.1 - SO 2.2 - SO, 2.3</p> <p>IOM will continue supporting regional, national and local authorities to ensure the continuation of services, including primary health-care, mental health and psychosocial support services and WASH facilities and services, including strengthening of Infection Prevention and Control (IPC) measures, as well as strengthening the access to social networks and livelihoods for migrants, IDPs, and other vulnerable populations. It will also anticipate, prevent and address potentially negative community security impacts on social cohesion related to lack of awareness and information about COVID-19 pandemic among local communities. IOM will also engage with national authorities and UN partners to support the procurement, storage and distribution of critical supplies..</p>

AGENCY	OVERVIEW OF RESPONSES
IOM	<p>Strategic Priority 3 – SO 3.1 - SO 3.2</p> <p>IOM will continue to enhance local-level capacities to ensure monitoring of assistance, protection and access to services of all migrants, displaced populations and local communities by:</p> <ul style="list-style-type: none"> • Providing assistance to stranded migrants to access services; • Supporting existing protection mechanisms and social services to identify and support people in need of care or protection and refer them to appropriate services; • Disseminating RCCE key messages on service delivery, health and hygiene to migrants, IDPs and other vulnerable populations. <p>Technical guidance and tools will be prepared to ensure risk communication messages are culturally and linguistically tailored while advocacy efforts will emphasize migrant-inclusive approaches that minimize stigma and discrimination. Activities will be implemented to improve living conditions of displaced populations to minimize the risks related to the spread of COVID-19 disease, including improvement of camps and camp-like settings, provision of WASH services, and shelter assistance to support density reduction and isolation.</p>
UNDP	<p>Strategic Priority 2 – SO 2.1 - SO 2.2 - SO, 2.3</p> <p>UNDP will support the procurement and provision of health products, and support non-medical requirements for the overall response and coordination. Salary/incentives payments will be made to existing and new health workers in resource-constrained settings.</p> <p>While further funds are awaited, UNDP is using the US\$3.2 million CERF allocation by applying its strong experience in health procurement and supply chain management through its global procurement architecture as a result of its global partnership with the Global Fund. This has allowed it to respond to the requests that have been received in GHRP-eligible countries from the Ministries of Planning and/or Health. UNDP is specifically allocating these funds towards the procurement of PPE and other COVID-related protective and response equipment from Ministries of Health in eligible countries. This means providing personal protective equipment including gloves, surgical masks, facemasks, biohazard bags, hand sanitizers, goggles, face shields, digital thermometers, non-contact infrared thermometers, aprons, etc. In certain cases, it could also include the provision of medical devices (e.g., ventilators).</p> <p>UNDP is responding to requests from Afghanistan, Bangladesh, Burkina Faso, Burundi, Cameroon, Chad, Ethiopia, Iran, Libya, Mali, Nigeria, South Sudan, Sudan, Ukraine and Venezuela.</p> <p>Strategic Priority 2 - SO 2.1 - SO 2.2</p> <p>UNDP will provide emergency employment, public employment services, as well as basic livelihood and start-up grants including cash aid. It will support the Emergency Operation Centers/ Civil Protection/ National Disaster Management Committees to set up helplines manned by community volunteers to respond to queries of the general public on COVID 19 with special outreach to most vulnerable groups; and community volunteering to help with contact tracing and other information useful for decision making and later recovery planning. UNDP will also conduct rapid needs and impact assessments to identify the most affected population and inform livelihood assistance and recovery. UNDP will also provide immediate support to deliver essential services to enhance protection of fundamental human rights, justice and security needs of vulnerable people and communities.</p> <p>Strategic Priority 3 - SO 3.2</p> <p>UNDP will increase its support to local governments to plan and deliver vital basic services rapidly in an inclusive manner to mitigate sources of tensions. It will contribute to mainstream social cohesion and conflict sensitivity across the humanitarian plans in priority countries and nationally-led response plans, help address issues to stigma and discrimination issues, and enable society to maintain cohesive structures and capacities.</p> <p>To date, UNDP has received limited funding through the GHRP. and will report on progress against Strategic Priorities 2 and 3 in future updates. However, UNDP has mobilised its core resources to 22 countries that are listed above to support emergency employment, public employment services, as well as basic livelihood and start-up grants including cash transfers. Support is also provided to deliver essential services and enhance the protection of fundamental human rights, justice and security needs of those groups. Rapid needs and impact assessments are being conducted to identify the most affected populations and to inform livelihood assistance and recovery efforts. UNDP is also analysing the impact of containment measures on vulnerable populations and proposing alternative measures to limit transmission to national governments.</p>

AGENCY	OVERVIEW OF RESPONSES
UNFPA	<p>Strategic Priority 2 - SO 2.2 - SO 2.3</p> <p>UNFPA will ensure the continuity of national and local health system capacity to provide access to integrated quality sexual and reproductive health and ensure continuity and adaptation of sexual and reproductive health and gender-based violence services. Services will include; basic and comprehensive emergency obstetric neonatal health and psychosocial support, family planning through provision of commodities and supplies including modern contraceptives and personal protective equipment, among many other services.</p> <p>UNFPA will mitigate the impact on supply chain and logistics management for lifesaving sexual and reproductive health supplies, ensuring continuity of supplies and care for lifesaving sexual and reproductive health services, as indicated in the Minimum Initial Service Package throughout the COVID-19 pandemic. Likewise, it will provide basic personal protection equipment to midwives, nurses, obstetricians, and anesthesiologists and support staff) and frontline gender-based violence service providers. Amid the movement restrictions, UNFPA is employing alternative solutions to deliver services including virtual outreach, mobile clinics, hotlines for survivors of GBV, and provision of dignity kits in isolation centers.</p> <p>Strategic Priority 3 - SO 3.2</p> <p>UNFPA will provide risk communication and community engagement for primary prevention and stigma reduction, strengthening risk reduction messages and addressing needs of women of and girls reproductive age, pregnant, delivering and lactating in quarantine so they can have access to essential, and COVID-19 sensitive sexual and reproductive health interventions. UNFPA interventions will include distribution of dignity kits, dissemination of risk mitigation information on gender-based violence, sexual and reproductive health and COVID-19 adapted to local languages, health education materials to raise awareness for targeted groups, promote integration of gender based violence risk mitigation into all relevant sectors including WASH, Shelter, Food Security and CCCM sectors, and managing toll-free hotlines and offering services for mental health and psychosocial support.</p> <p>UNFPA leads gender-based violence coordination in 37 contexts and is working with partners to ensure that life-saving care and support to gender based violence survivors is in place (i.e. clinical management of rape and psychosocial support) amidst the challenges of containing the rapidly spreading COVID-19 virus in countries and communities already facing long-running crises, conflict, natural disasters, displacement and other health emergencies.</p>
UN-Habitat	<p>Strategic Priority 2 - SO 2.2 / Strategic Priority 3 - SO 3.2</p> <p>UN-Habitat will support preparedness and response to the COVID-19 pandemic among the most vulnerable populations in urban settlements, especially in informal settlements and slums. Key interventions include:</p> <ul style="list-style-type: none"> • Enhanced WASH mobilization and services in informal settlements, • Modeling of movement in urban areas, both within the cities and flowing out from the cities as populations return to rural areas perceived as more protected from the virus • Messaging and advisory capacity to local city authorities on preparedness and response, including safe mobility in urban areas, and community mobilization in informal settlements to address preparedness, reduced transmission, community tracing, treatment, and solidarity.
UNHCR	<p>Strategic Priority 2 – SO 2.1 - 2.2 - 2.3</p> <p>UNHCR will ensure refugees and persons of concern have continued access to essential health, nutrition, education, and protection services. UNHCR has strengthened its supply chain to ensure continued access to and distribution of essential items both in kind and through cash.</p> <ul style="list-style-type: none"> • UNHCR has procured \$70 million-worth of health materials, personal protective equipment. • Cash based assistance of \$30 million has been provided, including front-loading 2-3 months in some cases. <p>Strategic Priority 3 - SO 3.1</p> <p>UNHCR is supporting ministries of health and partners with the following:</p> <ul style="list-style-type: none"> • Disease surveillance, alert notification, case investigation and case reporting implemented in refugee hosting districts; training of rapid response teams, health staff, community health workers on case definitions, isolation procedures, referral mechanisms for suspect cases, and contact tracing. • Isolation, quarantine and case management and infection prevention and control through procurement of medicines and medical supplies including PPE, provision of equipment for health facilities • Support to laboratories in refugee settings, including host communities, with equipment and supplies (swabs, viral transport media, furniture and refurbishments, packing materials and personal protective equipment (PPE)). • WASH minimum standards in health facilities, reception centres, transit centres, community centres, women's centres and points of entry. These include handwashing, enhanced water supply, sanitation as well as adapted management of medical waste.

AGENCY	OVERVIEW OF RESPONSES
UNHCR	<ul style="list-style-type: none"> • UNHCR will assist governments in meeting humanitarian standards and ensure that the needs of all those seeking protection are taken into account. Critical protection functions include: maintaining or increasing registration or enrollment, case management, counselling and referrals to ensure access to health and other essential services (including for gender-based violence and child protection) and, risk communication and community engagement. <p>Likewise, UNHCR will continue to put affected people first and to advocate for inclusion in humanitarian aid (focusing on persons with disabilities and older persons in particular) in line with its accountability to affected people commitments.</p> <p>Strategic Priority 3 - SO 3.2</p> <ul style="list-style-type: none"> • UNHCR has undertaken targeted messaging in camps, settlements and host communities at highest risk on hygiene practices through its communication within communities approach • UNHCR has increased WASH facilities, hygiene supplies and urgent procurement of medicines and medical supplies and has procured and delivered a total of 6.4 million masks, 850,000 gowns, 3,600 oxygen concentrators and 640 ventilators to 25 high priority countries • UNHCR has improved shelter conditions to reduce density and provide isolation facilities; and enhance inpatient and outpatient services, intensive care capacity and burial facilities. • UNHCR has provided US\$30 million in cash-based assistance • UNHCR has reinforced and improved shelters including for isolation and quarantine purposes, including contributing X refugee shelter units to countries to allow for social distancing and isolation to occur; • UNHCR has provided core relief items, particularly for distribution in congested urban and camp settings. • UNHCR continues to support education and livelihood opportunities where health protocols allow as well as continue preparations for a gradual and appropriate re-opening of education institutions and resumption of livelihood activities
UNICEF	<p>Strategic Priority 1 - SO 1.1, 1.2, 1.3, & 1.4, 1.5, 1.6</p> <p>UNICEF will strengthen Risk Communication and Community Engagement activities to ensure women, children and their families know how to prevent COVID-19 and are encouraged to seek assistance while also contributing to improvement in Infection, Prevention and Control practices in communities, educational and health facilities is improved through training of health workers, teachers and provision of WASH services. In addition, UNICEF will provide supplies to communities, educational and health facilities to ensure appropriate prevention and treatment of COVID-19, including WASH supplies, Personal Protective Equipment, and case management supplies.</p> <p>Strategic Priority 2- SO 2.1 - SO 2.2 - SO 2.3</p> <p>UNICEF will ensure children and women have continued access to essential health-care, nutrition, education, child protection and GBV services. Specifically, it will ensure women and children have access to services such as immunization, prenatal and postnatal care, and HIV care and case management is adapted to children and pregnant women protection, promotion and support of and implementation of breastfeeding, nutritious complementary foods for children, micronutrient supplementation, home fortification, and related maternal and child nutrition, including the early detection and treatment of severe acute malnutrition with ready to use therapeutic foods and implementation of breastfeeding recommendations and nutrition support to patients, in an environment safe from infection.</p> <p>Strategic Priority 3 – SO 3.1 - 3.2</p> <p>UNICEF will continue to work closely with national authorities and partners to ensure that migrant and displaced communities are included in all phases of the response to COVID19. This includes protecting their rights in line with the Convention on the Rights of Child which applies to all children. This includes:</p> <ul style="list-style-type: none"> • Working with national authorities on including migrant and displaced children into national response plans. Where needed, ensure continuity of care by providing direct assistance to migrant and displaced children globally. • Continuing high-level advocacy on the rights of migrant and displaced children, including on access to services, deportations, returns, push backs, and child immigration detention. • Working on reaching children of all abilities and various migration and displacement status, including stateless, with child-friendly information in a language they understand, while engaging with the public on minimizing xenophobia and discrimination. • Collecting data and evidence to support evidence-based interventions and support decision-making.

AGENCY	OVERVIEW OF RESPONSES
UNRWA	<p>UNRWA has made a number of adjustments to its services across all fields of operation (Syria, Lebanon, Jordan, Gaza and West Bank, including East Jerusalem), in accordance with host government directives to ensure the safe delivery of critical services while implementing measures to mitigate the spread of COVID-19. Key activities under each strategic priority include:</p> <p>Strategic Priority 1 – SO 1.1, 1.3, 1.4, 1.6</p> <ul style="list-style-type: none"> • Distribution of Personal Protective Equipment (PPE) to front line health and sanitation staff; • Use of triage systems at UNRWA Health Centres to screen patients with respiratory symptoms and minimize exposure and contact with other patients; • Suspension of non-critical health services and introduction of telemedicine, to reduce footfall at clinics • House to house delivery of non-communicable disease medicine in Jordan, where UNRWA clinics are closed in line with national instructions • Continued deployment of sanitation workers in all Palestine refugee camps, with appropriate PPE. • Preparations to set up and support isolation and quarantine centres in some fields, in support of government responses • Local procurement of essential medicines has begun in Gaza to avoid stockouts due to potential breaks in supply chains. <p>Strategic Priority 2 - SO 2.1, 2.2</p> <ul style="list-style-type: none"> • Maintenance of food and cash distributions in all fields of operations, with measures introduced to limit overcrowding and protect beneficiaries and staff. • In Gaza, UNRWA is delivering food parcels to beneficiaries' homes, to avoid the risk of transmission in overcrowded distribution centres, reaching 73,000 households to date. • Additional cash distributions for Palestine refugees in Jordan (113,000), in Lebanon (285,000) and in West Bank (41,600) • As UNRWA's 709 schools and 8 vocational training centres remain closed in all UNRWA fields, self-learning materials have been made available to the 540,000 children and youth enrolled in these installations, as part of the UNRWA Education in Emergencies approach. Psycho-social support is also being made available remotely to students, parents and teachers <p>Strategic Priority 3 - SO 3..2</p> <ul style="list-style-type: none"> • Awareness campaigns conducted in Palestine refugee camps to contain the spread of the virus, including hygiene practices and physical distancing in public places and at home, with a special focus on most vulnerable groups (older people, persons with disability) • Outreach to communities through messaging targeting women and girls on the impact of COVID-19, aimed at mitigating increased risks related to gender based violence and child protection. • Establishment of dedicated hotlines and remote support by counsellors to ensure protection monitoring, case documentation and referrals, legal counselling, psychosocial support and counselling remain available to Palestine refugees
WFP	<p>Strategic Priority 2- SO 2.1 - SO 2.2</p> <p>At the global level, WFP is focusing on tangible assets and services required for humanitarian and health actors to be able to deliver the response outlined in this Global HRP. The upstream services outlined in this GHRP serve the global health and humanitarian service requirements.⁹ Specifically, at the upstream level WFP is:</p>

⁹ While the vast majority of countries benefiting from services are those captured in the revised GHRP, given the fast evolving nature of the crisis there will be countries not captured in this current revision to the GHRP which become priorities of the health and humanitarian response for which the services here outlined will be leveraged for response.

AGENCY	OVERVIEW OF RESPONSES
WFP	<ul style="list-style-type: none"> • Establishing (or reinforcing) International Consolidation Hubs and Regional Staging Areas, • Providing cargo transport through aircrafts and sea vessels, among others, from international staging areas to regional hubs, and onwards to priority country points of entry • Providing passenger air services in the interim that commercial air services remain interrupted, • Providing the humanitarian community with medical evacuation services and the infrastructure for field clinics for front line aid workers • Coordinating logistics needs and manage related consolidation, air and sea services for maximum efficiency and effectiveness and ensuring pipeline visibility of cargo to partners • Expanding real-time remote monitoring systems to collect continuous data food security, market and health related indicators to support coordinated analysis and informed decision making for governments and partners <p>Note that several work streams are underway at the country level which will be detailed in revised response plans (HRPs, RRP, and national multi-sector plans).</p>
WHO	<p>Strategic Priority 1 - SO 1.1 -SO 1.2 - SO 1.3 - SO.1.4 - SO,1.5 - SO 1.6</p> <p>WHO will continue to respond to the direct impact of the COVID-19 outbreak in order to contain its spread, prevent, suppress and interrupt transmission. It will:</p> <ul style="list-style-type: none"> • Support interventions to detect and test cases through surveillance and laboratory testing. • Provide safe and effective clinical care to individuals at most risk • Gain and share knowledge about COVID-19 to increase effectiveness of response efforts • Secure the continuity of essential health services and systems and related supply chains. <p>Strategic Priority 3 - SO 3.1- SO 3.2.</p> <p>WHO will support Member States and partners for their efforts in preparedness, prevention and response to COVID-19 in refugee, asylum seekers migrant and host populations. This includes:</p> <ul style="list-style-type: none"> • Provide global leadership, high level advocacy to raise awareness to ensure the inclusion of refugees, asylum seekers and migrants in the national and local COVID-19 prevention and response programs; lead the development guidance and tools; provide technical assistance; and strengthen health information system and information sharing on COVID-19 outbreaks in refugees, asylum seekers and migrants. • As co-lead of the Working Group on access to services of the UN Network on Migration, support multilateral actions; cross border, inter- country, inter- regional and global collaboration for COVID-19 response; and continuity of care in migrant and host populations affected by COVID-19. • WHO co-chairs (along with IFRC) the IASC Mental Health and Psychosocial Support in Emergency Settings Reference Group, a collaboration between 57 international organizations, to support mainstreaming of mental health and psychosocial support as a crosscutting area of work relevant to all sectors and clusters in the response, and to support multi sectoral country level mental health and psychosocial support working groups in all emergency settings. <p>WHO will work with Member States and partners including academia in the development of COVID-19 evidence-based information and conduct research, support evidence- based policy development, and decision making; support/ develop communication strategies and key messages to counter xenophobia, and to dispel fears and misconceptions among host populations regarding refugees and migrants and COVID-19 outbreaks. WHO will support the integration of mental health and psychosocial components as part of essential health packages for all affected populations especially for people with mental, neurological and substance use conditions.</p>
ICVA, Interaction and SCHR (representing NGOs)	<p>NGOs are delivering a large variety of programmes including clinical services, significant scale up of cash programming, and sectoral programming that falls under the WASH, Protection (including gender based violence and child protection), Education, Food security, Health, Nutrition and Camp Coordination and Camp Management clusters. They have also led analysis processes on differential impacts COVID-19 by gender and other potential vulnerabilities. Some key NGO achievements across humanitarian operations are summarized in this link: www.unocha.org/sites/unocha/files/COVID-19_Response_Achievements.pdf</p>

Annex C

Country and regional plans: Humanitarian Response Plans

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- 26 Chad
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- 29 Ethiopia
- 30 Haiti
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- 33 Mali
- 34 Myanmar
- 35 Niger
- 36 Nigeria
- 37 oPt
- 38 Somalia
- 39 South Sudan
- 40 Sudan
- 41 Syria
- 42 Ukraine
- 43 Venezuela
- 44 Yemen
- 45 Zimbabwe

Afghanistan HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$108.1M

OF WHICH:

HEALTH: \$21.7 M
NON-HEALTH: \$86.4 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$803.8M

OF WHICH:

COVID-19: \$108.1 M
NON-COVID-19: \$695.7 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 29 April, almost 2,000 people in Afghanistan had tested positive for COVID-19 and 60 had died. Low case detection is a concern with less than 10,000 tests conducted for a population of almost 40 million people. Short supply of personal protective equipment continues to expose health workers to undue risk. More than 115,000 undocumented returnees arrived from Iran over a two-week period in March at the height of the crisis there – the highest return on record. The total number of returnees (from Iran and Pakistan) between January and March 2020 was almost 222,000, up from almost 99,000 over the same period in 2019.

Women and girls face additional challenges. The combination of restrictions on men providing medical treatment to women and a shortage of women health professionals compromises their access to sustained and quality health care.

Due to physical distancing, two polio vaccination programmes have been suspended. This is of particular concern as the wild polio virus exists only in Afghanistan and Pakistan. Nutrition services, often co-located in health centres, are also being negatively affected; in-patient and out-patient treatment for severe acute malnutrition are down 38 per cent and 10 per cent respectively. With some 13.4m people estimated to be in crisis and emergency levels of food insecurity (IPC 3 & 4) until June 2020, the immune systems of a large proportion of the population are very weak.

All population groups in Afghanistan's Humanitarian Response Plan (HRP) – IDPs, returnees, shock-affected non-displaced people, acutely vulnerable people (reeling from the impact of constant war and abject poverty) and refugees – are at risk of disproportionately suffering both from the health and socio-economic impacts of this outbreak.

Indirect impacts on people and systems

Four decades of conflict and recurrent natural disasters have eroded people's capacity to cope with shocks and the impact of COVID-19 on livelihoods, employment and food systems is, therefore, grave.

Economic inactivity, falling incomes and reduced consumption are expected to push many of the 32 million who are already below the poverty line to need either humanitarian assistance or social safety nets. Market monitoring data as of 29 April shows that the purchasing power of casual labourers and pastoralists has significantly deteriorated by 19 per cent and 10 per cent respectively, when compared to 14 March.

As of 29 April, schooling had not resumed, and the suspension is expected to last into the second half of the year, affecting more than 7.5 million children. While alternative learning modalities, such as broadcasting classes, are being implemented, these are not accessible to many children whose families do not own televisions or have electricity.

Response priorities and challenges

Priorities and early achievements

The health response is focused on preparedness, containment and mitigation. It is guided by the Ministry of Public Health National Emergency Response Plan for COVID-19 (24 March), with support from the UN, in particular WHO. Emergency elements of these plans are reflected in Afghanistan's three-month Multi-Sector Humanitarian Country Plan.

The Health Cluster has supported the Government in establishing a national isolation centre and regional and provincial centres. Total capacity now stands at 2,000 beds although patients are showing a reluctance to seek hospital care. Health partners have been supporting the Government in establishing eight of 15 planned testing laboratories across the country.

A Risk Communication and Community Engagement Working Group is tackling rumors and misinformation. Some 6,600 religious leaders and community influencers have received targeted health awareness and sensitisation outreach.

Under the COVID-19 Multi-Sector Country Plan, some priority non-health activities include:

- Undertaking double-ration food distributions over the next three months to support people in the event of movement restrictions. A major scale-up of food and cash assistance is required.
- Scaling-up of handwashing messaging and provision of hand washing facilities in IDP sites, nutritional centres and border entry points is well underway and will continue, reaching well over 1 million people.

Challenges and impact to operations

An OCHA in-country survey to evaluate humanitarian partners' response capacity indicates that two-thirds of organizations remain at full operational capacity and continue to deliver critical humanitarian assistance. Border closures are causing pipeline issues and some ongoing activities have been suspended.

The COVID-19 response is being delivered against the backdrop of ongoing conflict and frequent attacks on healthcare personnel and facilities. These are being discussed with all parties to the conflict.

With international commercial flights suspended, UNHAS has established an airbridge to move staff in and out of the country. The humanitarian response will rely on UNHAS domestic and international operations for the coming months.

* COVID-19 requirements: \$108.1 million is required for Afghanistan's COVID-19 Multi-Sector Country Plan (April-June 2020), with an estimated increase to \$400 million through the end of the year, to be confirmed once a parallel HRP revision is completed by 31 May 2020.

Burkina Faso HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$60.0 M

OF WHICH:

HEALTH: \$15.0 M
NON-HEALTH: \$45.0 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$336.4 M

OF WHICH:

COVID-19: \$60.0 M
NON-COVID-19: \$276.4 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 28 April, 632 cases of COVID-19 had been confirmed (252 women and 380 men with 42 deaths). Ouagadougou remains the epidemic’s epicentre, but nine of the country’s 13 regions are also impacted. Low access to healthcare and weak epidemiological surveillance put the whole population at risk. Insecurity in the northern and eastern regions has led to the closure of 12% of health centres and left another 12% at minimum capacity, preventing or limiting access to needed healthcare services for 1.6 million people. By 22 April, more than 848,000 people were internally displaced by the crisis, most living with inadequate healthcare, water, sanitation and hygiene and at particular risk of COVID-19. Rising levels of food insecurity, malnutrition and lack of means to pay for healthcare increases their vulnerability.

Burkina Faso has minimal capacity to hospitalize and manage COVID-19 cases. The displacement crisis and ongoing outbreaks of polio and measles create further challenges for epidemic control measures and increase the risk of COVID-19 spreading to new areas. The health system must put in place a robust monitoring system, including the establishment of a contact tracing and tracking system, and deployment of rapid response teams. Additional structures to isolate and manage cases require financial resources as well as dedicated, equipped and trained staff.

Indirect impacts on people and systems

Movement restrictions and the economic slowdown will result in income loss, with significant consequences for the poor and vulnerable. Nearly 40% of the population lives below the poverty line, and unemployment was already high, especially among young people (79% of the population is below 35 years of age). The country dependency ratio is 87.9%, mostly of youth dependency.

The adverse economic impacts will have consequences across all humanitarian sectors. With food and nutritional insecurity already on the rise, market disruptions will have a negative impact, particularly in areas affected by insecurity and displacement. By June 2020, more than 2.1 million people will require food assistance. Increased food insecurity will lead to higher mortality and morbidity.

With education suspended, distance learning remains inaccessible to most children, especially in rural areas and for displaced and refugee children. Immunization will see further deterioration. Protection concerns, including around the containment measures and related to GBV, are on the rise.

Response priorities and challenges

Priorities and early achievements

The MoH has revised its COVID-19 preparedness and response plan. Achievements to date include strengthened disease surveillance at the regional level, in affected districts and at points of entry; establishment of a second laboratory; and identification

of isolation areas in health facilities in affected areas. Priorities include supporting regional authorities implement their preparedness and response plans and ensuring multisectoral response planning for medium and longer-term socio-economic impacts of the epidemic.

The WASH Cluster is providing WASH and IPC support to health centres; installing hand washing facilities in public places and IDP sites; distributing household IPC kits; and organising a COVID-19 communication campaign to reach 2 million people.

Decongestion of IDP sites, temporary shelters and reception centres is a priority, and national guidance is being developed. Priorities include mapping the density of urban collective centres and IDP sites and securing additional shelter to support physical distancing. Shelter actors are conducting training on transmission prevention and providing PPEs.

The humanitarian community has re-prioritized the existing HRP and will release a COVID-19 addendum to the HRP. WASH programmes are expanding water trucking at a time of seasonal severe water shortages and expanding WASH in nutrition and health facilities. Other priorities are rehabilitation of water points; communication on handwashing and soap distribution; and construction of sanitation facilities and handwashing equipment in IDP sites. Nutrition actors are strengthening nutritional surveillance and nutrition services in health centres. The Food Security Cluster continues to prioritize food distribution for 1 million people and livelihood support for 1 million people and is adapting its arrangements for food distribution, increasing the use of cash transfers and livelihood protections.

Protection activities focus on reducing people’s vulnerability to physical and psychosocial risks, training to prevent discrimination, stigma and violence, enhancing remote communication and direct assistance such as case management through adequate referrals. The Education Cluster is strengthening distance education, particularly radio education programmes.

Challenges and impact to operations

Burkina Faso is grappling with intensifying security and humanitarian crises, which have 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. The risk of diversion of health efforts from preventing and managing other pathologies is significant.

Adaptations to existing humanitarian programmes include distance-based forms of communication, implementing increased health and sanitation measures during distributions, adopting new intervention modalities, and planning for increased costs due to the pandemic. It is difficult to impossible for IDPs, refugees, and host communities to comply with physical distancing measures due to crowded living conditions.

* COVID-19 requirements: \$60 million, including \$35.2 million to support re-prioritization and adaptation of projects within the 2020 HRP and \$24.8 million to support new activities.

Burundi HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$36.7 M

OF WHICH:

HEALTH: –
NON-HEALTH: \$36.7 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$168.4 M

OF WHICH:

COVID-19: \$36.7 M
NON-COVID-19: \$131.7 M

Impact of COVID-19

Immediate health impacts on people and systems

The Burundi health context remains fragile. According to the 2020 HNO, over half a million people need health assistance, of whom 260,000 live in districts considered as high risk, affected by diseases with high epidemic potential and IDP presence. Of 112,000 IDPs, over 36 per cent have no access to pharmacies and 93 per cent of displaced households cannot afford health-care. Only 79 per cent of returnee households have access to healthcare and refugees in camps and urban areas fully rely on international assistance.

Should COVID-19 cases increase from the 12 reported as at 26 April, the health system could be overburdened. Essential services, including pre and post-natal consultations, curative and preventive services, and the availability of human resources and medicines could be jeopardized. Government and partners have put in place preventative and treatment measures, but challenges remain related to surveillance, detection, and case management. Quarantine facilities outside Bujumbura are ill-equipped to host large numbers, thus the urgent need to ensure such facilities receive adequate food, water and other basic supplies.

Indirect impacts on people and systems

GDP growth is projected to average two per cent; less than the population growth (3,2 %), which would result in a negative GDP per capita growth. Heavy reliance on Chinese supply chains could also impact the economy. With Burundi reliant on importing 30 per cent of its food, COVID-19 related restrictive measures are expected to impact food availability on the market as well prices. The outbreak could also lead to job losses with consequences on household purchasing power.

COVID-19 will disproportionately impact the most vulnerable, especially malnourished women and children, who may become immune-compromised. The elderly and people living with HIV/TB are at high risk and will require specific nutritional support if infected. Inadequate access to WASH services could increase vulnerability and interruptions in supply chains could severely disrupt therapeutic services and nutrition interventions, as well as other aid supplies such as shelter. Other vulnerable groups include IDPs, returnees, refugees, single-parent or female-headed households, host communities and those affected by food insecurity. Containment measures raise some protection concerns for groups such as returning migrants as well as risk of sexual exploitation, particularly for children.

More than 1,8 million people are food insecure and food availability is expected to decline until June due to the combined effects of the lean season and COVID-19. From June to August, availability should improve with the second harvest; however, the food supply chain may continue to be disrupted.

Response priorities and challenges

Priorities and early achievements

Government and partners are working to contain the spread of COVID-19. UN and partners have put in place a Strategic Response Plan to support the Government's effort. The plan currently requests US\$ 22.5 million to support the 6-month Government Contingency Plan costed at \$58.2 million.

The national laboratory has been equipped with diagnostic machines to conduct tests and several hospitals are being supported to build triage and isolation structures. PPEs in stock have been reinforced but remain insufficient. Risk communication and community mobilization is raising awareness through various channels and misinformation is being tracked. To prevent and mitigate the impact of the containment measures and supply chain disruptions, the Logistics Sector is seeking to preposition stocks, secure reliable access to transport, fuel, supplies and expanding storage capacity.

To date, some \$14 million has been identified for the COVID-19 response. Humanitarian partners are also currently reviewing the 2020 HRP to adapt the response to the current situation. The HRP is focused on meeting the needs of the most vulnerable and targets people in areas prone to food insecurity, natural disasters, internal displacements as well as presence of returnees, generally located in the northern and eastern provinces. While the focus will be maintaining ongoing operations, as a result of COVID-19, the priority areas of intervention will need to be adapted. In addition to the 630,000 people targeted in the HRP, an additional 1.1 million people are considered to have severe needs that could deepen. The different sectors under the humanitarian architecture have conducted a programme criticality exercise. In parallel, partners have identified a series of COVID-19 activities focusing on awareness raising; hygiene promotion to limit transmission; support to the most vulnerable in containment situations; and support to refugees, returnees, IDPs, vulnerable people affected by the crisis through multi-sectorial and coordinated interventions and logistical support activities.

Challenges and impact to operations

In view of movement restrictions, discussions are ongoing to ensure that the necessary humanitarian personnel and capacity can return and is deployed in the country to conduct operations.

Implementing activities in the HRP will require some adjustments on requirements. Hygiene and sanitation measures, physical distancing and distribution measures have already had an impact on the cost of interventions and restriction measures will continue to impact the import and cost of aid supplies.

* COVID-19 requirements: \$55.1 million, including \$36.6 million for new COVID-19 activities and \$18.5 million to support projects within the 2020 HRP.

Cameroon HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$99.6 M

OF WHICH:

HEALTH: \$23.0 M

NON-HEALTH: \$76.6 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$392.4 M

OF WHICH:

COVID-19: \$99.6 M

NON-COVID-19: \$292.7 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 22 April, 1,400 COVID-19 cases with 48 deaths have been 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. The epidemic continues to spread across the country with 15 confirmed transmissions in areas affected by violence in the South West and North West. Nine out of ten regions are now affected by the pandemic. COVID-19 has exacerbated these vulnerabilities and also triggered population movements, increasing the risk of COVID-19 transmissions.

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. The humanitarian situation is expected to worsen 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 who estimate 4.9 million people are in need of humanitarian assistance for the remainder of 2020, of whom 3.1 million people are targeted.

Indirect impacts on people and systems

While land, air and sea borders are closed, the transportation of cargo by air and road is permitted under supervision; however, a slowdown in supply has been noted with delayed waiting time in ports. Cameroon is continuing to transport essential supplies with landlocked neighbours Chad and CAR.

The drop-in oil has meant massive losses to Cameroon's economy and budget cuts are projected to lead to reduced social protection programmes and unemployment. The loss of jobs and income due to Government measures taken to combat COVID-19 poses a security threat, especially in major towns, as it is encouraging banditry in the absence of mitigation measures. This may translate to increased security costs for humanitarian partners.

By diverting resources from critical investments needed to boost quality and access of healthcare, access to HIV, sexual and reproductive health services and products will become increasingly challenging. Reduced access to family planning services will most likely increase the risk of unplanned pregnancies and the closure of maternal health clinics will lead to heightened maternal mortality rates across the regions.

Response priorities and challenges

Priorities and early achievements

The Government has put in place a National Preparedness and Response Plan with the support of UN and other partners. Priorities include implementing an Incident Management System and training staff at national and regional levels; training health personnel in epidemiology; deploying Rapid Response and Investigation Teams to ten regions; developing a medical countermeasures plan as part of the logistic and emergency supply chain; conducting surveillance at entry points; and setting up isolation units in each region.

WHO, in support of the MoH, is providing regional delegations with medical supplies and guidance documents on case management, infection prevention and control and laboratory services.

UNDP facilitated the procurement of medical equipment from China, and the first batch arrived in mid-April, including 20 ventilators, 2,400 infrared thermometers and PPEs. More equipment is expected in the coming weeks with WHO and Jack Ma foundation donations.

OCHA is working closely with WHO to strengthen the Government's response coordination, to align humanitarian activities at regional level with regional Government response plans. Humanitarian partners have intensified their sensitization efforts on hygiene and other COVID-19 prevention measures in health facilities and in the community through awareness raising campaigns.

Pre-existing emergency programmes are maintained throughout the country for criticality levels one and two, including food distributions, following strict physical distancing and hygiene measures.

Challenges and impact to operations

Despite efforts by governments to decentralize case management capacities in each region, ongoing gaps include a limited number of facilities equipped with respiratory platforms, a shortage of testing kits, limited health-care personnel capacity, insufficient training and PPE. Only four out of ten regions have laboratory testing capacity.

Meanwhile, the Child Protection sub-Sector has temporarily suspended all child protection activities such as Child Friendly and other Safe Spaces, Psychosocial Support Units and other activities that require gatherings and could expose children and communities to further harm.

* COVID-19 requirements: \$99.6 million in addition to adjusted 2020 HRP requirements.

Central African Republic HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$152.8M

OF WHICH:

HEALTH: \$7.7 M

NON-HEALTH: \$145.2 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$553.6M

OF WHICH:

COVID-19: \$152.8 M

NON-COVID-19: \$400.8 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 24 April, 19 COVID-19 cases were confirmed, half through local transmission. Almost half the population needs lifesaving health services and given the country's weak health system and absence of the State administration delivering basic services, the impact of COVID-19 on medical infrastructures and human resources could be catastrophic, as these also struggle to address other ongoing epidemics such as poliomyelitis and measles (the latter with up to 20,000 cases since January 2020 and a fatality rate of 0.66 per cent).

Aggravating factors include limited access to water and sanitation facilities (only a third of the population has access to potable water and only one person in ten can access hygiene facilities), poor hygiene behaviour, low immunization coverage, ongoing conflict between armed groups and lack of State administration in some regions, limiting a coordinated response and creating high dependency on international assistance. The Government has adopted restrictive measures to prevent propagation, though is facilitating critical humanitarian response, but implementation faces challenges. Should the pandemic spread, particularly in remote areas, health structures would be unable to provide the necessary services to the most vulnerable populations.

Indirect impacts on people and systems

Due to partial border closures with Cameroon and DRC, the cost of imported food and NFIs has increased by 31 per cent since end March. Physical distancing measures have resulted in a 67 per cent increase in urban transportation prices. Continued commercial restrictions will have long-term consequences on markets and households whose purchasing power is already weak. The World Bank estimates a GDP decline of at least 1 per cent.

School closures impact 1.3 million children, and over 18,500 teachers, leaving them without WASH facilities or feeding programmes, raising nutrition and protection concerns. Current social unrest related to COVID-19 restrictions may further complicate the security and operational environment. Movement restrictions would affect over 1.3 million people receiving protection services, including over 10,000 GBV survivors.

A sharp increase in food insecurity (an additional 632,000 people) is expected. Movement restrictions, possible disruption of humanitarian operations and further deterioration of livelihood opportunities would jeopardize already precarious conditions. A quarter of the population depends on food distributions, with 2.1 million people considered food insecure. 2.3 million people would be left in need of WASH assistance; 1 million people in need of NFIs, shelter and site management services. High risk groups include over 702,000 IDPs countrywide, 282,000 living in congested sites with limited access to WASH and health services and whose movement freedom is limited due to protection risks. Around 45 per cent of the host population is also considered at risk (an addi-

tional 1.4 million people), as are refugees, asylum seekers and the poor living in highly populated areas with limited to no knowledge of preventive measures and access to healthcare.

Dozens of COVID-related threats and violence against foreigners and humanitarian personnel have been recorded, fueled by a disinformation media campaign. Humanitarian staff continue to deliver assistance, including in very remote areas prone to high levels of insecurity. Healthcare structures and personnel might be further targeted by acts of violence. Heavily dependent on external procurement, aid pipelines could face ruptures and stock-outs, depriving the most affected from the only existing safety net.

Response priorities and challenges

Priorities and early achievements

Key responses include strengthening of health districts' epidemiological surveillance; distribution of WASH kits and establishment of hand washing stations in hospitals, markets and key public areas; boosting of face mask and soap local production also to generate income; strengthening of sanitation control measures at entry points; awareness raising, and community outreach to counter misinformation and stigmatization.

Humanitarian partners are working to sustain ongoing assistance and scaling up activities to respond to new needs, adapting programming to mitigate the spread of COVID-19. In view of an expected sharp increase in food insecurity nationwide, partners have developed a contingency plan that foresees an increase of 632,000 food insecure people as a worst-case scenario. Humanitarian partners are prepositioning stocks and creating isolation areas, especially on IDP sites, monitoring market prices and GBV trends, providing additional WASH supplies, engaging with communities, and providing education kits. Scaling up of cash-based interventions, including cash for work and income generating activities, will also help address the complementarity of humanitarian and development activities. A revision of the HRP will be undertaken.

Challenges and impact to operations

Challenges exist in case management, including due to insufficiency of PPEs; limited oxygenation and respiratory equipment; shortage of qualified personnel and capacity for infection prevention and control in healthcare facilities, particularly outside Bangui. Available PPE stocks in country are less than one tenth of the identified need based on a scenario of 10,000 COVID-19 cases by end June.

Immediate funding is needed to support capacity and medical resources, such as mobile clinics and vaccination campaigns, to address other ongoing epidemics and nutritional needs without which morbidity and mortality rates will increase.

* COVID-19 requirements: \$152.8 million in addition to 2020 HRP requirements (HRP revision pending).

Chad HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$99.5 M

OF WHICH:

HEALTH: \$6.0 M
NON-HEALTH: \$93.5 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$710.2 M

OF WHICH:

COVID-19: \$99.5 M
NON-COVID-19: \$610.7 M

Impact of COVID-19

Immediate health impacts on people and systems

Since the first confirmed case on 19 March, numbers have risen slowly but steadily through April. The majority remain in the capital, N'Djamena, but 8 April saw the first case in Abeche, the eastern province of Ouaddai, and 6 April the start of community transmission. To date, the majority of confirmed cases are men, in the age range 25-59.

The health status of the population is already a major concern, particularly among the oldest population, people with underlying conditions and women whose access to health services remains dependent on social and cultural norms. There is widespread malaria and an on-going measles epidemic since May 2018, with vaccination impacted by restrictions on movement and large gatherings. Some half a million children under five already suffer severe acute malnutrition and the food security 'lean season' is approaching. Rains just starting in the south, and due shortly in other areas of the country, will lead to floods and a potential resurgence of cholera.

Major challenges pertain to the limited and poorly equipped and under-staffed number of health facilities, even in the capital. Active Government efforts to reduce transmission and respond are hampered by lack of vital equipment, medicaments and materials (from ventilators to masks) in the country.

Indirect impacts on people and systems

A 12.5% drop in Chad's GDP is predicted as the oil price plummets. With the potential paralysis of the formal and informal economy, and despite planned national stimulus and fiscal measures, unemployment will rise and purchasing power drop.

Non-food markets are now restricted across the country, leaving many families without their only means of subsistence. Around 52,500 of the most vulnerable households in N'Djamena, who have lost their informal income-generating activities, are expected to require assistance to meet their basic needs.

There is not yet a food or cash shortage at national level. However, prices have increased for certain basic foods such as cereals (up to 10% in some places) and this trend is expected to extend to other basic commodities.

Transport restrictions and quarantine measures are likely to hinder small farmers' access to markets, pastoralists seasonal movement of animals, restrict production and prevent sale of products. With casual labour shortages, cereal production is predicted to drop by 3.2% over 2019. There is a 42% fodder deficit already, and access is now reduced to animal feed and slaughterhouses.

Chad anticipates significant deterioration in nutritional status as it enters the lean season. The closure of schools impacts on both essential education and nutritional support for other 3 million children. Children no longer receive 40% of their daily food intake, a nutritional contribution from school feeding.

COVID-related containment measures have significantly restricted the protection space and exacerbated the vulnerabilities of forcibly displaced persons, including up to 30,000 newly-displaced in March-April in Lac province. Protection monitors in Lac have reported stigmatization, due to COVID fears, of those crossing porous borders and coming out of quarantine near border registration points.

With the closure of borders, some 600 migrants are currently blocked in the country, unable to return to their countries of origin. The arrival of expelled Chadian migrants and third-country nationals is on the rise.

Response priorities and challenges

Priorities and early achievements

Humanitarian and development actors quickly scaled-up activities and supported Government development of a National Preparedness and Response plan, and 13 provincial plans. Food security actors have expedited and expanded food deliveries, in advance of the lean season and potential movement concerns, including two months ration of food assistance to all beneficiaries (IDPs, returnees and refugees) for April and May 2020. In six Eastern camps, food actors exceptionally resumed distributions to all refugees with a two months ration. At the urgent request of the State, basic supplies have been provided for thousands of returning Chadian students (mostly from Cameroon) and migrants held in quarantine, and their later transport to places of origin.

To quickly access much-needed financial resources, some of the just-received CERF 2020 allocation (12 million) for under-funded emergencies was reprogrammed, reorientating funds to urgent health, nutrition, WASH and NFI (soap, washing stations) needs for vulnerable groups.

Challenges and impact to operations

The Government is supportive of maintaining humanitarian programmes. However, restriction measures and confinement negatively impact on the nutritional situation, with gaps in procurement and prepositioning for therapeutic and supplementary food, materials and equipment for feeding units and for hygiene and protection. Local procurement is also affected by shop and market closures. Passenger flight suspension prevent return of significant numbers of staff outside Chad, blocking also options of bringing in essential technical expertise to bolster national capacity.

There is also a need to strengthened border protection monitoring and to ensure that persons in confinement at registration/ border crossing points are protected and have access to adequate health and WASH facilities. Continued advocacy also is required to ensure that IDPs, refugees and stateless persons have non-discriminatory access to health services and are integral to the national COVID-19 prevention and response plan.

* COVID-19 requirements: \$99.5 million in addition to 2020 HRP requirements (HRP revision pending).

Colombia HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$197.0 M

OF WHICH:

HEALTH: \$152.7 M
NON-HEALTH: \$44.4 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$406.7 M

OF WHICH:

COVID-19: \$197.0 M
NON-COVID-19: \$209.7 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 27 April, 5,597 cases of COVID-19 had been confirmed in Colombia, including 253 deaths. In response to the pandemic, the Government took preventive measures including a nationwide mandatory curfew and the closure of all borders as well as schools. By now, 26 of the country's 32 territories are affected, incorporating a mortality rate of 4.7 per cent. According to the National Health Institute, 4 million people could potentially contract the virus with up to 800,000 people requiring hospitalization, of which 200,000 could require intensive care-unit (ICU) treatment. Only 5,300 ICU beds are available across the whole country with even fewer ventilators.

The country-specific risk groups are people living in rural areas, such as indigenous communities with no health facility in close to medium proximity; as well as the displaced, confined, the homeless, refugees and migrants, many of whom live in crowded spaces or areas without sufficient sanitary infrastructure. The COVID-19 pandemic comes as a fourth affliction to vulnerable populations, which in many areas already have humanitarian needs due to armed conflict hostilities, natural disasters and mixed population movements from neighboring countries.

Indirect impacts on people and systems

The crisis and associated preventive measures have exacerbated existing and generated new humanitarian needs, particularly with regards to food security. In the last few weeks, WFP received requests to assist an additional 950,000 people. Protests of people seeking assistance are beginning in various parts of the country.

The interplay between ongoing hostilities and the pandemic remains a key area of concern, as protection space is reduced. Armed groups are taking advantage of COVID-19 to exert pressure on communities so they remain confined, forcing others to flee, threaten human right defenders and reduce humanitarian access. In the first quarter of 2020, over 10,000 people have been displaced; more than 7,300 people experienced confinement and almost 100 have been affected by landmines.

The crisis is also expected to have a deep socio-economic impact. UNDP estimates a 4 to 11 per cent GDP decrease in 2020 combined with an increase in unemployment rates to 37-70 per cent. To mitigate this, the Government is exploring a gradual re-opening of various sectors, which may increase transmission risks.

Many women, children, disabled and homeless people; the LGBTI population; people belonging to indigenous communities; as well as victims of armed conflict, forced displacement and confinement, and particularly children and adolescents at risk of recruitment, are particularly susceptible to further hardship and face increased risks due to their precarious living conditions and reliance on services provided by humanitarian actors. Even prior to the pandemic, many of the 1.8 million refugees and migrants had been suffering from medium and long-term food insecurity and malnutrition, loss of livelihoods, as well as limited or no

access to essential medical services.¹⁰

Response priorities and challenges

Priorities and early achievements

The priorities of the COVID19 response plan align with the strategic objectives under GHRP and Colombia's 2020 HRP. To contain the spread of the pandemic and reduce the mortality and morbidity of COVID-19, the UN took the following actions, among others:

- PAHO/WHO strengthened national and local capacities for epidemiological surveillance, and joined forces with the Ministry of Health in the area of risk communication;
- The MPTF for Sustaining Peace in Colombia approved US\$4.6 million to PAHO/WHO, IOM and UNFPA to support rural health facilities, provide protection to health care providers and strengthen epidemiological surveillance in rural areas most affected by the conflict;
- An interagency group to manage procurement processes and a logistics working group were established;
- Efforts are ongoing to strengthen decentralized coordination and support response efforts at territorial level.

To mitigate the socio-economic effects of the pandemic, the following interventions, among others, are planned:

- Support to farmers and ethnic groups to ensure production through the acquisition of agricultural inputs, including to ex-combatant farmers and ex-coca growers.
- Provision of food assistance in kind or through cash transfers and emergency shelter for affected families as well as refugees and migrants.
- Development of community protection networks for women at risk or survivors of GBV and construction of temporary shelters.
- Several humanitarian actors are looking at a significant scale up in their interventions.

The Colombia HCT has developed an integrated COVID-19 response plan, complementary to the HRP, which highlights key priorities to respond to the immediate sanitary crisis as well as the humanitarian impact of lockdown measures. The plan identifies priority areas and activities to be implemented until the end of the year.

Challenges and impact to operations

Global shortages of health supplies remain a key constraint. Healthcare and social protection systems require operational, financial, technical and material scale-up and support by humanitarian actors, particularly at decentralized level. Access to health and WASH services, as well as to safe housing and cash transfers, which are necessary for self-isolation, is widely insufficient. Special support to contain the spread of the virus in impoverished rural areas affected by the armed conflict is needed. The Colombia HRP is only funded at 3 per cent.

¹⁰ The response to Refugees and Migrants, including Colombian returnees, and their host communities, including activities and financial requirements within the COVID-19 response will be included in the revision of the 2020 Refugee and Migrant Response Plan carried out within the framework of the Interagency Group for Mixed Migration Flows and the Regional Platform, led by IOM and UNHCR.

* COVID-19 requirements: \$197 million in addition to 2020 HRP requirements for immediate needs. For more details see the Colombia integrated COVID-19 response plan.

Democratic Republic of the Congo HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$287.8M

OF WHICH:

HEALTH: \$119.4 M
NON-HEALTH: \$168.4 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$2.11B

OF WHICH:

COVID-19: \$287.8 M
NON-COVID-19: \$1.82 B

Impact of COVID-19

Immediate health impacts on people and systems

The DRC registered the first confirmed case of COVID-19 in Kinshasa on 10 March. As of 24 April, 417 cases were confirmed, including 29 deaths. Six provinces (Kinshasa, North Kivu, South Kivu, Ituri, Kwilu and Haut-Katanga) and 36 health zones are affected. The city-province of Kinshasa remains the epicenter with 97 percent of cases (404). People between 30 and 49 years old represent 50 percent of cases with a median age of 42, and extremes ranging from 10 months to 87 years old. Over 63 percent of cases are male. At least eighteen health workers were infected, representing 8.3 percent. As expected, COVID-19 has a greater impact on the morbidity and mortality of vulnerable groups such as the elderly, chronically ill, those with underlying pathologies and the immunologically compromised.

COVID-19 is straining the country's already very fragile health system. Health coverage was about 30 percent before the outbreak and only 27 percent of health institutions had standard capacities (personnel, equipment, medical inputs, protocols). The number of artificial respirators available is extremely limited. Access to healthcare is further limited in some areas due to insecurity (especially in the east). A major risk is the prevention and management of other pathologies (measles, Ebola, cholera, malaria, malnutrition), potentially leading to new epidemic outbreaks. Likewise, preventive health services, prenatal and postnatal care are expected to drastically decrease, putting women and children at risk, respectively representing 50.8 percent and 58.5 percent of people in need (HRP 2020).

Indirect impacts on people and systems

Restrictions of movement and the economic slowdown are leading to income losses, with major consequences for people with low incomes and daily workers. Almost 77 percent of the population live below the international poverty line of US\$ 1.90 per day, making DRC one of the poorest countries in the world.

COVID-19 hit DRC's economy, which particularly relies on the mining sector and is highly dependent on imports with Europe and China (accounting for 85 percent of import/export). During the first quarter of 2020, copper and cobalt prices fell sharply. Combined with a reduction of purchasing power, inflation has already been observed in some areas.

Protection risks are increased due to the epidemic and the measures taken to limit its spread. GBV cases have been on the rise since the start of COVID-19 (up to 100 cases notified in one month against 25 cases/month before COVID-19). Following the closure of schools, education is interrupted for 18 million children aged 3 to 17. Increased incidents against aid workers and foreigners are already observed. Furthermore, most of the population has

multiple overlapping vulnerabilities such as poor access to basic services (including health care, water and sanitation) due to insufficient resources, discrimination, inaccessibility for geographic or security reasons or high promiscuity making physical distancing difficult (populated urban areas, displacement / refugees).

Response priorities and challenges

Priorities and early achievements

A COVID-19 multisectoral humanitarian response plan was published on 18 April as an addendum to the 2020 HRP. The plan targets 19.5 million people and is aligned with the national preparedness and response plan to COVID-19. The response to the direct impact has been prioritized and includes health and WASH activities aiming at containing the spread of the epidemic and decreasing mortality, while 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.

On-going COVID response focus primarily on prevention with sensitization activities notably through radio programmes, distribution of WASH kits, support to health centers, trainings of community focal points. In addition, epidemiological surveillance and health control at points of entry are provided. As of 19 April, the follow-up rate to the 1,445 registered contacts is 65.5 percent in Kinshasa, 100 percent in South Kivu, 74.2 percent in North Kivu, 68.8 percent in Ituri and 80.9 percent in Kwilu. Nevertheless, the surveillance capacities remain limited (lack of human resources, tests etc).

Challenges and impact to operations

Humanitarian partners' capacity to respond to priorities identified in the 2020 HRP, while ensuring an emergency response to the needs arising from COVID-19, is likely to be quickly overwhelmed. Humanitarian access, already challenging due to the volatile security situation and logistical constraints, is further restricted by governmental COVID-19 preventive measures. According to a rapid impact analysis, 80 percent of responders are directly affected by various dispositions (limitation of gatherings to 20 people impacting directly distributions, closure of schools, closure of borders to passengers, suspension of passenger flights between Kinshasa and the rest of DRC, partial confinement). Likewise, 36 percent of responders and only 4 percent of organizations have contingency stocks available or under replenishment.

Although cargo remains authorized under health surveillance, the international and national restrictive measures in place are already causing disruptions of the supply chain, which could worsen. The recent resurgence of Ebola is another challenge.

* COVID-19 requirements: \$288 million in addition to 2020 HRP requirements.

Ethiopia HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$322.6M

OF WHICH:

HEALTH: \$100.0 M
NON-HEALTH: \$222.6 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.32B

OF WHICH:

COVID-19: \$322.6 M
NON-COVID-19: \$1.00 B

Impact of COVID-19

Immediate health impacts on people and systems

On 13 March 2020, Ethiopia reported the first confirmed case of COVID-19 in Addis Ababa. As of 27 April, there were a total of 124 COVID-19 confirmed cases (31 per cent female) of which 50 fully recovered. 14,588 tests were conducted. Three COVID-19 related deaths were reported. Confirmed cases are mainly reported from mandatory quarantine facilities, health facilities and through contact follow up while self-reporting is low.

Indirect impacts on people and systems

It is estimated the crisis will have far-reaching health, economic, social, and security impacts.

Due to lack of adequate health care staff, medical facilities, supplies, and access, patients infected with the virus might not be able to be identified and isolated, and when falling sick to receive quality and timely treatment. Diversion of resources and health workers to the COVID-19 response will severely impact regular health provision and ignore other ongoing disease outbreaks in the country mainly cholera, yellow fever, dengue, tuberculosis, HIV, and measles.

Overstretch of the health system coupled with deterioration in food security and compromised access to markets will result in increase in acute malnutrition.

As a result of school closures, children may particularly be vulnerable to psychosocial distress, abuse and exploitation, including domestic violence at home.

Response priorities and challenges

Priorities and early achievements

WHO and other partners continued to harness and harmonise all efforts for the readiness and response to COVID-19. Through the incident management system, all key stakeholders within the health sector have been supporting Government through surveillance, laboratory capacitation, points of entry screening, risk communication and community engagement, procurement and distribution of essential supplies, and trainings of health and non-health workers.

Two-rounds of food distributions are being delivered at once to limit number of visits to distribution sites. Hand washing facilities are made available at food distributions sites and physical distancing measures are in place in accordance to a newly released distribution guideline. Clusters have developed various guidelines and protocols to adjust their respective interventions in to the COVID-19 pandemic. For instance, according to the Nutrition Cluster adjustment recommendations, acutely malnourished children will only visit health facilities bi-weekly instead of weekly to mitigate risks. Key nutrition messages were also adopted to integrated COVID-19 related messages.

For the refugee response, protocols on COVID-19 and case definitions for surveillance have been shared with camp-based health staff and all health facilities. Ongoing border surveillance including COVID 19 has been scaled up in line with MOH guidance and are being introduced in locations not done previously (e.g. along Eritrean border). Screening of all new arrivals for symptoms specific to COVID-19 will be conducted in addition to the routine screening currently carried out in reception centers

Challenges and impact to operations

On 10 April, Ethiopia declared a five-months long nation-wide State of Emergency (SoE). Due to movement restrictions and ban on gatherings, various planned interventions were cancelled, delayed or redesigned. Beneficiary verification exercises, workshops, trainings, surveys, assessments, and community engagement forums have been cancelled. This will compromise the quality of humanitarian programs. Ensuring safe distributions prolonged the process and incur additional financial cost. Similarly, Community Management of Acute Malnutrition (CMAM) is hindered by the ban on gathering and physical distancing measures at health facilities and food distribution sites. Adoption of the program has financial implications.

To date, 1,780km² (out of 3,000km² surveyed) is affected by desert locust infestation. To date, this has resulted in additional one million people who require emergency food and livelihoods support. The desert locust control operation has been severely hampered due to COVID-19 related restrictions. FAO is challenging to surge experts from other countries, competition over PPEs for insecticide spraying, delayed procurement, delays or cancellation of field trips and limited community engagement due to movement restriction and ban on gatherings.

In addition, the impact is being felt on logistics and supply chain. Availability of food and non-food commodities on the market, limited access to market and limited importation of key commodities will continue to challenge the humanitarian operation.

* COVID-19 requirements: \$323 million in addition to 2020 HRP (HRP revision pending).

Haiti HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$105.0 M

OF WHICH:

HEALTH: \$105.0 M
NON-HEALTH: -

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$424.3 M

OF WHICH:

COVID-19: \$105.0 M
NON-COVID-19: \$319.3 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 30 April, 76 COVID-19 cases had been confirmed and seven deaths reported. The peak of the outbreak is expected in coming weeks, with alarming projections. Despite ongoing efforts, a lot remains to be done for Haiti to be in a position to respond to the expected caseload.

The sharp increase in the number of cases is likely to cripple the country's threadbare health system. The effects of the COVID-19 pandemic on the latter are already showing. Activities related to reproductive health, gender-based violence, routine immunization and surveillance for diseases such as malaria and diphtheria have been disrupted. Many health services, such as maternal and newborn care, have been reduced or stopped due to the lack of personal protective equipment (PPE) for health workers. Certain hospitals are refusing to treat patients due to PPE shortages.

Indirect impacts on people and systems

The COVID-19 outbreak is likely to have a devastating effect on people's food security, livelihoods, protection and access to basic services. The closure of the border with the Dominican Republic has led to irregular crossings, affecting virus monitoring and surveillance at the border. Since 16 March, around 17,000 migrants have returned from the Dominican Republic to Haiti on a voluntary basis or have been deported. An increase in domestic and gender-based violence is also a concern, while life-saving care and support to survivors may be disrupted.

COVID-19 is expected to further deteriorate the food security situation. This will possibly push an additional 3 million people into emergency levels of food insecurity, while some 4.1 million people, or 40 percent of Haiti's population, already need food and livelihoods assistance. The rate of severe acute malnutrition at the national level was already above the emergency threshold of 2 per cent in December 2019; now, as a result of this pandemic, the number of malnourished children under the age of 5 is expected to increase by 25 per cent. The loss of livelihoods and thus access to nutritious food is exacerbated by the suspension of nutrition services at community and health facility levels.

Schooling has been disrupted for more than 4 million children. Distance learning is unlikely to work for the most marginalized children, including those with disabilities, struggling learners, migrant and displaced children, or those living in rural and poor communities. The loss of protection and school-based nutrition compromise children's well-being.

Response priorities and challenges

Priorities and early achievements

The UN supported the Haitian authorities to elaborate an operational response plan for COVID-19 which includes strengthening surveillance systems, investing in medical care, reinforcing preventive WASH activities, community mobilization and awareness-raising, ensuring logistics and procurement.

In support of the Government of Haiti, the UN and NGO partners have, among other activities:

- Conducted communication and community mobilization campaigns to raise awareness, promote hand washing and improve access to clean water.
- Strengthened surveillance by the addition of 11 national epidemiologists to support the case investigation.
- Commenced work to enhance the detection, referral and follow-up of suspected cases among migrants and returnees at the border with the Dominican Republic.
- Provided 6,500 COVID-19 tests to the National Laboratory and strengthened laboratory capacity.
- Supported the preparation of four health facilities to receive COVID-19 patients, provided medical equipment and supplies to the MSPP and trained 1,216 frontline health workers.
- Started joint work by development, humanitarian and private sector organisations to establish and maintain an uninterrupted supply chain of PPE kits, oxygen and essential drugs, including through scaling up local production.

Challenges and impact to operations

The identification and preparation of health structures urgently needed to respond to the expected peak of the outbreak remains a major concern, as well as the lack of equipment and materials including PPE, oxygen, ventilators and hospital beds. Families are reluctant to receive community health workers without PPEs and lack of such devices also endangers health workers and responders.

The response is further hampered by the lack of immediate funding, as allocations from International Financial Institutions will mostly be used for a later stage of the response. Several coordination challenges also exist.

Fear and misinformation, including the denial of the existence of COVID-19 among some parts of the population, are likely to increase behaviour that facilitates contagion. At the same time, stigmatization and discrimination of affected persons that may lead to violence is widespread. The ability to guarantee security and to secure health facilities is thus another challenge.

* COVID-19 requirements: \$105 million in addition to 2020 HRP requirements.

Iraq HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$263.3 M

OF WHICH:

HEALTH: \$20.4 M
NON-HEALTH: \$242.9 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$660.7 M

OF WHICH:

COVID-19: \$263.3 M
NON-COVID-19: \$397.4 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 27 April, 1,847 COVID-19 cases had been confirmed in Iraq and 88 people have died. Although confirmed cases have spread across the country, the areas hosting the highest numbers of people in need of humanitarian assistance have seen the lowest numbers of confirmed cases so far. Displacement camps are a key concern, as conditions in camps could increase the risk of spreading the disease.

While efforts are underway, Government capacity to identify and rapidly respond to disease outbreaks is limited. Health authorities lack adequate capacity to respond to sudden-onset public health emergencies and health workers struggle to conduct surveillance and rapid response. There is a shortage of personal protective equipment; a lack of sterilization agents and testing reagents; and shortage of isolation units in referral hospitals. This is coupled with the pre-existing humanitarian access constraints that have been exacerbated by the COVID-19-related curfews. The Early Warning Alert and Response Network lacks trained health workers and has seen a high turnover of staff. Referral services are also a major concern.

Indirect impacts on people and systems

The Iraqi economy is heavily reliant on the oil sector, with about 90 per cent of revenues based on oil production. The collapse of the oil price since the COVID-19 outbreak will have a significant impact on Iraq's national budget, with expected ripple effects throughout the society.

Movement restrictions and curfews have disrupted trade and transport sectors, limited bank and financial services, and affected legal services, protection and psycho-social support. Since mid-March food prices have started to surge. Of 18 governorates in Iraq, 17 have reported price increases in food items; nine governorates have reported a price increase for hygiene items and three reported increases in fuel prices. FAO, WFP, and the World Bank are tracking agriculture production and impact on the overall food system. The Iraq Information Center has received more than 1,600 calls from displaced people, returnees and people in host communities and more than 80 per cent of them related to loss of employment opportunities or livelihoods, shortage of food, delayed food distributions or requests for cash assistance. More than 9 million children have been affected by school closures.

A mapping of vulnerability to the disease is underway to better understand the impact on people who were already in need of some form of humanitarian assistance. Conflict-affected people who live in crowded tents or temporary shelters; share water, sanitation and hygiene facilities; or have limited options for self-quarantine or isolation are a key concern.

Response priorities and challenges

Priorities and early achievements

Humanitarian partners in Iraq have prioritized activities in the 2020 Humanitarian Response Plan (HRP) and are working with national and local authorities to implement priority activities.

Key activities include:

- Ensuring immediate health-related response, including to prevent the spread of the disease. This includes hygiene promotion, water and sanitation, disease outbreak preparedness and response, quarantine and isolation measures, communication with communities and awareness raising.
- Adjusting existing programmes to continue activities during COVID-19. This includes remote protection monitoring and case management, psycho-social support, legal assistance, alternative education, alternative care for unaccompanied children, and capacity building for humanitarian actors to operate during COVID-19.
- Providing food assistance, multi-purpose cash and livelihoods support for the most vulnerable. This includes focusing on the HRP target population and expanding cash-based food assistance, cash for work for rehabilitation of key service infrastructure, agricultural input and multi-purpose cash.

Health programming through the 2020 HRP is on track but if travel restrictions continue, there is a risk of disruption of medicine and supply deliveries between federal Iraq and the Kurdistan Region of Iraq, as well as referrals.

Challenges and impact to operations

Health and WASH activities by humanitarian partners are affected by access constraints related to the COVID-19 lockdown procedures. Access restrictions, particularly between governorates, continue to affect movement of medical and health staff and equipment. In March, movement restrictions prevented WASH actors from reaching 18,000 people with hygiene promotion services and 13,000 people in camps with adequate water and sanitation services.

The risk of outbreaks in camps is high, as people are moving in and out of camps. Agreement with the government is needed to establish quarantine/isolation areas in camps as a contingency plan, in case suspected and mild/moderate confirmed cases and their contacts cannot be referred to outside facilities.

There is a limited ability to identify and refer new protection related cases, to manage high risk cases, provide legal assistance services or provide psycho-social support due to the current situation although humanitarian partners are working to establish remote detection, delivery and follow-up modalities.

Funding is urgently required for immediate health response and outbreak mitigation in camps, continued efforts of protection to reduce the impact on most at-risk populations.

* COVID-19 requirements: \$263.3 million in addition to adjusted 2020 HRP requirements.

Libya HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$38.8M

OF WHICH:

HEALTH: \$38.8 M
NON-HEALTH: –

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$129.8M

OF WHICH:

COVID-19: \$38.8 M
NON-COVID-19: \$90.9 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 27 April, there are 61 confirmed COVID-19 cases and two deaths in Libya. The numbers are expected to be higher as testing capacity is limited with only two testing laboratories in Tripoli and Benghazi. Many points of entry, particularly land borders, are not secured and lack resources for testing and quarantining.

The government health system capacity is limited. Only some health facilities report to the Early Warning and Response Network and municipalities lack funding, personnel and equipment to respond. Immediate needs include support to rapid response teams; procurement and distribution of PPE; enough laboratory diagnostic kits; establishment of isolation sites and wards; provision of training; distribution of awareness materials and health education.

Despite calls for a global ceasefire, fighting has continued to heavily impact civilians and health care structures. People's ability to access basic services and for humanitarian organizations to reach people in need is curtailed. This year has seen at least 11 conflict-related incidents on health infrastructure. In April, the al Khadra Hospital in Tripoli, which had been assigned to receive patients infected with COVID-19, was struck by rockets.

Indirect impacts on people and systems

Although preventive measures are enforced, inter-community transmission is occurring which affects people, many of whom are already vulnerable. Diminished exports limit food availability and other goods leading to price increase. According to a recent assessment, half of assessed cities reported food shortages and 86 per cent reported food price spikes. On average food items have increased 27 per cent and hygiene items by 12 per cent.

Access to cash is limited across the country with increased lack of confidence in the banking system, and instability in exchange rates resulting in a liquidity crisis. Libya relies on oil exports with oil production dropping to 80,000 barrels per day (bpd) by end of March, from an average of 1.2 million bpd in 2019 costing more than \$4 billion in lost revenues.

With the closure of schools, distance learning is being carried out by authorities through TV for specific grades and students, but students in poor families or vulnerable groups struggle to access these services.

Libya is a patriarchal society in which women and girls face discrimination in law and in practice, putting them at increased risk of abuse in the home. Women are at more risk of lost income as the majority earn through the informal economy.

Response priorities and challenges

Priorities and early achievements

Through the Libya National Centre for Disease Control, WHO provides health response coordination and technical support in coordination with the Inter-Sector Coordination Group. Immediate priorities include:

- Ensuring surveillance, testing and case management. Capacity-building is underway for Rapid Response Teams; there are 74 teams of the 217 required. Procurement and distribution of essential medical supplies and test systems are prioritized to reach all parts of the country. More than 50,000 swabs and 300 testing kits have recently been delivered. Support for refurbishment of isolation sites, including at points of entry, is ongoing.
- Preventing and controlling infection. Fumigation and disinfection at health facilities, displacement sites and detention centres is ongoing. More than 10,000 displaced people, migrants and refugees have benefitted from hygiene kits, soap and WASH supplies. Training of frontline workers on infection, protection and control and hygiene awareness activities continue.
- Supporting awareness raising and risk communication. More than 160,000 COVID-19-related information materials have been disseminated; training has been provided to civil society organizations and helplines for counselling. Existing call centres are used for information dissemination and to report symptoms. The Emergency Telecommunications Sector-managed Common Feedback Mechanism has received 10,500 calls.
- Maintaining humanitarian response. This includes adapting assistance modalities with mitigation measures for distributions, including remote methods for case management and psychosocial support and coordinating with authorities on remote learning tools.

Challenges and impact to operations

Insecurity, bureaucratic impediments and COVID-19 restriction measures hamper humanitarian access. A third of respondents in a recent Health Sector survey said they could only continue with specialized services for vulnerable and high-risk cases since the onset of COVID-19. Of the 851 reported access constraints in March 2020, 19 per cent were in relation to COVID-19 prevention measures. Key challenges include slow customs clearances, unpredictable humanitarian flights, and the inability to undertake assessments. Methodologies are being reviewed to assess the humanitarian impact without raising risks of transmission.

Funding for humanitarian operations is low. Following the onset of COVID-19, a Health Sector COVID-19 plan has been developed, requesting \$14.3 million, of which \$4.2 million has been received, including \$2 million from CERF. The HCT has also recently re-prioritized the most urgent requirements for the HRP. About \$31 million is needed to sustain the operation until June of the \$115 million requirement for 2020.

Stigma and misinformation could lead to people refraining from seeking care to avoid discrimination. Migrants and refugees are at particular risk and along with internally displaced people have poor living conditions and struggle to access to health assistance.

* COVID-19 requirements: \$38.8 million in addition to the 2020 HRP.

Mali HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$46.0 M

OF WHICH:

HEALTH: \$10.1 M
NON-HEALTH: \$35.9 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$396.7 M

OF WHICH:

COVID-19: \$46.0 M
NON-COVID-19: \$350.7 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 28 April, 408 COVID-19 cases were recorded, including 112 recoveries and 23 deaths. In light of the humanitarian needs analysis, humanitarian actors were about to target 3.6 million out of 4.3 million people in need through the 2020 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. Twenty-three per cent of health facilities in conflict-affected areas are not functioning and those that are functioning do often not have the required equipment and treatment capacity. Containing the virus will be difficult if it spreads within IDP sites (over 220,000 IDPs are recorded in Mali) or host families, in prisons, military camps etc. In a context of high COVID-19 numbers, the system will not be able to cope. As COVID-19 spreads, resources are being diverted from basic healthcare and other health emergencies such as Crimee-Congo fever, meningitis, malaria and measles. Preventative (vaccinations) and primary healthcare (including related to malnutrition), are likely to be severely impacted.

Indirect impacts on people and systems

The indirect and direct impact of COVID-19 on the Malian economy is already being felt. 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. Between June and August, more than 1.3 million people will be affected by severe food insecurity according to findings of the "Cadre Harmonisé". More people could become severely affected in the event of additional shocks.

Children are particularly vulnerable in the present context, and care structures' response capacity for non-accompanied children or children associated with armed groups are impacted negatively. 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 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.

The humanitarian system is providing regions and districts with the human and logistical resources to support the government's response (prioritizing surveillance, prevention and care).

Cluster members are providing NFI kits to IDPs and host families to improve personal hygiene and will ensure that IDP settlements are re-organized and, where necessary newly identified, to be followed by relocation of IDP populations in order to respect physical distancing.

A first set of activities relates to the continuity of educational activities (through the establishment of distance learning) and the second to supporting preparations for the school reopening in a protective environment. All students from IDP sites, returnees, host communities and local population are targeted. 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.

Ensuring that food security assistance modalities do not expose personnel or beneficiaries is essential. The Food Security Cluster continues to prioritize food distribution for 1.3 million people at risk of being in phase 3 or 4 of the Cadre Harmonisé by August and is adapting its food distribution arrangements, increasing the use of cash transfers and livelihood protections.

Challenges and impact to operations

As the supply chain is more difficult (due to closure of borders) and given the suspension of MINUSMA flights in-country, there are problems with the entry/exit of international experts to support the COVID-19 response. Humanitarian partners with the main donors in-country, are undertaking advocacy to safeguard humanitarian action countrywide.

Humanitarian access to hard-to-reach areas and widely to zones of people in need remains a challenge with potential impacts on COVID-19 responses. A strategic and coordinated approach to access negotiations with the Government is in place under the leadership of the EHP and GIACs and the support of existing coordination structures, including the health cluster, access working group, CMCoord cells, UNDSS and INSO.

The current HRP 2020 is only 16% funded, triggering a high risk of unmet humanitarian needs. COVID-19 impact on humanitarian activities is also linked to the additional costs of implementing preventive measures during distributions and other humanitarian activities to mitigate the risk of the spread of COVID-19.

* COVID-19 requirements: \$46 million in addition to revised 2020 HRP requirements.

Myanmar HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$46.0M

OF WHICH:

HEALTH: \$18.1 M
NON-HEALTH: \$27.9 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$262.3M

OF WHICH:

COVID-19: \$46.0 M
NON-COVID-19: \$216.3 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 30 April, 150 COVID-19 cases confirmed in Myanmar with six deaths. The Ministry of Health and Sports (MoHS) has expanded surveillance at international border crossings and community-level systems have been enhanced. Laboratory capacity is being expanded in other locations following the establishment of a COVID-19 testing at the National Health Laboratory in Yangon in February. The UN has delivered 23,000 test kits. The Government is procuring an additional 54,000 testing kits, and a further 30,000 will be provided by the UN by early May 2020. COVID-19 treatment hospitals have been designated and contact tracing and other measures to manage transmission risks have been scaled up.

Despite these efforts, the Myanmar health system faces very serious challenges in terms of equipment, supplies and case management capacities. There is a high risk of stigmatization and discrimination of health workers and of persons with suspected or confirmed cases of COVID-19, particularly amongst marginalized groups and stateless persons.

Indirect impacts on people and systems

COVID-19 is increasingly impacting the economy, notably exports, tourism and border trade. Border closures are having a significant impact on livelihoods due to imports of raw materials from China being disrupted and leading to the closure of garment factories since February.

The rapid return of tens of thousands of migrant workers from Thailand and elsewhere has generated additional needs for basic forms of assistance in quarantine facilities. Their presence will also strain already fragile health systems and put additional pressure on community resources in areas of origin.

In areas where the nutritional status of the vulnerable population, especially pregnant and lactating women and children, is already a major concern, the effects of the pandemic may be worse due to weak immune systems. In addition, appropriate infant and young child feeding are being undermined by uncertainty around mother-to-child transmission, thus reducing breastfeeding rates in hospitals and in the community.

Educational facilities and child-friendly spaces for displaced communities have been suspended, reducing opportunities for awareness-raising, and increasing child protection risks and school dropouts. Closure of schools can also expose adolescent girls to heightened protection risks, which can lead to gender-based violence. The prolonged use of schools as quarantine and treatment facilities will have a longer-term impact on the education sector. Services for survivors of sexual and gender-based violence are also negatively impacted by movement restrictions and potentially by response workers having to self-isolate.

Response priorities and challenges

Priorities and early achievements

The Humanitarian Country Team has developed a three-month

COVID-19 Addendum to the 2020 Myanmar Humanitarian Response Plan, that outlines priority preparedness and response actions to address COVID-19 in humanitarian settings, in particular Chin, Kachin, Kayin, Rakhine and Shan states. A COVID-19 Country Preparedness and Response Plan has been developed to consolidated and focus UN support to the national health system.

Humanitarian organizations have scaled up COVID-19 prevention and response capacity in camps, displacement sites and conflict-affected areas, as well as support of Government efforts to provide basic assistance to returning migrant workers. Activities include strengthening of surveillance systems, infection prevention and control measures in public places, quarantine and health facility settings, and case management and contact tracing.

Examples of response activities include:

- Food Security: Provision of double rations for two months where feasible. Distributions through local committees to help transport rations.
- Health: Supporting continuity of essential and life-saving healthcare services.
- Nutrition: Re-positioning available nutrition supplies to state and regional hubs to cover interventions for the next six months.
- Protection: Development of child-friendly messages as well as targeted guidance for women and girls on continued service provision and GBV referrals.
- WASH: Increasing supply of hand washing stations and hygiene promotion, and hand washing materials and disinfectants at household, community and institution levels.

Challenges and impact to operations

The operating environment is highly constrained and becoming more challenging. Existing access restrictions for aid organizations – notably in non-government-controlled areas and parts of Rakhine and Chin subject to active fighting – will likely persist, while newer restrictions aimed at preventing the spread of COVID-19 are further limiting humanitarian movement. Communities in conflict-affected areas are also at higher risk and the killing of a WHO driver in Rakhine State on 20 April after his marked UN vehicle came under fire, highlights the risks posed by continued fighting.

While access to healthcare for many beyond urban centres is challenging in general, the restricted access of Rohingya IDPs and communities to health care and other basic services outside camps due to movement restrictions is a longstanding concern. For IDPs in camps, overcrowding, poor sanitary conditions and lack of space for quarantine will exacerbate the risk of COVID-19 spreading quickly and make the response extremely challenging.

International supply chain disruptions have led to serious challenges in procuring life-saving items including medical supplies and food for IDPs. The onset of the monsoon rains in May will also complicate COVID-19 control efforts while response to a natural hazard event could be hindered due to COVID-19 control measures limiting movement of people and supplies.

* COVID-19 requirements: \$46 million in addition to 2020 HRP requirements.

Niger HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$76.6 M

OF WHICH:

HEALTH: \$9.9 M
NON-HEALTH: \$66.7 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$509.8 M

OF WHICH:

COVID-19: \$76.6 M
NON-COVID-19: \$433.3 M

Impact of COVID-19

Immediate health impacts on people and systems

By 22 April, Niger had 662 confirmed COVID-19 cases, including 22 deaths. Of the five regions affected, Niamey is at the epicenter (94% of cases). In Tillaberi, Tahoua, Diffa and Maradi, access to healthcare, already difficult due to the state of emergency and insecurity, is even more constrained, particularly for IDPs with underlying pathologies. Confined and overcrowded living conditions are putting the displaced at additional risk.

The pandemic has weakened an already fragile health system. Human resources are insufficient in number (0.4 health practitioners per 1,000 inhabitants in 2018) and qualifications. The distribution of nursing staff is poor with only 26% deployed in rural areas where 80-90% of the population lives. Availability and access to medication is low and unequal due to a dysfunctional supply system. Health insurances cover less than 10% of the population.

Niger has declared a health emergency until 11 July. Containment measures ban gatherings, and air and land borders (except for cargo) are closed. The MoH has developed a COVID-19 preparedness and response plan. Effective prevention and response, however, need to be strengthened with decentralization of activities at the community, district and regional level, including laboratory activities for rapid diagnosis and consolidation of community-based surveillance in all health districts.

Indirect impacts on people and systems

Economic growth in 2020 is expected to drop from 6.9 to 4.1% due to a decline in food processing activities; contraction of commercial activities; sharp drop in air transport and informal transport activities and a decline in the tourism and services sector. Job loss rate is estimated at 2.4% while the overall salary decline is expected to reach 1.8%.

Responding to COVID-19 may result in neglecting other diseases and vaccinations (measles, meningitis, cholera, hemorrhagic fevers) and managing other conditions. Increase in food insecurity, pressure on coping mechanisms and the deterioration of preventive health and nutrition services threaten to increase severe and moderate acute malnutrition, respectively at 2.7% and 10.7%. Restrictions on movement could increase food-related expenses by 30% due to price increases. The food insecure will reach 5.6 million people; 23% per cent of the population.

With schools closed, children are increasingly facing protection risks (child marriage and labour, sexual abuse, recruitment by armed groups) and may lose education gains. The likelihood of school drop-outs is concerning considering the low level of enrollment (less than 10% of primary school children).

Closure of rural markets and restrictions on movements, which exempts transportation of goods, are prohibiting farmers living close to urban centers from selling their crops and returning with manufactured goods. They are also affecting traditional mechanisms of destocking local agricultural products and

livestock trade by pastoralists and agro-pastoralists. Urban/rural poor, employed in low skill wage labour, are particularly at risk, with no savings or food stocks to withstand disruption in the informal system.

Border closures in West Africa, including in Niger, has put a strain on the Assisted Voluntary Return and Reintegration programme with thousands of migrants stranded in Niger. Evacuations from Libya, resettlement programmes and other alternative legal pathway (humanitarian flights/humanitarian corridors) are drastically reduced due to restrictive measures.

Response priorities and challenges

Priorities and early achievements

According to the Government PRP, without measures in place, 40-70% of the population would be infected (9 to 6 million people). 80% would recover spontaneously, while around 20% would require hospitalization. Of the latter, 5% of cases would require respiratory assistance and 4% would die. The plan focuses on activation of rapid intervention teams; surveillance at entry points; epidemiological surveillance, particularly community-based; prevention and control of infections; case management; testing and diagnosis.

All clusters have reviewed their operating procedures to reduce the risk of transmission, including new modalities of delivering assistance. In refugee sites, equipment and disinfectant for three months have been prepositioned and WASH activities adjusted by integrating prevention modalities.

Nutrition actors are maintaining activities to treat severe and moderate acute malnutrition, thanks to local production and to additional orders of products not available in-country. Food security actors are supporting the scale-up of the National Adaptive Social Protection Programme for households to cope with the socio-economic impacts of COVID-19. Education actors are supporting relevant ministries to redefine the content of essential education subjects to be given as take-home exercises and catch-up classes to ensure the completion of the school year.

Challenges and impact to operations

While the 2020 HRP will be revised, a challenge remains in securing funding for additional COVID-19 related activities as well as ongoing humanitarian programmes.

While humanitarian access in insecure areas remains a challenge, there is also a risk that overall attention on the ground could focus on COVID-related activities only, overlooking the urgent ongoing and planned humanitarian response.

Presently, humanitarian cargo to/from Niamey is permitted. However, food security partners need to be ready to respond to unpredictable restrictive measures reducing food availability and access ahead of the lean season. Timely purchase and pre-positioning of stocks is a priority.

* COVID-19 requirements: \$76.6 million, including \$46.1 million to support adaptation of projects within the 2020 HRP and \$30.4 million to support new activities.

Nigeria

HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$259.8 M

OF WHICH:

HEALTH: \$85.2 M
NON-HEALTH: \$174.6 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.10 B

OF WHICH:

COVID-19: \$259.8 M
NON-COVID-19: \$839.0 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 27 April 2020, 1182 COVID-19 cases have been confirmed in Nigeria, with 35 deaths and 222 recoveries.¹¹ Borno, Adamawa and Yobe (BAY) States recorded nine confirmed cases in Borno. With limited capacity and pace of testing, confirmed cases could be seriously underestimated.¹²

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 a high-risk due to the extreme congestion in IDP camps - less than 1m square meter per person in some locations - which makes it practically impossible to practice physical distancing measures.

The humanitarian situation is expected to worsen due to COVID-19, mainly against the backdrop of damaged health infrastructure and ongoing stressors on the health system, and an increase on current projections of people in need. A tightening of pre-existing movement restrictions, economic deterioration 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 first recession in 25 years due to the outbreak.¹³ As a significant producer of crude oil, a continued reduction in revenue will likely result in a large-scale cut in public expenditure and financing, which could hamper the ability of the government to fund its social safety net programs. Reduced social protection programs will see a rise in vulnerabilities, and income inequality will impact livelihoods and poverty. A disruption to supply chains could severely hamper the capacity of humanitarian actors to assist affected communities.

As COVID-19 spreads, health resources are being diverted from primary and preventive healthcare, and tackling other health emergencies. There has been a significant disruption of vaccination campaigns and other essential health services for children and other vulnerable groups in inaccessible areas.

The short, mid and long-term effects of the crisis will increase dependency on food assistance and thus expanding the current humanitarian burden across the BAY States and beyond. Food consumption is expected to deteriorate further as vulnerable households approach the peak lean season around June, July, and part of August. 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 3.7 million,¹⁴ up from 3.3 million people food-insecure pre-COVID-19.

Response priorities and challenges

Priorities and early achievements

With rising cases in the BAY states, high level of congestion in IDP camps, porous borders with neighbouring countries (Cameroon, Chad, and Niger), and constant movement of people due to conflict around the Lake Chad Basin, humanitarian actors are maintaining critical programmes to ensure partners deliver to the most vulnerable.

As many as 400,000 IDPs could become infected in the event of a simultaneous outbreak in camps classified as 'highly congested'. CCCM, Shelter and NFIs sectors' partners have developed a decongestion concept note to advocate for additional land to decongest camps, especially in Borno's 49 highly congested camps.

The country's testing capacity has increased from five to thirteen labs, including one in Borno. Measures are in place to ensure routine health services remain available to all camp populations and host communities. Access to emergency obstetric care and skilled birth attendance for all deliveries are needed, including postpartum monitoring.

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

During this period of school closure, humanitarian actors in collaboration with different education stakeholders are working to gather, develop, and adapt existing curricula into other options such as radio programs.

Challenges and impact to operations

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. To address these problems, the humanitarian team is undertaking advocacy efforts to promote humanitarian principles and are lobbying for an allocation of 1,274 Hectares. Human to human transmission can significantly be reduced with the decongestion of reception centers and camps through proper site planning and appropriate shelter construction.

The lack of adequate MUAC and sufficient RUTF are impacting the scaling up of Mother/Family MUAC approach and pipelines to cover a possible increase in severe acute malnutrition and to optimally preposition supplies in all the LGAs and health facilities.

¹¹ <https://covid19.ncdc.gov.ng/>

¹² UN in Nigeria, Briefing Note 2 (April 2020). COVID-19 Pandemic, Potential Impact on the North East

¹³ www.worldbank.org/en/news/press-release/2020/04/09/covid-19-coronavirus-drives-sub-saharan-africa-toward-first-recession-in-25-years

¹⁴ UN Nigeria, Briefing Note 2, ibid

* COVID-19 requirements: \$259.8 million in addition to 2020 HRP requirements.

occupied Palestinian territory HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$42.4M

OF WHICH:

HEALTH: \$19.1 M
NON-HEALTH: \$23.3 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$390.4M

OF WHICH:

COVID-19: \$42.4 M
NON-COVID-19: \$348.0 M

Impact of COVID-19

Immediate health impacts on people and systems

On 5 March, oPt declared a State of Emergency after detecting the first COVID-19 cases in Bethlehem. As of 23 April, 480 Palestinians were confirmed positive: 463 in the West Bank (144 in East Jerusalem) and 17 in the Gaza Strip, with four deaths and 74 recoveries. About 80 percent of positive cases are below the age of 50 and the majority are asymptomatic.

The crisis is managed between three authorities reflecting the territorial and political fragmentation: the Palestinian Authority (PA) in parts of the West Bank, Hamas in the Gaza Strip, and Israel in East Jerusalem with overriding control over the entire territory. Despite preexisting tensions, coordination between these authorities has significantly improved since the crisis.

Restriction of movements and the re-prioritization of resources reduction or suspension of other health services: some 10,000 elective surgeries postponed, around 210,000 pregnant and lactating women, and up to 30,000 newborns have limited services with a potential increase in mortality and morbidity. Some 1,000 patients in Gaza could not be referred to specialists in the West Bank due to crossing closures with Israel.

Palestinians entering oPt from Jordan, Egypt and Israel are medically checked and require mandatory quarantine (at home or at isolation facilities). However, due to the long and porous boundary between the West Bank and Israel, thousands of workers return from Israel unchecked and, according to the PA, constitute for nearly 80 percent of the caseload.

Indirect impacts on people and systems

Palestinian authorities scaled up restrictions on movement, commercial activities, public gatherings and suspended educational activities to reduce transmission. The restrictive measures adopted severely impacted economic activity in oPt and Palestinian employment in Israel, exacerbating unemployment (43 percent in Gaza) and reducing revenues from trade, tourism and transfers to their lowest levels in the last two decades. It is estimated that 53,000 families have fallen into poverty. On 20 April, a series of relaxation measures were announced to allow resumption of certain economic activities.

Movement restrictions reduced access to social services, with a higher impact on vulnerable populations, such as the elderly, persons with disabilities, Bedouin communities, households isolated by the West Bank Barrier and undocumented residents of East Jerusalem. The overcrowded living conditions are prevailing in 19 refugee camps (nearly 800,000 people) and other poor areas are of concern. UNRWA is leading containment measures in camps.

The closure of schools is affecting 1.43 million children. Distance-learning activities are being implemented, however, children in poor and overcrowded households, lacking computers and internet connectivity cannot benefit. Some 17,000 people are quarantined with shortages in supplies, food, sanitation and hygiene materials. MHPSS service providers indicate a surge in domestic violence affecting women and children.

Response priorities and challenges

Priorities and early achievements

The top priorities are scaling up testing, tracing of contacts, isolation and treatment of confirmed cases, and limiting human transmission through appropriate public health advice and protective containment action.

- Efforts led by the Palestinian authorities included laboratory capacity scale-up completing over 26,000 tests, setting up 51 formal and informal quarantine facilities, and preparing 18 health facilities for treatment in the West Bank and two in Gaza.
- Health partners provided testing kits and laboratory consumables for some 10,000 tests, PPE kits and other protective items for 5,000 health workers and a range of medical supplies in managing critical cases.
- A coordinated risk communication campaign reached 1.5 million Palestinians through social media and text with simple, effective messages about prevention and transmission of the virus.
- Protection partners adapted their modalities of delivery for GBV and MHPSS services, reaching thousands through online platforms and phone hotlines.
- Education partners supported the development of e-learning platforms reaching 100,000 children.
- WASH and shelter partners provided critical support to quarantine centres providing water, non-food items, hygiene kits and cleaning materials.
- Food security partners scaled up food e-vouchers allocation to include emerging vulnerable groups, adapting modality for food distribution and provided essential production inputs to vulnerable farmers and herders.

Challenges and impact to operations

Global shortages have impaired the ability of the authorities and humanitarian actors to procure essential medical and laboratory supplies including testing kits (500,000 needed as indicated by the PA), PPE and consumables. The first ventilators ordered will be received by June 2020.

The expected return of tens of thousands of Palestinians for the holy month of Ramadan will create challenges to support home quarantined people and those hosted in quarantine sites.

This is of particular concern in Gaza because the health system has been undermined by conflict between Hamas and Israel, the internal Palestinian political divide, an Israeli blockade, a chronic electricity deficit and shortages in specialized staff, drugs and equipment. As of end March, 44 percent of all essential drugs were at less than a month's stock and 35 percent completely depleted.

Across the oPt, movement restrictions and physical distancing measures limit the possibility of humanitarian services, conducting independent assessments, and monitoring. Cash assistance has been disrupted as banks have stopped receiving clients, while cash-for-work interventions were impacted due to the closure of education and other institutions.

* COVID-19 requirements: \$42.4 million in addition to 2020 HRP requirements.

Somalia HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$176.4M

OF WHICH:

HEALTH: \$72.1 M
NON-HEALTH: \$104.4 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.25B

OF WHICH:

COVID-19: \$176.4 M
NON-COVID-19: \$1.08 B

Impact of COVID-19

Immediate health impacts on people and systems

Somalia confirmed its first case of COVID-19 on 16 March. As of 26 April, 436 cases are confirmed, including, with 26 reported deaths. The vast majority of the cases are now community transmission. Somalia has two health-care workers per 100,000 people, compared with the global standard of 25 per 100,000. Less than 20 per cent of the limited health facilities have the required equipment and supplies to manage epidemics.

Indirect impacts on people and systems

Somalia is facing multiple simultaneous threats: COVID-related humanitarian impacts and local economic slowdown, reduced foreign remittances, the worst Desert Locust upsurge in decades and seasonal floods. The Somali economy is heavily reliant on imports. The lock down of key supply markets,¹⁵ the closure of borders and restrictions on domestic movements negatively impact the most vulnerable. Rising prices on key imported commodities are impacting low-income earners, particularly IDPs and rural communities.¹⁶ Reports indicate that remittances, received by an estimated 40 per cent of Somali households, have dropped by as much as 50 per cent.

With the Federal Government of Somalia (FGS) projecting an 11 per cent decline in nominal GDP through 2020,¹⁷ an economic slowdown threatens to erode access to livelihoods and income generating activities across Somalia, and to place additional pressures on households trying to meet basic needs.

The pandemic and related containment measures are likely to exacerbate forced evictions, a major protection challenge in Somalia. This year alone, 48,000 people have been evicted from their homes. Additional protection-related risks remain high: family separation due to infected caregivers; increased gender-based violence, particularly against women and girls; and stigmatization and targeting against specific communities, particularly marginalized groups, migrants and refugees.

Response priorities and challenges

Priorities and early achievements

Clusters have reviewed the 2020 HRP and identified interventions for scale up, reduction and adjustment in light of COVID-19. Clusters also prepared contingencies or new operational modalities should a wider outbreak undermine access or traditional response approaches

Existing humanitarian systems and tools are being used for surveillance, preparedness and health response to COVID-19. EWARN¹⁸ now includes the case definition of COVID-19 and will

be used to monitor severe acute respiratory infection trends in all health facilities, including generating alerts for investigation and reporting. 242 Rapid Response Teams, comprised of surveillance officers, community healthcare workers and volunteers have been mobilized to conduct active surveillance, contact tracing and management. Lab capacity to test for COVID-19 has been established in Mogadishu, Somaliland and Puntland. A Risk Communication and Community Engagement Task Force, led by the Federal Ministry of Health and Human Services (FMoH) and including UN Agencies, partners and donors was established and has reached over 150,000 Somalis.

The UN and partners Somalia COVID-19 Country Preparedness and Response Plan (CPRP) is a joint effort by UN agencies and NGOs to respond to the direct public health and indirect immediate humanitarian and socio-economic consequences of COVID-19. The CPRP is aligned and includes support to key interventions within the FGS Comprehensive Socio-Economic Impact and Response Plan for COVID-19. The humanitarian component of the CPRP seeks \$231.9 million out of a total CPRP ask of \$689 million

Challenges and impact to operations

Refugee status determination, resettlement interviews, repatriation of Somali refugee returnees, the Assisted Voluntary Returns and Reintegration activities have been suspended. Schools are closed and school feeding is suspended. While the Somali Government remains committed to facilitating the import of humanitarian goods, travel restrictions have led to additional bureaucratic requirements to bring supplies into the country, which has resulted in delays. Cash programming might also be impacted if commercial markets lack key goods or if commodity prices soar rapidly.

Although hygiene response is being scaled up to limit the spread of the virus through supporting risk management and infection prevention and control at community and facility levels, more is required in terms of surveillance, laboratory testing and personal protective equipment supply. WASH support also needs to be scaled up. 237 high risk IDP sites need to be decongested, covering close to 600,000 people. Access constraints could limit the ability to reach people living in hard-to-reach areas and areas controlled by non-state actors.

¹⁵ India, and Thailand among others.

¹⁶ WFP Somalia, Rapid Assessment: Impact of COVID-19 on Somalia Supply Chains, 3 April 2020.

¹⁷ Protection Cluster, Evictions Advocacy Brief, April 2020.

¹⁸ The Early Warning, Alert and Response Network (EWARN) is a network of health partners that collect and report surveillance data on selected epidemic-prone diseases, as part of establishing an early warning system for disease outbreaks in humanitarian situations. Termed as a 'syndromic surveillance system' it facilitates the rapid monitoring and investigation of unusual events or disease occurrence.

* COVID-19 requirements: \$231.9 million are required in total, including \$176.4 million for new COVID-19 related activities and \$54.6 million to support 2020 HRP activities.

South Sudan HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$217.2M

OF WHICH:

HEALTH: \$21.0 M
NON-HEALTH: \$196.2 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.77B

OF WHICH:

COVID-19: \$217.2 M
NON-COVID-19: \$1.55 B

Impact of COVID-19

Immediate health impacts on people and systems

As of 29 April, 34 cases of COVID-19 have been confirmed with no reported deaths. The 28 new cases are believed to have been in contact with a fifth COVID-19 patient, the first person to test positive of COVID-19 through local transmission. The very low testing capacity in the country limits the assessment of the scope of the pandemic. The population is highly vulnerable to epidemic diseases, due to low immunization coverage, a weak health system, and poor hygiene and sanitation. South Sudan has one of the highest under five mortality rates (90.7 deaths per 1,000 live births) in the world. The maternal mortality rate was 789 deaths per 100,000 live births in 2015 which is the 5th highest in the world, approximately threatening the lives of 2.2 million women.

Indirect impacts on people and systems

COVID-19 containment measures, including transport restrictions, are contributing to a slowdown of economic activity. As a result of reduced trade, there is an inflation of food prices (e.g. maize flour increasing by 36 per cent). The price spike compounded with households' declining purchasing power due to adverse impacts on livelihoods is further exacerbating the already dire food security situation.

Plummeting global oil prices will impact on the Government's revenue affecting the country's ability to meet import obligations and payments relating to public service salaries. The scarcity and erratic supply of fuel to markets is likely to trigger an upward pressure on the prices through inflated transport costs.

At least 6.01M people are facing acute food insecurity from February to April 2020. An estimated 1.7 million women and children are acutely malnourished. South Sudan also has 1.67 million IDPs and 300,000 refugees. Over 430,000 people (30 per cent) of all of the IDPs are sheltering in camps or camp-like settings. The congested nature of the sites presents a high risk of the spread of the COVID-19.

An outbreak of COVID-19 could also have significant impacts on women, the elderly, adolescents, youth, children and persons with physical and psychological disabilities. Women and girls will be at higher risk of Gender Based Violence, Intimate Partner Violence and COVID-19 infection, especially for women who are caregivers. Quarantine measures, school closures and movement restrictions have also disrupted children's routine and social support structures. Closure of schools have affected an estimated 1.9 million children. The interruption of school feeding programmes have serious nutritional implications. 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 Ministry of Health, WHO and CDC have identified eight "at risk" locations in the country for COVID-19. Ongoing response include surveillance / case investigation / contact tracing, case management,

risk communications, and active COVID-19 screening at IOM-supported Point of Entries (PoEs). The current surveillance mechanism for COVID-19 related alerts and case detection is two-fold: i) Integrated Disease Surveillance and Response (IDSR) system which is used by health facilities to report on a weekly basis or a real-time basis in case of an alert; and ii) emergency hotline which is used by the public to report any health related emergency issue.

Health supplies are to be pre-positioned in high-risk locations as part of a holistic response. Given the already stretched health capacity, partners have developed a household kit aimed at reducing the burden of common diseases such as malaria and acute watery diarrhoea on health facilities. The kit includes mosquito nets, items for home water treatments, and soap. It also supports good hygiene practices, one of the key strategies for COVID-19 prevention. The kits are prioritized to be distributed in high risk congested locations, initially targeting 250,000 households. The kit content may evolve in the medium term to include items such as face masks and paracetamol – contingent on availability of stock - to support a home-based care strategy.

Meanwhile, double ration food distributions - as a COVID-19 transmission reduction measure - are underway across the country. The distribution is completed in high risk locations such as refugee camps and POC sites.

Challenges and impact to operations

South Sudan is dependent on medical supplies imported from outside the country in order to facilitate routine care. Given that the public health emergency response is already constrained, capacity for emergency response is extremely limited. South Sudan is also highly dependent on imported food commodities. Reduced regional supplies from neighboring countries and a slowdown in importation is likely to keep cereal prices high.

On 13 April, the High-Level Taskforce on COVID-19 suspended all passenger internal flights within South Sudan. Previously agreed exemptions for humanitarian cargo and passengers were expected to remain valid. Efforts are continuing in engaging with national authorities to enable programme critical passenger movement.

The capacity of humanitarian partners to import emergency life-saving relief items is contingent to availability of funding. Prior to the COVID-19 outbreak an alert was raised on funding pipelines that are likely dry up by May 2020 in the absence of timely funding. Food assistance, nutrition treatment supplements, reproductive dignity kits were all at risk of imminent pipeline breaks.

Limited availability of critical medicines and hospital supplies, Personal Protective Equipment (PPE), masks and other consumables constrain response. As of 22 April, WHO estimates that only five per cent of the total PPE requirement is available in country. Furthermore, efforts by the humanitarian partners to distribute COVID-19 household kits targeting hard-to-reach areas, has been hampered by lack of funding and timely sourcing of supplies.

* The 2020 South Sudan HRP is 13 percent funded as of 20 April. Without adequate funding, humanitarian partners cannot respond to the existing emergency and emerging COVID-19-related needs of vulnerable populations. \$217 million is required at this stage for South Sudan's COVID-19 response. An additional \$80M is required to support the needs of an additional urban vulnerable population caseload under a social protection/safety net programme. Humanitarian partners are further undertaking a re-prioritization exercise that includes identifying what stands out as priorities among the existing HRP non-funded projects that can support the COVID-19 response and highlighted as needing funding as well as re-purposing current HRP project activities to focus on the COVID-19 response. The addendum to the HRP and the National COVID-19 plan will be aligned to the extent possible to avoid duplication of response activities and costings.

Sudan HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$87.5M

OF WHICH:

HEALTH: \$87.5 M
NON-HEALTH: –

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.44B

OF WHICH:

COVID-19: \$87.5 M
NON-COVID-19: \$1.35 B

Impact of COVID-19

Immediate health impacts on people and systems

As of 22 April, the Ministry of Health had confirmed 140 cases of COVID-19, including 13 fatalities, and Sudan was experiencing community transmission. The actual number of cases is believed to be higher, due to asymptomatic carriers and limited testing availability. Among the most at risk are those without access to adequate health services (8.6 million); improved water sources (5.3 million); improved sanitation (6.2 million), and hygiene facilities (7.5 million). Particularly vulnerable groups include 2.1 million IDPs and 1.1 million refugees, many living in crowded conditions; 2.7 million children under five suffering from acute malnutrition; the elderly; and those with chronic diseases.

After decades of underinvestment, the health system lacks qualified staff, infrastructure, equipment, medicines and supplies. The surveillance system does not cover the entire country, and can be slow in confirming cases. In 2019, there were significant shortages of medicines for the second year in a row. COVID-19 cases may also force health facilities to close to other patients due to isolation procedures. Regular treatments for malnutrition or maternal care may have to be suspended. Mobilization for COVID supplies is likely to place more stress on already limited services and supplies. WHO categorizes Sudan's preparedness capacity as Level 3.

Indirect impacts on people and systems

Sudan already faces economic crisis which will be exacerbated by border closings, reduced internal movements, and reduced remittances. GDP is projected to fall by over 7 percent in 2020. WFP projects that the number of food insecure people could increase from 6.2 million to 8.2 million.

Imports of required cereals could be disrupted by border closures. Preventative measures – including lockdowns, curfews, restrictions on transportation, and physical distancing – will further affect the economy, particularly those whose livelihoods depend on daily wages.

Border closures exacerbating shortages of fuel and high inflation. Oil export earnings are likely to drop steeply, but this may be offset by reductions in the cost of fuel subsidies. The agricultural and livestock sector – a key source of exports - will also be affected by trade disruptions. Remittances from the Sudanese diaspora are likely to decline by some \$500 million.

The closure of schools is affecting children's access to education. Children and families benefitting from school feeding programmes will also be affected. Existing protection challenges will be compounded, including gender-based violence. With the lean season starting in May, more negative coping mechanisms are likely, including for children and women, who are more likely to be employed in the informal sector.

Response priorities and challenges

Priorities and early achievements

Humanitarian partners have developed a COVID-19 Country Preparedness and Response Plan. Most states with humanitarian operations have established dedicated task forces and plans. Partners are working to step up preparedness and response efforts in IDP camps and settlements including risk communication, infection prevention and control, and identifying areas for isolation. A contingency plan for refugee settlements is being developed and a surveillance system has been set up in camps. WASH supplies have been dispatched to support two isolation centres each in 13 states. WHO is working with State health officials to build capacity and provide medical equipment and supplies. Organizations plan to distribute 2-3 months' worth of food rations in advance, as well as larger quantities of nutrition supplies, to limit the frequency of gatherings. WFP will import 200,000 metric tons of wheat, which the Government will repay in local currency, enabling the Central Bank to maintain hard currency needed for importing key commodities. New guidelines are being developed to deliver immunizations and nutritional supplements, and to maintain feeding programmes.

While schools are closed, activities are focused on health messaging and developing remote programming. Activities addressing GBV include distribution of dignity kits, and scaling up messaging.

Challenges and impact to operations

The airport remains closed until 20 May, only operating cargo flights and evacuations of foreign nationals, limiting the ability to bring in additional humanitarian staff. Internal UNHAS passenger flights have been stopped, but cargo flights continue. To date only Khartoum and North Darfur have initiated lockdowns, but this may change as the virus spreads. The Humanitarian Aid Commission announced directives which allow humanitarians to move during the lockdown in Khartoum, but there have been challenges with issuance of permits. All points of entry remain closed, and ground transportation is not allowed.

All sectors have seen limitations in field missions and monitoring activities. Education activities have stopped with schools closed since mid-March. Some nutrition activities like mother support groups and community mobilization have been suspended. Most protection monitoring is being conducted remotely. Activities which involve gatherings, like trainings, workshops, meetings, and awareness sessions are on hold or evaluated on case-by-case basis.

WASH partners need additional support to ensure water provision for hand washing and disinfection. Additional resources are needed to support training of non-medical staff on IPC and personal hygiene.

Due to movement restrictions and the upcoming rainy season, access to refugee sites by humanitarian partners may be increasingly difficult.

* COVID-19 requirements: \$87.5 million in addition to 2020 HRP (HRP revision pending).

Syria HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$384.2M

OF WHICH:

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

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$3.81B

OF WHICH:

COVID-19: \$384.20 M
NON-COVID-19: \$3.42 B

Impact of COVID-19

Immediate health impacts on people and systems

A first case of COVID-19 was announced on 22 March, with 43 cases and three fatalities reported by 27 April. WHO classifies Syria as high risk; infections are almost certain to rise with potentially catastrophic impact amongst a population that has suffered through more than nine years of conflict.

The health system across Syria has been significantly weakened, with only 53 per cent of hospitals and 51 per cent of primary healthcare centres (PHCs) across Syria fully functional as a result of hostilities, a significant shortage of health care workers and key equipment, and insufficient rehabilitation/maintenance. Overall testing capacity remains vastly insufficient with the Central Public Health Laboratory (CPHL) able to carry out 70 tests a day. Health care workers are operating without PPE and without access to COVID-specific equipment such as ventilators. As caseloads rise, health care worker shortages will be worsened when staff become infected.

People living in densely populated areas, with frequent movements, and without adequate health and WASH services are most at risk. This includes 1.4 million IDPs in last resort sites and camps, more than two thirds of whom are concentrated in north-west Syria; almost 9 million people living in densely populated communities with high ratios of IDP and returnees, including Damascus, Rural Damascus and most districts in north-west Syria; as well as areas in north-east and southern Syria where critical service delivery is significantly curtailed.

Indirect impacts on people and systems

COVID-19 prevention measures have impacted essential services, including education and civil documentation. Schools across Syria have closed. Financial institutions and legal services are partially closed. Many health facilities have suspended non-emergency consultations. Border and movement restrictions disrupted supply chains for commercial and humanitarian goods, several humanitarian partners are only maintaining emergency services

Before COVID-19, an estimated 90 per cent of the population already lived below the poverty line and significant economic decline and currency devaluation throughout 2019 had already led to a sharp reduction in household purchasing power and a 22 per cent increase in the number of food insecure people by early 2020. COVID-19 related mitigation measures have exacerbated these trends since, with prices for food staples for example having increased on average 40-50 per cent since mid-March 2020. Prices for items such as masks and hand sanitizers increased by up to 5000 per cent in some places, prices for fuel by more than 160 per cent (diesel) and 248 per cent (gas) in the informal market within a month.

The loss of production during critical agricultural seasonal activities is expected to further limit the availability of food, pushing more people over the threshold of requiring assistance and exacerbating existing vulnerabilities.

Response priorities and challenges

Priorities and early achievements

Activities across all three operational hubs for Syria are guided by the 8 pillars of WHO SPRP, complemented by multi-sectoral preparedness and response to address the socio-economic impacts for the most vulnerable.

Response priorities in Government-controlled areas are 1) enhancing surveillance capacity and active surveillance including expanding laboratory testing capacity; 2) protecting health care workers by training and providing PPE (900,000 PPE provided so far); 3) ensuring proper case management, isolation and contact tracing; 4) raising awareness and risk communication

In the absence of confirmed cases in north-west Syria, focus is on preparedness and prevention: 1) community awareness, 2) enhanced WASH services, 3) training of healthcare workers; 4) establishment of community-based isolation centres (CBI). Selected hospitals are being repurposed and equipped with ICU capacities and triage tents.

In north-east Syria, focus is on 1) Risk Communication and Community Engagement (RCCE); 2) Infection Prevention Control (IPC) in last resort sites and densely populated urban areas; 3) Enhancing health system capacity responding to critical cases. Humanitarian partners anticipate increased needs for food and NFIs during extended periods of isolation/quarantine. By mid-April 1.4 million materials of information, education and communication were distributed.

Challenges and impact to operations

Fragmented governance and dynamic population movements negatively impact prevention measures. Containment and mitigation efforts are particularly difficult in north-west Syria where 4 million people are in acute humanitarian need living in a small area with few options for self-isolation. In north-east Syria, movement restrictions, border closures, limited supplies and procurement options affect operations.

Increases in humanitarian response costs and the need to adjust programming and delivery modalities may lead to a reduction in people reached with assistance if additional funding is not made available, leaving people without access to vital assistance and basic services as needs are increasing.

Global shortages, travel restrictions and closures of international conveyance pose a challenge to mobilize supplies and personnel. Access across the country has hampered humanitarian programming. Facilitation procedures to address restrictions impacting for humanitarian movements across the country are gradually being established. Monitoring and assessments will be key to fully capture the effect of the crisis but remain difficult to implement. Protection risks have increased; children are significantly impacted with a further reduction and suspension in protection, education, and psychological support services in areas where access and availability were already limited.

* COVID-19 requirements: \$384 million in addition to 2020 HRP requirements.

Ukraine HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$47.3M

OF WHICH:

HEALTH: \$16.6 M

NON-HEALTH: \$30.7 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$205.1M

OF WHICH:

COVID-19: \$47.3 M

NON-COVID-19: \$157.8 M

Impact of COVID-19

Immediate health impacts on people and systems

Within eight weeks of the detection of the first case of COVID-19 on 29 February, the number of confirmed cases has increased to over 10,000 people across Ukraine, with 261 deaths. In conflict-affected eastern Ukraine, 316 cases have been reported on both sides of the 'contact line'.

The primary COVID-19 challenge is laboratory testing capacity, where gaps in referrals, equipment and supplies, staff knowledge, access to information and logistical capacities have been reported. Only 1 per cent of primary healthcare facilities report having testing capacity, while half of secondary and tertiary facilities are able to perform Rapid Diagnostic Tests for screening purposes. Almost 70 per cent of health facilities and four 14 COVID-19-designated hospitals in Donetsk and Luhanska oblasts GCA lack the capacity or equipment required to collect samples.

Eastern Ukraine is particularly vulnerable to COVID-19 due to the high proportion of elderly (36 per cent of Donetsk and Luhanska oblasts – compared to the national average of 23 per cent), particularly in isolated, hard-to-reach settlements, and the deterioration of the healthcare system as a result of the cumulative impact of the armed conflict.

The pre-existing access constraints to essential services and for humanitarian organisations to reach people in need have been aggravated by COVID-19 restrictions. Humanitarian organizations' ability to organize humanitarian aid convoys through the 'contact line' to NGCA remains limited.

The people in need identified in the Ukraine HRP – the elderly, women, children, people living in rural areas along the 'contact line', IDPs, pensioners in Non-Government Controlled Areas (NGCA) – are at risk of suffering both from the health and socio-economic impact of this outbreak.

Indirect impacts on people and systems

Considerable livelihoods and economic recovery needs post-COVID-19 restrictions are expected as Ukraine's national GDP is now forecasted to shrink by 7.7 per cent in 2020 instead of the predicted 3.6 per cent growth. Many businesses have been forced to close or partially shutdown, and the prices of food and other goods are reported to have increased since the start of the COVID-19 pandemic. Small farmers have lost access to local markets, while self-employed people risk losing access to income generating activities. Nearly half a million people on both sides of the 'contact line' are food insecure, which is likely to be exacerbated by the COVID-19 crisis.

With the closure of crossing points across the 'contact line' some 300,000 pensioners living in NGCA who had previously regularly crossed to Government-controlled areas each month have lost access to pensions and social benefits. This situation is likely to worsen the already fragile and deteriorating socio-economic conditions in NGCA, particularly if the crossing points remain close for an extended period of time.

The closure of all education facilities across the country – until 11 May so far, subject to extension – could result in interrupted education, gaps in childcare, and economic burdens for working parents.

Since the start of the quarantine, there has been a 30 per cent increase nationwide in the number of calls seeking support to address domestic violence. The risk of GBV is particularly high in the conflict-affected region, given the high military presence, deepening socio-economic vulnerability and the high levels of stress and anxiety associated with both ongoing hostilities and COVID-19.

Response priorities and challenges

Priorities and early achievements

The magnitude of the COVID-19 effects – both direct and indirect – will depend on the speed with which the public health response measures (including risk communication component) can be scaled up and sustained, and how long the multiple restrictions will be in place. There continues to be solid coordination between the United Nations and other international actors with the Government of Ukraine to step up the response. Examples of activities include:

- Support in strengthening laboratories, detection capacity for COVID-19 and enhancing national and regional laboratory networks.
- Procurement of PPE and test kits that follow the recommended standards for further distribution in Ukraine, including in the conflict-affected areas on both sides of the 'contact line.'
- Delivery of 20 tons of hygienic items, test kits, ventilators and PPE to Non-Government Controlled Areas for distribution among healthcare and social facilities.
- Conducting contact tracing and follow-up of COVID-19 patients in eastern Ukraine (GCA).
- Reprioritization of current programming to focus on infection prevention and control (IPC) as well as hygiene promotion campaigns.

Challenges and impact to operations

While most humanitarian actors in eastern Ukraine have managed to adapt the modality of their operations and utilized various communication technologies to deliver assistance, challenges remain. As these creative modalities rely heavily on technology, the reach of such 'virtual' assistance may be uneven depending on geographical areas and population groups.

Some humanitarian organizations have adopted an 'individual service delivery' or 'door-to-door delivery' approach to minimize beneficiaries' exposure to COVID-19. For example, one NGO provides support to facilitate remote medical consultation for people.

* COVID-19 requirements: \$47.3 million through to end of year in addition to 2020 HRP requirements.

Venezuela HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$72.1 M

OF WHICH:

HEALTH: \$44.1 M

NON-HEALTH: \$28.0 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$822.1 M

OF WHICH:

COVID-19: \$72.1 M

NON-COVID-19: \$750.0 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 27 April, Venezuela confirmed 329 cases of COVID-19 with 142 recovered cases and 10 deaths. The cases are roughly evenly split among men and women. The Ministry of Health has designated 50 hospitals and health centers for the COVID-19 response and has developed a National Prevention and Response Plan. The Government implemented early quarantine and response measures, declaring a 'state of emergency' on 13 March and putting in place a nation-wide 'social quarantine' to enforce physical distancing.

The rate of daily new cases remains low, averaging nine per day, and can be managed with current available capacities and humanitarian assistance. However, if the virus spreads further, the health care system will come under strain and require additional support, especially in terms of epidemiological surveillance, laboratory testing capacity, infection prevention and control measures, and the diagnosis and treatment of patients.

The current prioritization of the COVID-19 response could also impact the functioning of other health care services, such as follow-up of patients with chronic conditions, sexual and reproductive health services for women and girls and ongoing efforts to tackle other outbreaks such as malaria, measles and diphtheria. Nutritional services and treatment may become harder to access.

The lack of regular access to water and sanitation services and hygiene products remains a challenge for prevention and control. This situation affects the capacity of some people to implement basic protective measures at home, such as handwashing with soap and household cleaning.

Indirect impacts on people and systems

The quarantine measures have already impacted people's livelihoods, especially for workers in the informal economy, those engaged in cross-border economic activity and those dependent on remittances, which have fallen due to the economic impact in neighboring countries. Fuel shortages and movement restrictions have put production means and supply distribution systems under strain. Prices have increased for some essential commodities. The socio-economic effects of the quarantine measures will become more acute over time and will likely increase the risk of food insecurity and malnutrition. In response, the Government announced several social protection measures to help mitigate these impacts.

School closures until the end of the education cycle have led to a shift to remote learning modalities. The quarantine measures may increase the risk of gender-based violence for people living in close quarters. Families will have to cope with anxiety and stress, increasing the need for mental health and psychosocial services. The overall provision of protection services has come under strain.

The economic impact in neighboring countries have triggered the return of an estimated 40-60,000 people. After initial health screening at the points of entry, most returnees are directed to temporary shelter arrangements to fulfill a quarantine period before proceeding to their destination. Once returnees complete their quarantines, epidemiological surveillance is required to prevent COVID-19 clusters at their destination. On 7 April, the authorities requested UN support to strengthen the multi-sectoral response to the returnees.

Response priorities and challenges

Priorities and early achievements

To complement national efforts to contain the pandemic, the UN and partners are implementing a COVID-19 Inter-sectoral Prevention and Response Plan focused on health, WASH, mass communication and the response to the returnees. The Plan also seeks to ensure that other critical cluster activities continue. The first phase of the plan will last from April to June. During the second phase, the prioritization of activities will be reviewed based on the evolution of the epidemiological situation.

The primary focus is the public health response, which prioritizes areas with the highest number of cases, high population density and border states where there are greater risks of transmission. 16 hospitals in ten states have been prioritized for the first phase of the response.

As of mid-April, humanitarian partners had reached over 300,000 people as part of the multi-sectoral COVID-19 response, 62 per cent of which were women. On 8 April, an UN-organized plane carrying 90 tons of medical, WASH supplies, as well as schooling inputs, arrived in Venezuela. Local procurement has also been accelerated to meet emerging needs, including the direct attention to COVID-19 cases, WASH and energy support and the provision of equipment and medical supplies to hospitals and health centers.

Challenges and impact to operations

Critical humanitarian staff are working on-site, with protective measures required. The UN facilitated an agreement with the authorities to issue special access permits, with almost 300 passes issued to date for UN agencies, NGOs and private contractors. Further passes and support are required to continue operating in a timely and effective manner, including predictable access to fuel.

Many of the 81 humanitarian partners in-country have had to limit or temporarily suspend their activities, although efforts are in place to ensure critical programmes continue with new distribution methods, such as cash programming and remote service provision for protection and education.

A lack of funding for the overall humanitarian response remains a key challenge.

* COVID-19 requirements: \$72 million for immediate needs as part of the 2020 HRP (HRP revision pending).

Yemen HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$179.1M

OF WHICH:

HEALTH: \$101.6 M
NON-HEALTH: \$77.6 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$3.38B

OF WHICH:

COVID-19: \$179.1 M
NON-COVID-19: \$3.20 B

Impact of COVID-19

Immediate health impacts on people and systems

Coronavirus has been present in Yemen since late March. Although the number of publicly confirmed cases is currently low, officials warn that the virus is likely to spread faster, more widely and with deadlier consequences than in most other countries. Five years of continuous war, and multiple epidemics including the worst cholera outbreak in modern history, have exhausted people's immune systems, increased acute vulnerabilities and degraded Yemen's health infrastructure. Modelers warn that as many as 16 million people, 55 percent of the population, will become infected in the most likely scenario. Unless efforts to suppress and contain the virus are scaled-up quickly, 300,000 people will need hospitalization, including 200,000 people who may become severely ill, requiring ICU support to survive.

Indirect impacts on people and systems

The humanitarian crisis in Yemen is already considered the worst in the world. More than 80 percent of the entire population requires some form of humanitarian assistance or protection. Two-thirds of all Yemenis are hungry, half are acutely vulnerable and do not know where their next meal will come from, nearly a quarter of the population is malnourished, and 12 percent are displaced. Economists estimate that 70 percent of all remittances, one of the country's main sources of foreign exchange, will be lost because of COVID. The currency has depreciated nearly 20 percent in recent months and will almost certainly weaken further. Basic food prices continue to rise, increasing the likelihood of a return to pre-famine conditions. Although Yemen is one of the first 25 countries to benefit from COVID-related debt relief, extreme pressures on public revenue are impacting liquidity, stifling credit and further interrupting salary payments to civil servants. 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 early achievements

Although capacities and resources are limited, humanitarian agencies are taking decisive steps to help authorities suppress the spread of COVID-19 and to prepare and equip facilities in case people become ill. Efforts are focused on five key priorities: helping to suppress transmission of the virus; identifying and treating cases; educating the public about the virus; protecting the existing health system and maintaining the humanitarian operation already in place.

As the leading international health agency in Yemen, the World Health Organization is funding the work of 333 Rapid Response Teams. These five-person teams are present in every single district across the country, responsible for detecting, assessing, alerting and responding to suspected COVID-19 cases. People can reach out to these teams through multiple channels including newly established hotline numbers. The aim is to increase the number of teams to 999 in coming weeks, a tripling of existing detection capacity. WHO is also equipping and helping to upgrade specialized isolation units in the 37 hospitals across the country that authorities have designated for COVID. Thirty-two of the 37 hospitals have already received equipment funded by WHO and 7 specialized isolation units are now

fully operational. The remaining 30 will be upgraded by mid-May 2020.

WHO, with support from other UN agencies, has moved quickly to secure equipment on global markets, where supplies are limited, prices high and buyers for Yemen face stiff competition from other countries. Hundreds of ICU beds and ventilators and thousands of tests have been secured and distributed. More than 1,000 additional beds, tens of thousands tests and hundreds of ventilators are being mobilized through a unique public-private partnership with leading multinational and Yemeni companies. This equipment is on its way to Yemen and will be distributed as soon as conditions permit.

Knowing how important first-line treatment is, WHO is working with partners to re-purpose the 26 Emergency Operations Centres (EOC) which were established at the height of the cholera epidemic to address COVID-19. Partners have already trained nearly 900 health personnel on rapid response, infection control, case management, psychological first aid and helping children cope with stress.

As part of efforts to educate people on COVID, UNICEF is training 10,000 community volunteers across the country. The role of these volunteers is to explain to people how the virus is transmitted, what someone can do to protect themselves and what steps to take if someone becomes ill. Using the 26 emergency operating centers being repurposed by WHO, volunteers are tracking rumors, providing information and sensitizing key influencers. At the community levels, the volunteers are helping to identify cases and trace contacts.

The strategy for protecting existing health services focuses on providing the Minimum Service Package in non-COVID facilities, providing essential medicines and vaccines to people who need them the most including cancer patients and children, and helping to contain and respond to deadly outbreaks including cholera, diphtheria, dengue and malaria.

In addition to COVID-specific efforts, 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 13 million people monthly, cash assistance to 9 million people, and nutritional support to 2.5 million malnourished children. It also includes reaching 8.8 million people with primary health care; providing and rehabilitating 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 response in Yemen faces three major problems. The most difficult to overcome is the severe shortage of essential supplies and equipment including tests, protective equipment, ICU and hospital beds and ventilators. The second major gap is funding for the existing operation. 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. Even before the COVID crisis, fighting was intensifying along nearly half of the 38 active front-lines. For months, partners have faced paralyzing restrictions, particularly in northern Yemen, impacting nearly every aspect of their work and undermining donor confidence in the operation. These were compounded in mid-March when authorities in both northern and southern Yemen closed air and sea borders and started to tightly control land movements.

* COVID-19 requirements: \$179.1 million in addition to 2020 HRP requirements

Zimbabwe HRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$84.9M

OF WHICH:

HEALTH: \$35.0 M

NON-HEALTH: \$49.9 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$800.7M

OF WHICH:

COVID-19: \$84.9 M

NON-COVID-19: 715.8 M

Impact of COVID-19

Immediate health impacts on people and systems

Zimbabwe recorded its first case of COVID-19 on 20 March and had confirmed 31 cases by 26 April, including four deaths (all with co-morbidities). Of the 10 provinces in Zimbabwe, four (Bulawayo, Harare, Matabeleland North and Mashonaland East) have confirmed COVID-19 transmission.

COVID-19 is expected to heighten the risks of people living with co-morbidities and in challenging living conditions. Zimbabwe is facing an escalating malaria outbreak, with more than 150 people reportedly killed. There are close to 2 million patients affected by chronic non-communicable diseases, and 1.3 million people living with HIV, across the country. An estimated 5 to 6 per cent of the population is over 60 years of age.¹⁹ One year after Cyclone Idai hit, 128,270 people still need assistance in Manicaland and Masvingo provinces, while there are 21,328 refugees and asylum seekers in Zimbabwe who need international protection and assistance. A growing number of Zimbabweans are returning from abroad, with an estimated 13,500 returning in the three-day period ahead of South Africa's lockdown. Women, who already shoulder most of the care work in Zimbabwe, are more likely to provide care to ill family members, and in doing so put themselves at higher risk of exposure.

The COVID-19 outbreak is taking place against an over-stretched health system. Prior to COVID-19, at least 4 million vulnerable Zimbabweans were facing challenges accessing primary health care, with frequent health worker strikes and stock-outs of drugs and consumables. Following a rapid assessment, 13 hospitals have been designated for the COVID-19 response. However, preparations are not complete, and there is an urgent need to increase: the number of beds in the health facilities nation-wide for isolation; available medical equipment, including ventilators; availability of laboratory supplies and consumables; availability of personal protective equipment for health workers; and capacity to safely refer patients by ambulance.

Indirect impacts on people and systems

The COVID-19 pandemic arrived in Zimbabwe at a time when 7.7 million people were already in urgent need of humanitarian assistance due to economic challenges and climatic shocks. With a poverty rate of over 70 per cent, the second largest informal sector in the world (85 per cent of economic activity), and no access to international capital, Zimbabwe is expected to face severe consequences due to the global economic slowdown.

Food and nutrition security are already being jeopardized. Prior to COVID-19, more than 4.3 million people were severely food insecure in rural areas in Zimbabwe and a further 2.2 million people in urban areas were "cereal food insecure". Pending the results of new assessments, food security partners estimate that an additional 200,000 people will require assistance due to the COVID-19 situation. Admissions in the Integrated Management of Acute Malnutrition (IMAM) programme fell from 952 in January to 354 in March (201 girls and 153 boys), following the lockdown.

The early closure of Zimbabwe's 9,625 primary and secondary schools to contain the spread of COVID-19 can potentially impact the well-being of more than 4.6 million young people of school going age (3 to 17 years), teachers and school communities. Distance-learning tools are not an option for the majority of households. If schools remain closed, the most vulnerable children will not receive school feeding, with potential consequences for their nutrition status.

GBV is reportedly rising as an indirect consequence of COVID-19 infection prevention measures, including restricted movements, increased demand and limited access to public services and basic commodities. By 22 April, the national GBV Hotline had recorded 972 GBV calls, an increase of over 70 per cent compared to the pre-lockdown trends.

Response priorities and challenges

Priorities and early achievements

The Humanitarian Country Team (HCT) in Zimbabwe has developed a COVID-19 Addendum to the Humanitarian Response Plan 2020, which prioritizes the most urgent and life-saving interventions to be carried out in the next six months (April to September 2020) in support of the Government-led response to COVID-19. The Addendum has identified 7.5 million People in Need of assistance due to COVID-19's public health impacts and secondary consequences; of whom partners will target 5.9 million. It complements the Government's response by focusing on: 1) the direct public health impacts of the COVID-19 outbreak, including through health programming, risk communication and community engagement, as well as infection control and prevention and availability of water supply and heightened hygiene and sanitation intervention; 2) ensuring continuity of life-saving essential services and humanitarian action; and 3) providing an enabling environment to address COVID-19 and its consequences.

Humanitarian partners have received written authorization from authorities, enabling them to continue operating during the nationwide lockdown, and are finding innovative ways to sustain programming. For example, with survivors of child protection violations struggling to report or to access services as they are trapped with their alleged perpetrators, partners are attending to critical sexual abuse cases by providing community cadres with airtime to facilitate follow up support and reporting of new cases by telephone.

Challenges and impact to operations

There are gaps in reagents for testing for COVID-19 and availability of personal protective equipment (PPE). There is a need to strengthen contact tracing and to increase risk communication to create awareness about COVID-19 at all levels and counteract stigma. At the same time, essential service systems -including for health, nutrition and WASH- were already strained pre-COVID-19 and will struggle to cope with additional pressures. Life-saving care and support to GBV survivors, and sexual and reproductive healthcare, in particular may be disrupted. The cost of maintaining humanitarian assistance -especially food and livelihoods- will likely increase due to COVID-related containment measures.

¹⁹ www.helpage.org/newsroom/latest-news/inadequacy-of-healthcare-in-ethiopia-mozambique-tanzania-and-zimbabwe-revealed-in-new-helpage-report

* A total of \$84.9 million is required for the COVID-19 response in Zimbabwe, in addition to the 2020 HRP.

Annex C

Country and regional plans: Regional Refugee Response Plans

- 47 **Burundi** *Regional*
- 48 **DRC** *Regional*
- 49 **Nigeria** *Regional*
- 50 **South Sudan** *Regional*
- 51 **Syria** *Regional*

Burundi Regional RRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$65.4 M

OF WHICH:

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

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$275 M

OF WHICH:

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

Targeted population

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

Countries covered

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

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

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 especially 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. Potential new arrivals in need of international protection may be denied entry due to border closures of the main countries hosting Burundian refugees.

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, and personal protective equipment), 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. Slowed procurement and delivery processes, including for international importation, present additional challenges.

Voluntary repatriation of Burundi refugees from Tanzania has continued despite border closure and other mobility restrictions. While additional health screening measures and protocols have been put in place, RRP partners continue to advocate with the two governments to temporarily suspend the program given the health-related risks.

Response priorities and challenges

Priorities and early achievements

While there has been no large-scale outbreak amongst Burundi-an refugee populations so far, the need for further preparedness is urgent. Cases of local transmission have now been reported

in all countries of the region. Prevention 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 and community engagement, and critical protection case management, including protection monitoring and registration; and supporting education systems.

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 distribution of essential assistance. Using these SOPs, partners have 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 are carrying out risk communication and community engagement activities, with educational materials in Kirundi language. Handwashing facilities have been established in public sites in Tanzania including at distribution centers. Thermal screenings have been established at entrance gates to camps and departure centers for voluntary repatriation.

Challenges and impact to operations

With additional funding, response partners will work to scale up the capacity of health personnel; establish additional water storage capacities and improve WASH facilities at schools, health centers, other public facilities and at household level; support government health facilities in refugee hosting areas; procure essential medical items and nutritional food items; expand information and awareness campaigns; increase cash assistance for additional hygiene items; strengthen referral, case management and protection monitoring mechanisms; develop psycho-social counselling systems and community based protection work with local actors; provide support to the most vulnerable among urban refugees and asylum-seekers who are unable to provide for their families due to movement restrictions and price increases; and invest in early recovery/livelihood activities to help refugees cope with the economic impact of the crisis.

Coordination

Coordination structures are in place in all asylum countries, with dedicated Crisis Management Teams and Task Forces by sector. 37 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."

* The original 2020 budget for the Burundi RRP was 266 million. The table indicates preliminary budget breakdown as full reprioritization exercise and the revision is ongoing. COVID-19 requirements for DRC are reflected in the DRC HRP and taken out from the calculation of the Burundi RRP.

DRC Regional RRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$155.7M

OF WHICH:

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

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$639M

OF WHICH:

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

Targeted population

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

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. The poor, elderly and vulnerable as well as urban refugees have been disproportionately affected by the pandemic and efforts to contain it. Already strained for resources following years of conflict, instability and displacement, the situation has placed further pressure on Congolese refugees, asylum-seekers and host countries.

Countries in the region have seen decreased access to outpatient and inpatient health services due to closure of health facilities, repurposing of health workforce and stock-outs of medicines and other supplies. Concerns exist for continued healthcare support as healthcare workers lack protective gear.

Indirect impacts on people and systems

National efforts to contain the virus have included closure of borders and national lockdowns, which create concerns over ensuring continued access to asylum as well as how people will be able to make a living to survive. Most refugees earn their livelihoods through informal activities, such as trade, farming or fishing. Others receive social assistance through cash-based transfers, or in-kind food distribution. Due to containment measures, livelihood activities are on hold and may not resume soon. A significant number of Congolese refugees and asylum-seekers in urban areas have lost jobs, experienced reduced business or have had to close. With issuance of movement permits out of the settlements suspended, traders are not able to restock, which is disrupting access to basic goods in camps and settlements.

Movement restrictions are making it increasingly difficult to reach refugees and asylum-seekers – particularly those living in urban and rural areas that have been temporarily closed off. This is resulting in increased vulnerability for refugees and asylum-seekers, especially those at high risk, such as persons with specific needs, the elderly, and single women with young children. Due to the prolonged confinement and isolation, there are heightened risks of SGBV, especially for women and children. With schools and universities closed across the region, education of children and youth is of rising concern as many refugees and asylum-seekers have limited capacities to access online schooling and other forms of remote education.

Response priorities and challenges

Priorities and early achievements

As part of the emergency response to the COVID-19 pandemic,

countries within the DRC RRP are reviewing COVID-19-related needs to complement national authorities' response capacities. Ensuring the delivery of life-saving activities and supporting COVID-19 prevention and response activities, with adapted, largely remote, response modalities. RRP partners are developing COVID-19 preparedness and response plans for refugee settings, complementing national responses and supporting governments with additional staff and training as well as sourcing additional medication, equipment and protective gear.

RRP partners are expanding health facilities in line with COVID-19 readiness and response needs providing essential medical items and nutritional food, while strengthening the capacity of health personnel and establishing quarantine and isolation facilities. The response aims at supporting access to government testing and case management facilities by strengthening COVID-19 referral systems in refugee and asylum-seeker hosting districts and contributing to national case management efforts. In the WASH sector, increasing water production, treatment and distribution in refugee settings, installation of washing stations in public places and increased soap provision as well as extending WASH interventions to host communities. Partners are establishing remote protection monitoring and response mechanisms through enhanced community involvement to address SGBV and child protection and identify persons with specific needs. Support activities also target urban refugees and asylum-seekers who are unable to provide for their families due to restrictions on movement and price increases for basic commodities.

Challenges and impact to operations

Gaps and challenges include a lack of funding, limited operational capacity of some stakeholders, lack of water and sanitation facilities in some camps and transit centres, insufficient capacity of camp-based health facilities (infrastructure, equipment, staffing, medicine and protective gear), inadequate referral systems, overcrowding in some locations impeding physical distancing efforts, a shortage in food rations, limited therapeutic food items for malnourished children, a need to set up toll free lines for protection monitoring, slow procurement and delivery processes, including for international importation, the depletion of refugee livelihoods and purchasing power, price inflation and limited access to basic commodities in local markets, and lack of social and financial safety nets.

Coordination

66 RRP partners are working with governments, WHO, other UN agencies and NGOs to secure the inclusion of refugees, IDPs and other marginalized communities in national preparedness and response measures for COVID-19. Partners and government officials hold regular virtual coordination meetings. The DRC RRP will continue to serve as a regional coordination and planning tool aimed at improving protection space, preparedness and response for refugees and host communities and facilitating a more targeted and effective response to COVID-19.

* The original 2020 budget for the DRC RRP was 621 million. The table indicates preliminary budget breakdown as full reprioritization exercise and the revision is ongoing. COVID-19 requirements for Burundi are reflected in the Burundi HRP and taken out from the calculation of the DRC RRP.

Nigeria Regional RRP

COVID-19 REQUIREMENTS*

REQUIREMENTS	OF WHICH:
	HEALTH: -
	NON-HEALTH: -

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS	OF WHICH:
	COVID-19: -
	NON-COVID-19: -

Targeted population

Some 292,000 Nigerian refugees and 100,000 host community population.

Countries covered

Cameroon, Chad and Niger.

Impact of COVID-19

Immediate health impacts on people and systems

The lives and livelihoods of refugees and host communities around the Lake Chad Basin and in the Maradi region of Niger are further threatened by the COVID-19 pandemic and governments face unprecedented challenges. The pandemic overlays an already complex crisis driven by extreme poverty, climate change and conflict. Nigerian refugees live in congested camps or settlements in remote areas or in poor urban locations and face difficult circumstances, including food insecurity, exposure to recurrent disease outbreaks, with many also suffering from chronic illnesses and disabilities. Physical distancing is very difficult to implement in these circumstances.

While Nigerian refugees can access national health systems, health care facilities are overstretched, under-resourced and heavily dependent on humanitarian support. A COVID-19 outbreak could amplify the pre-existing vulnerabilities of refugee and host communities. A limited number of health personnel are trained in emergency response and case detection management. Isolation and treatment units to handle this kind of health crisis are insufficient and personal protective equipment is lacking. Water supply is sub-standard in most refugee hosting areas and critical needs persist in sanitation with almost half the refugee population having no access to latrines. With COVID-19 prevention hinging largely on sound hygiene practices, the provision of WASH facilities/services is crucial. Construction, rehabilitation and maintenance of health and WASH infrastructure remain essential to ensure adequate service provision.

Indirect impacts on people and systems

With the lean season approaching, there is an alarming rise in food insecurity leading to severe malnutrition. Recurrent insecurity has restricted freedom of movement and access to land, and disrupted food production and distribution. Refugees and their hosts suffer from limited access to livelihoods and have difficulty purchasing food. These conditions are intensified by the COVID-19 pandemic, which will have a serious impact on the already fragile food security and nutritional status of Nigerian refugees and their hosts.

High levels of violence have led to limited education opportunities, with low enrollment rates among Nigerian refugees. Measures put in place to slow the spread of the virus, such as temporary school closures, aggravate the situation. Persons with specific needs as well as those with chronic health conditions are at higher risk with reduced access to services and livelihoods. The risk of SGBV, child protection risks and negative coping mechanisms are also heightened in this context.

Response priorities and challenges

Priorities and early achievements

RRP partners are reprioritizing actions in all areas emphasizing health, WASH, shelter, protection and livelihood interventions, and are expanding cash-based interventions and adopting a social safety net lens. Direct support to national health systems to strengthen infection prevention and healthcare responses is done through providing medical equipment and supplies, bolstering isolation/treatment centers and training health personnel. RRP partners will support surveillance at entry points to refugee sites and borders, case detection, referral mechanisms, and contact tracing in collaboration with health ministries and WHO. Access to clean water and effective waste management in healthcare facilities and camp settings is being scaled up and hygiene supplies increased. Additional handwashing stations and latrines are being provided. To mitigate the risks of overcrowded refugee sites and incidence of other respiratory diseases prevalent among vulnerable refugees, targeted shelter interventions are planned.

Innovative approaches to deliver essential protection services are being established, such as online and phone consultations to meet physical distancing measures. SGBV remains a priority and teams are adapting case management modalities, introducing remote assistance and integrating cash-based interventions for women at risk and SGBV survivors. Partners are working with education ministries to adjust education services in response to school closures. Risk communication and community engagement efforts are expanding and include training for refugees on COVID-19 behavioral change interventions and use of community mobilization tools (local radios, music, "village speakers") and digital approaches (SMS, WhatsApp).

Challenges and impact to operations

Movement restrictions, limitations of missions inside and out of the three countries, and the deterioration of economic conditions are leading to increased needs and making the delivery of humanitarian assistance more challenging. As governments take measures to contain the spread of COVID-19, including through border closures, refugee and asylum-seekers' access to safety and to seek asylum may be compromised. Stigmatization and discrimination against refugees in the context of COVID-19 is another potential risk.

Coordination

Coordination of the Nigerian refugee and affected host community response brings together 40 partners. Under the Refugee Coordination Model, the response is led by the Governments with UNHCR's support. To mitigate the impact of COVID-19 on Nigerian refugees and their hosts, partners 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 camps and settlements.

* The revision of the RRP in progress and the table indicates preliminary breakdown. COVID-19 requirements for Cameroon, Chad and Niger are reflected in the Cameroon, Chad and Niger HRPs, respectively. The non-COVID-19 components of the Nigeria Regional Refugee Response plan are accounted for in corresponding country plans.

South Sudan Regional RRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$128.8M

OF WHICH:

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

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.34B

OF WHICH:

COVID-19: \$129 M
NON-COVID-19: \$1.21 B

Targeted population

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

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, which have now been affected 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. Most refugees face high levels of poverty, limited access to livelihood opportunities, and are hosted in some of the poorest regions of the country, where communities are already struggling.

The majority of South Sudanese refugees rely on food distributions which due to funding shortfalls often do not meet minimum standards. Food rations for South Sudanese in Ethiopia have been reduced by 15%, while Kenya and Uganda have had to introduce 30% ration cuts. 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

Critical gaps include the lack of adequate water and sanitation facilities in some camps and settlements, shortage of medical supplies including personal protective equipment, and insufficient material for infection prevention and control. Overcrowding of camps and settlements remains a concern, as physical distancing and self-isolation may be impossible for refugees and could lead to fast spread of the virus. Health facilities in refugee hosting areas often lack medical staff, have weak case management systems and poor infrastructure that does not meet infection control standards. The risk of infection is underscored by the fact that host communities in some locations rely on refugee medical facilities, stretching their limited capacity. Facilities do not have intensive care capacity and referral mechanisms are weak due to resource constraints.

Response priorities and challenges

Priorities and early achievements

Cases of local transmission have been reported in all countries

of the region. Prevention 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 and community engagement, and critical protection case management, including protection monitoring and registration; and supporting education systems. Construction of additional household shelters will facilitate relocation from reception centers to avoid congestion. Potential sites for isolation centers have been identified for use as emergency 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 is currently inadequate.

With additional funding, partners will scale up WASH and other critical humanitarian assistance for populations at high risk. Partners will seek to preposition badly needed medical equipment and supplies. The supply of alternatives to firewood may be required in the event of restriction on movement for camp-based populations. Community outreach will be expanded to conduct further awareness-raising, sensitization campaigns and hygiene promotion.

Synergies in support of government initiatives have been initiated, for example UNHCR, WFP and UNICEF's contribution to the food basket for urban refugees in Sudan as part of the Khartoum urban government initiative.

Challenges and impact to operations

The situation is aggravated by the remoteness of refugee locations, posing communications and logistics challenges. Under these conditions, local responses can only ensure quality services where there are sufficient funds and partners to reach remote communities. While health centers in refugee camps and settlements may be able to manage patients with mild conditions of COVID-19, there is little capacity for isolation and even less for the management of severe and critical conditions that require hospitalization and intensive care including oxygen therapy. The prolonged closure of schools may reverse efforts made towards enrolment and elimination of harmful cultural practices, exposing children to risks related to recruitment to gangs, child labour, child marriage and teenage pregnancy.

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.

* The original 2020 budget was 1.34 billion. The table indicates preliminary budget breakdown as full reprioritization exercise and the revision is ongoing. COVID-19 requirements for the DRC and Sudan are reflected in the DRC, Ethiopia and Sudan HRPs, respectively and taken out from the calculation of the South Sudan RRP.

Syria Regional 3RP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$643.8 M

OF WHICH:

HEALTH: \$82.6 M
NON-HEALTH: \$561.1 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$6.21 B

OF WHICH:

COVID-19: \$643.8 M
NON-COVID-19: \$5.56 B

Targeted population

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

Countries covered

Egypt, Iraq, Jordan, Lebanon and Turkey.

Context

The five countries covered under the Regional Refugee and Resilience Plan for the Syria crisis (3RP) – Turkey, Lebanon, Jordan, Iraq and Egypt – generously host over 5.5 million registered Syrian refugees, as well as additional refugees, asylum-seekers and other vulnerable groups of many nationalities. Within the context of overall response efforts, the 3RP response to COVID-19 immediately seeks to help countries and communities curb the risk and lessen the social and economic impact on refugees and host communities alike.

Impact of COVID-19

Immediate health impacts on people and systems

COVID-19 is having a profound impact on all 3RP countries and is likely to have far reaching health and socio-economic impacts in the medium term. In the face of a growing pandemic, host governments have adopted necessary measures to limit the spread of the virus among the population. While these have helped to limit the spread of the virus, health challenges remain, including access to quality health services for treatment beyond the scope of COVID-19. Meanwhile, preliminary assessments and evidence on COVID-19 impacts point to several worrisome trends emerging across 3RP countries, exacerbating vulnerabilities of refugees and host communities alike.

Indirect impacts on people and systems

While poverty and unemployment rates for Syrian refugees were already high prior to the onset of COVID-19, they face even greater challenges in earning a livelihood, covering basic needs such as shelter or food and accessing key services, such as health care. For those in densely populated areas or shelters, social distancing and/or limiting outdoor activities are extremely difficult to implement. Against such a backdrop, protection risks, such as sexual and gender-based violence, child labour, and exploitation, are heightened, while the use of negative coping mechanisms may rise.

Likewise, for host communities, business closures and other measures have significantly reduced income and livelihoods opportunities for vulnerable men and women in host communities, which face higher risks of unemployment, underemployment and impoverishment. Many, particularly informal workers, are not covered by social security or other safety nets. Women are particularly affected, bearing increased domestic and care burdens and facing increased risks of domestic violence.

National infrastructure providing essential services, such as water and sanitation have already been seriously impeded or are

under increased strain, adding to vulnerabilities among entire communities. Closures of schools and educational institutions have also left many vulnerable children and young people without access to quality education. Disruptions in economic activities and supply chains for key goods and services due to lockdowns are also negatively impacting government revenues, making the delivery of public services more challenging.

In some countries, the prevailing conditions, as well as potential misinformation and misperceptions about COVID-19, mean there is also an increased risk of tensions between host and refugee communities.

Response priorities and challenges

Priorities and early achievements

The 3RP continues to implement its response based on existing plans, reaching millions of refugees and host community members over the first quarter of 2020. Indeed, most on-going activities in existing 3RP country plans directly or indirectly support national efforts to curb the spread and lessen the impact of COVID-19 and 3RP partners have also played a critical role in national preparedness activities even before the outbreak of the virus. These activities remain a vital pillar of 3RP support, and partners are also leveraging the use of innovative tools and approaches to reach those in need in ways that respect physical and physical distancing.

Challenges and impact to operations

Within the context of overall 3RP plans, countries have also developed specific COVID-19 responses, both through reprogramming some activities to specifically deal with the impact of the virus, as well as introducing new and additional activities to address the most pressing challenges arising from the outbreak. While timeframes and focus of COVID-19 specific responses under the 3RP vary between countries to ensure complementarity with national efforts, key activities include direct health interventions, as well as providing cash and other assistance to meet basic needs, enabling key protection activities and a range of education, WASH, and livelihoods support. Meanwhile, 3RP partners will continue to assess how best the 3RP can help governments and communities deal with, and eventually recover from, the impact of COVID-19 and so full 3RP plans will be adjusted as required in the months ahead.

Coordination

As with the overall 3RP plans in each country, the 3RP COVID-19 plan is firmly rooted in supporting national and local efforts. While the exact modalities vary by country, the 3RP plan for COVID-19 is aligned and complimentary to government-led preparedness and response plans, the WHO-led Country Preparedness and Response Plans (CPRPs), initiatives by UN Resident Coordinator Offices, as well as the work of development actors, including International Financial Institutions.

* Countries involved in the 3RP have identified an additional requirement of USD 644 million while full prioritization exercise is ongoing, pending consultation with host governments and partners. The existing 3RP 2020 budget is 5.5 billion.

Annex C

Country and regional plans: **Regional Refugee and Migrant Response Plans**

126 **Horn of Africa** *Regional*

127 **Venezuela** *Regional*

Horn of Africa and Yemen *Regional* RMRP

COVID-19 REQUIREMENTS

REQUIREMENTS

OF WHICH:

HEALTH: –

NON-HEALTH: –

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

OF WHICH:

COVID-19: –

NON-COVID-19: –

The IASC Emergency Directors Group identified the Regional Migrant Response Plan (RMRP) for the Horn of Africa and Yemen for inclusion in the GHRP. Consultations have taken place in Yemen under the RMRP and the Humanitarian Response Plan coordination processes, and as such, this iteration of the GHRP already includes the humanitarian needs of migrants in Yemen. Consultations are ongoing in Ethiopia, Djibouti and Somalia as the other countries covered by the RMRP. Once these consultations conclude, the overall humanitarian needs under the RMRP will be revised and included in the next iteration of the GHRP.

Venezuela Regional RMRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$438.8M

OF WHICH:

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

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$1.41B

OF WHICH:

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

People in need

2 million people (refugees and migrants and affected host community members)

Targeted population

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

Countries covered

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

Impact of COVID-19

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, in recent years, 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 presents an additional challenge of unforeseeable magnitude, putting to the test the health and social welfare systems, and countries' ability to maintain an inclusive society.

Immediate health impacts on people and systems

Refugees and migrants, particularly those in irregular situations, are at high risk of being left out of health and social welfare programs, thereby becoming more vulnerable to a range of health and protection risks. Moreover, many families and persons amongst the refugee and migrant populations who have lost their livelihoods are exposed to increasing levels of evictions and resulting homelessness, increasing food insecurity, poor nutrition levels, discrimination, violence, exploitation and abuse.

While the COVID-19 pandemic is yet to reach its peak in the LAC region, overstretched public health services are expected to be challenged over the coming months. Availability of hygiene items and personal protective equipment is a challenge for people on the move, as well as response actors. In these conditions, unimpeded access by refugees and migrants, many of which are already in very vulnerable situations, to health and sanitary facilities will be key, also for containing the virus.

Indirect impacts on people and systems

In a region characterized by high levels of informal labour, the implementation of movement restrictions has had a disproportionately grave impact on refugees and migrants.

Unable to cover regular basic needs such as shelter, food, sanitary and healthcare, and equally unable to comply with quarantine measures and physical distancing, an increasing number of Venezuelans is left with no alternative but to consider returning to Venezuela in an unregulated and potentially dangerous manner that poses significant protection and health risks for the region.

Amongst those most at-risk are persons with pre-existing chronic illnesses and specific needs (children, elderly, 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 has been exacerbated, impacting especially women and children in violent households. With schools and universities closed across the region, education of children and youth is of rising concern as many refugees and migrants have limited capacities to access on-line schooling and other forms of education available for nationals.

Response priorities

The R4V Platforms are co-led by UNHCR and IOM, with a range of different agencies and organizations co-leading thematic sectors and working groups 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 is to complement governments' responses in the region, through the Regional Refugee and Migrant Response Plan (RMRP) for Refugees and Migrants from Venezuela. The R4V Platform will continue to collaborate with other coordination mechanisms in place, as foreseen in the Global Humanitarian Response Plan, and as reconfirmed with the regional OCHA office. Most crucially, the Regional Inter Agency Coordination Platform (R4V) continues to advocate for full inclusion of refugees and migrants in the national COVID-19 responses of the 17 countries covered by the R4V response. As part of its emergency response to the COVID-19 pandemic, a review of the Regional Refugee and Migrant Response Plan (RMRP) has been undertaken, taking into account COVID-19-related needs and priorities of host governments. The key focus of this exercise has been on responding to refugees' and migrants' particular needs in the areas of Health, Protection, Shelter, WASH, Nutrition, Food, and Livelihoods and Integration.

Reflective of the rapid reprioritization of the 151 RMRP partners' activities, the COVID-19-related review of the regional inter-agency response plan has resulted in a notable 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, many R4V partners plan to deliver life-saving activities and COVID-19 prevention activities, with adapted, largely remote, response modalities. Some of the specific COVID-19-related responses include e.g. 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, focused provision of technical support to authorities to enhance their capacities to the COVID-19 pandemic; establishment of early warning systems and rapid response mechanisms to contain the spread of COVID-19 among refugees and migrants; and enhanced monitoring and analysis of the impact of COVID-19 on refugees and migrants.

* The table reflects full revision of the RMRP. As a result of the reprioritization and identification of additional requirement, the original total budget of USD 1.35 billion increased to USD 1.4 billion

Annex C

Country and regional plans: Other plans

56 Rohingya Crisis

57 DPR Korea

Rohingya Crisis JRP

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$117.2M

OF WHICH:

HEALTH: \$71.8 M

NON-HEALTH: \$45.3 M

Targeted population

860,000 Rohingya refugees and 444,000 Bangladeshi host communities

Impact of COVID-19

Immediate health impacts on people and systems

Cox's Bazar District is at extreme risk of severe impact from COVID-19, given congested conditions in the refugee camps, high levels of vulnerabilities among the refugee and Bangladeshi populations, and the near total lack of intensive care and public health capacity. In line with wider efforts of the Government of Bangladesh, humanitarian partners in Cox's Bazar are working to prepare and respond to an outbreak of COVID-19 and its wider impacts. Limitations on movement, the grounding of aviation and closing of borders, have impacted the availability of surge staff and supplies, severely constraining the humanitarian response and the safety of staff.

Some 860,000 Rohingya refugees currently reside in 34 highly congested camps in Cox's Bazar district. The District is one of the poorest in the country, home to 2.65 million Bangladeshis. To reduce transmission of the virus to the camps and surrounding communities, the Government has halted all but critical services in the settlements. Authorized services are in health, nutrition, food and fuel distribution, hygiene, water and sanitation, construction of health facilities and additional WASH infrastructure, identification of new arrivals/quarantine and family tracing. Services that are temporarily closed include educational facilities, women and child friendly spaces, training facilities, registration, and markets.

Indirect impacts on people and systems

The impact on livelihoods is considerable; the District Administration predicts that more than 700,000 people in Cox's Bazar district will be immediately jobless due to the movement restrictions. This loss of livelihoods coupled with decreased access to local markets will result in extra needs for Bangladeshis in the district. In addition, the social impact of the outbreak could deepen inequalities. In Cox's Bazar, relations between refugee and host communities were already fragile before the pandemic. Emergency provisions enacted to curtail the spread of COVID-19 must conform to human rights standards, and avoid disproportionately affecting key populations, leading to discrimination and potential for conflict. Women and girls are likely to be disproportionately impacted due to restrictive gender norms. People with disabilities or chronic illnesses, and the elderly (4% of the Rohingya population are over 60) are at high risk. The prevalence of respiratory illnesses combined with underlying factors such as malnutrition and other undiagnosed diseases could increase the impact of an outbreak in the camps.

Response priorities and challenges

Priorities and early achievements

JRP partners are working with the Government and refugee communities to slow the spread of COVID-19 in Cox's Bazar District. In line with the Bangladesh Country Preparedness and Response Plan (CPRP), measures are being taken to support a national suppression strategy designed to break transmission at community level and buy time to prepare health facilities. Densely populated areas, such as camps and other settlements in the District, present a challenge, since physical distancing and other containment strategies used in higher income settings cannot be implemented in the same way. Tailored approaches are being applied instead. Partners have already ramped up prevention activities, including raising awareness in multiple languages. Educational facilities in camps were closed in line with the national policy to suspend schools. Distribution of soap continues as well as installation of additional hand washing facilities.

Challenges and impact to operations

The refugee population is entirely reliant on humanitarian assistance. Movements of humanitarian workers to the camps have been limited to decrease the risk of infection among the refugee population. Restrictions to supply chain and travel imposes a scaling back of the response, and decisions are being taken on which interventions should be prioritized in these circumstances. Challenges lie ahead due to the monsoon and retaining key activities to mitigate these risks in the coming months.

Construction of new Severe Acute Respiratory Infection Isolation and Treatment Centres (SARI ITCs) has been initiated and quarantine sites are being identified. SARI ITCs are planned based on staffing and equipment capacity rather than on anticipated need: current modelling of the likely trajectory of the epidemic indicates that needs will far outstrip availability. There are currently only two ICU beds at the Cox's Bazar Sadar Hospital. In addition to scaling up the refugee and host community health response, the humanitarian community must establish new medical facilities to serve thousands of staff and frontline health workers.

Coordination

The 2020 inter-agency Joint Response Plan (JRP) remains the core document for enhanced coordination, laying the foundations for more targeted and efficient delivery of the COVID response. A total of 117 partners contribute to the JRP. A COVID-19 Response Plan is being developed, that will include revised additional COVID-19 needs and priority 2020 JRP requirements adjusted to COVID-19 response. Through the Inter-Sector Coordination Group (ISCG), the humanitarian community works closely with the Government of Bangladesh and district health authorities.

* Preliminary priority response for COVID-19 in four priority sectors - Health, Food, WASH and Communications with Communities - for April-September 2020 (6 months). Revised new COVID-19 related requirements, plus total 2020 JRP requirement adjusted to COVID response, will be presented in the June GHRP update.

Democratic People's Republic of Korea Other

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$39.7M

OF WHICH:

HEALTH: \$19.7 M
NON-HEALTH: \$20.0 M

TOTAL HUMANITARIAN REQUIREMENTS

REQUIREMENTS

\$146.7M

OF WHICH:

COVID-19: \$39.7 M
NON-COVID-19: \$107.0 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 17 April, there were no confirmed cases of COVID-19 in DPRK, as some 740 people have been tested and found negative. Borders remain closed and an inbound/outbound travel ban is in place, while quarantine measures for international staff were lifted after 1 March, albeit expatriates are only allowed limited movement within Pyongyang. The Government has been systematically detecting, testing, and putting in place measures to prevent the importation/transmission of COVID-19 cases. However, the scope and testing capacity is unclear.

Vulnerable groups are exposed to exacerbated needs as the focus is on COVID-19. For example, some 38,000 tuberculosis patients and 10,000 children may not receive treatment; 36,000 children under 1 year may not receive routine immunizations and 300,000 pregnant women and an equal number of lactating mothers may not receive adequate pre- and post-natal care as a consequence of the ongoing travel restrictions that has prevented the shipment of medicines, vaccines and other medical supplies into DPRK.

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 health-care providers.

Children are among the most vulnerable to all aspects of need in the DPRK. Nearly one in 10 children under the age of five is underweight and nearly one in five children is stunted. Additionally, maternal health has been identified as a priority for intervention due to increased vulnerability toward and immediately after maternity.

Indirect impacts on people and systems

Containment measures adopted by the Government, such as long quarantines that affected more than 25,000 people as well as cargo, the closure of border and travel restrictions within the country will negatively affect the economy.

Food security was a key focus prior to containment measures, this has been augmented by the uncertainty during the current two agricultural planting seasons, especially the main crop season began March/April. Challenges include ensuring the availability of super-seeds and restriction on internal movement, risking a low yield during the harvest period. This may result in a decline in food consumption and lack of access to sufficient kinds of food and quantities, reduced availability of essential agricultural inputs, and negative coping strategies. Moreover, the prioritization of the Public Distribution System (PDS), a major source of food for many, and other impediments are likely to adversely impact the vulnerable groups, mainly rural farming communities.

A proportion of food staples arrive through import from China; the closure of borders since February and the ensuing reduction in imported supply may exacerbate the food security gap.

Schooling continues to be suspended, with no alternative education options or nutritional support for children; for example, 101,000 kindergarten children and some 10,000 children in boarding schools will be provided with fortified foods; around 45,000 acutely malnourished children will not receive treatment.

Response priorities and challenges

Priorities and early achievements

The Health Sector Working Group, in dialogue with the Ministry of Public Health, is developing a draft strategic operational plan to support country preparedness and response for COVID-19 (CSPRP). Meanwhile on-going health sector humanitarian interventions are being extended based on the pre-positioning of essential medicines and those in the pipeline that are expected to arrive in a couple of weeks. The plan aims to limit human-to-human transmission; identify and reduce transmission from animal sources, communicate critical risk and minimize socio-economic impacts of the pandemic.

As part of the initial response, humanitarian capacities and supplies in-country were redirected, including protective gear, diagnostic capabilities for other diseases and basic medication. WHO has regularly provided guidance to the Government while the IFRC has trained volunteers in COVID-19 epidemic control. Initial shipments of COVID-19 items, including PPEs from UNICEF and MSF have arrived in Pyongyang and disbursed to health facilities.

Challenges and impact to operations

Strict measures at port of entry for supplies remain while naval entry has begun at a reduced rate, allowing prioritized shipments to be released after a 14-day quarantine in DPRK. However, the inability to bring in supplies and staff into the country, or to move internally have already affected delivery of services, for example:

- **Health:** Most supplies in country are expected to run out by or through the second quarter of 2020, including vaccines and medical supplies.
- **Food Security:** Among other projects, the implementation of a CERF project to replant vegetable crops in typhoon-affected areas has been delayed due to restrictions.
- **Nutrition:** The last WFP distribution of nutrition support took place in January. Local production of fortified foods (cereals and biscuits) is on hold, pending the opening of nurseries, kindergarten, etc. dependent on the lifting of COVID-19 measures
- **WASH:** Regular programme implementation is on hold except ongoing/continuing water supply and sanitation projects from 2019 for which supplies were already delivered. Some 89,500 people are unlikely to have their water supply systems restored after being damaged by Tropical Cyclone Lingling.

A Risk Assessment will be carried out by the country team and mitigating measures developed to contend with the COVID-19 environment challenges. Funding availability is crucial for the implementation of this plan.

* COVID-19 requirements: \$39.69 million in addition to 2020 Needs and Priorities Requirements.

Annex C

Country and regional plans: New plans

- 59 Benin
- 60 Iran
- 61 Lebanon
- 62 Liberia
- 63 Mozambique
- 64 Pakistan
- 65 Philippines
- 66 Sierra Leone
- 67 Togo

Benin New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$17.2M

OF WHICH:

HEALTH: \$10.9 M

NON-HEALTH: \$6.3 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 28 April, 69 COVID-19 cases were confirmed, including 33 recovered and 2 deaths. The cases are in Cotonou, Abomey-Calavi, Porto-Novo in the south, Savalou and Abomey in the Center, Natitingou, Malanville, Banikoara and Bembereke in the north, with most cases concentrated in Cotonou and Abomey-Calavi. Benin is not yet in the stage of extensive community transmission; however, risk is high given the presence of cases in various areas countrywide.

Benin's health system is fragile. By triggering the COVID-19 Response Plan, some health services, personnel and resources, mainly preventative and routine, have been diverted. Some 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.

Financing of health system is inadequate, which is constraining the implementation of prevention and response measures. The budget of the current national response plan is built around 9 pillars and amounts to \$75 million for the immediate response needs, and \$300 million for mid and long-term needs. So far, the immediate response plan is 20% covered. The Government launched appeals to mobilize additional resources for an adequate response to meet the challenge.

Indirect impacts on people and systems

The Government's response measures to counter the spread of COVID-19, added to the prolonged border closure with Nigeria is affecting economic activity with growth projected to decrease by 3.2% in 2020. The global demand slump resulting from containment and lockdown policies, with the disruption of supply chains, is affecting economic activity and may see a rise in job losses, underemployment and losses in revenues. 92% of the population works in the informal sector and the harshest hit would be women and people with disabilities. 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.

Schools closure could impact over 3.2 million children and the disruption of public transport impacts on a large number of vulnerable people. This situation calls for adjustments to be made so as not to deteriorate SDG achievements already recorded.

Households could suffer from food shortages and rise in food and basic goods prices. The risk of decrease in agricultural production will amplify food insecurity and the nutritional crisis for the most vulnerable. Food insecurity estimated at 8,32% before the 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, adolescent girls are at risk of dropping out of school, increasing their exposure to child marriage, while women are at increased risk of GBV.

Response priorities and challenges

Priorities and early achievements

Constituting an integrated response to support 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 resources mobilization for the country. This includes: the development of the health contingency plan; 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.

For Benin not to lose gains towards achieving the SDG targets, the response plan was coordinated through joint approach. It has focused on supporting Risk communication & community engagement including innovative digital engagement and rumors monitoring, supporting allocation of supplies (needed medicines, therapeutics, respirators, oxygen extractors) 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 15000 beneficiaries in the most affected communes and livelihoods response as well as providing WASH services and support for the informal sector and vulnerable population.

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, especially Emergency Treatment Unit, and laboratory capacity to confirm the diagnostic. To date, there is no yet Emergency Operations Center to centralize, analyze data and publish reports. 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 put the country's response system to scale.

* A total of \$17.2 million is required for the COVID-19 response.

Iran New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$89.5M

OF WHICH:

HEALTH: \$64.4 M

NON-HEALTH: \$25.1 M

Impact of COVID-19

Immediate health impacts on people and systems

Iran is the eighth most COVID-19 affected country globally. The first case was detected on 19 February, and as of 26 April there are 92,584 cases, with 5,877 deaths reported. All 31 provinces are affected. Screening facilities are installed at airports, rail-ways, bus terminals and city entry points staffed by over 5,000 volunteers of the Iranian Red Crescent Society resulting in more than 58 million people screened at end-March.

The Iran health response guided by the national COVID-19 Plan includes:

- As of 09 April, 15,000 tests carried out daily in 56 laboratories, aiming at 20,000 tests daily; in total 421,313 tests have been carried out so far;
- Temporary recovery settings and quarantine units for released patients unable to return home;
- Triage, early detection and contact tracing;
- Armed forces in the COVID-19 response;
- Self-assessment app linked to health information systems for users to self-screen symptoms and receive steps for follow-up.

Indirect impacts on people and systems

The country continues its measures against COVID-19 with the 'smart social distancing plan', implemented on 11 April, allowing medium and low-risk businesses to resume to work. Government offices continue their work with two-thirds of staff present at the workplace. Schools and universities remain closed; religious gatherings, cultural activities, public events are cancelled. Most international flights are suspended.

The Iranian economy is significantly based on oil production which has slowed considerably and will be impacted further by the recent crash of the global oil price. The service sectors are hit hard, impacting casual labourers and low-income families. An estimated 5-10 percent decline in GDP is expected which may push another 500,000 people into unemployment. A relief package worth USD 35 billion was introduced to target businesses and households for 3 months. The economic effects if left uncompensated will lead to lost consumer and investor confidence, weaker aggregate demand, rising debt, widespread insolvency, asset price deflation, and worsening income distribution causing further recession.

There are 4.5 million households considered poor, among them 1.5 million unemployed and 3 million self-employed, semi-skilled, unskilled and temporary workers. The most vulnerable groups are elderly, individuals with unstable sources of income with specific needs or poor health status, particularly female headed households, people living with HIV, pregnant women, children with disabilities, children without caregivers, people in prisons,

and refugees living in crowded settings. High levels of flooding and the ongoing locust invasion is further stretching coping capacities of farmers and vulnerable populations.

Given the economic impact of COVID-19, and the high mobility of people across the Iran-Afghanistan border, increased population movements are expected as people leave their place of residence looking for economic opportunities increasing the risk of virus spread. There are some 1 million Afghan refugees and an estimated 1.5 to 2 million undocumented Afghans.

Response priorities and challenges

Priorities and early achievements

In support of the Government, the response from the UN and international community focuses on: global procurement and supply chain delivering items to people most at-risk; risk communication and behaviour change; deploying technical experts; supporting refugee populations in settlements with hygiene items; and ensuring continuous health insurance coverage for vulnerable people akin to nationals.

The UN Resident Coordinator leads the Crisis Management Team (CMT) and the Country Preparedness and Response Plan (CPRP) as the main coordination mechanism for the COVID-19 response with critical support from Security, Operations and Communications teams. UN partners are working with national authorities to set up a shock resistant social protection mechanism to account for the indirect impacts of the crisis.

The Government has maintained a generous approach towards access of refugees and undocumented populations to primary health care. Cash and food distribution to 31,000 most vulnerable refugees in 20 settlements continues uninterrupted through WFP-led programmes, IOM continue to provide returning migrants with in-kind assistance packages, and UNDP work to articulate a 'Rapid Socio-Economic Relief Initiative Against COVID-19', targeting micro and small-sized enterprises and vulnerable households.

Challenges and impact to operations

Iran is a middle-income country prone to natural disasters (floods, earthquakes, drought and locust invasion). Protection concerns have increased for the already vulnerable refugees and non-registered immigrants in need of humanitarian assistance. The scarcity of global production and supply, travel restrictions and sanctions pose a great challenge for humanitarian operations. Investment in supplies needs to be matched by adequate investment in risk communication and community engagement. Otherwise, the number of affected people will increase, overload and disrupt the health system and may result in collapse. Critical gaps include: risk communication and community engagement; scaling up early detection, testing capacity and contact tracing; shortages of ICU equipment and other essential medical supplies.

* A total of \$89.5 million is required for the COVID-19 response in Iran.

Lebanon New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$70.7M

OF WHICH:

HEALTH: \$30.5 M

NON-HEALTH: \$40.2 M

Impact of COVID-19

Immediate health impacts on people and systems

Since the first confirmed case in Lebanon on 21 February, 667 confirmed cases have been reported, with 108 recoveries and 21 deaths, as of 21 April. The trend of confirmed cases has now levelled to under ten-a-day.

Rafik Hariri University Hospital remains the only public hospital available to screen, test and admit COVID-19 infected patients. The facility has sufficient COVID-19 kits to manage suspected cases with support from the Ministry of Public Health for analysis of epidemiological data.

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. Basic services are mainly provided through the private sector, and public services are under-financed and overstretched.

On 22 April, the first COVID-19 cases were reportedly confirmed in a Palestine refugee camp. Two other cases were confirmed of a Palestine and a Syrian refugee living outside camp settings.

Subsidized primary healthcare is available to Syrian refugees and vulnerable Lebanese. Primary healthcare is also available to Palestine refugees through UNRWA health clinics. Secondary healthcare in Lebanon is expensive and mostly private.

Indirect impacts on people and systems

COVID-19 comes as Lebanon experiences an unprecedented socio-economic crisis. Despite high levels of human development, almost 30 per cent of the population was living below the national poverty line. Prior to the COVID-19 outbreak, poverty levels were already projected to reach 52 per cent, with a doubling of extreme (food) poverty from 10 percent to 20 percent in 2020, translating into approximately 1.5 million people falling under the poverty line, of which 760,000 people would fall under the food poverty line. A crippling liquidity crisis has reduced purchasing power of already vulnerable people.

Limited domestic production is a major challenge. Lebanon is heavily dependent on imports with an open border with Syria and the airports and seaports for food and other items, including medical supplies. Restriction of movement, public administration and municipal measures have decreased access to essential services. Health centres may present a flashpoint for increased inter-communal tensions.

Protection needs are expected to increase for women and girls, refugees and migrants (including domestic workers), people with disabilities, older people and other vulnerable groups.

Response priorities and challenges

Priorities and early achievements

In support of the Government of Lebanon, the UN Resident Coordinator and Humanitarian Coordinator ad interim developed a Lebanon Emergency Appeal with humanitarian partners. The appeal 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. Adjustments to the plan will be made as the situation evolves.

The plan brings together activities in the COVID-19 Country Preparedness Response Plan (CPRP) for Lebanon, the 2020 Lebanon Crisis Response Plan (LCRP), and new relief activities to mitigate the impact of the economic crisis and COVID-19 and the containment measures on communities that previously did not receive humanitarian assistance. It is premised on the principle of a single health response for all people in need in Lebanon.

Four key priority workstreams requiring immediate attention are identified in the three-month plan:

- **Priority 1 (WHO lead):** Supporting the preparedness and response capacity of the Lebanese health system in coping with the COVID-19 emergency
- **Priority 2 (UNICEF lead):** Strengthening the engagement of and communication with communities, supporting good hygiene practices and ensuring COVID-19 specific support services
- **Priority 3 (UNHCR and UNDP co-lead):** Ensure uninterrupted delivery of critical assistance and services to the most vulnerable communities affected by the Syria crisis, including refugees and host communities, as foreseen in the LCRP Business Continuity Plan
- **Priority 4 (WFP and UNRWA co-leads):** Expand support to vulnerable population groups not included in the LCRP, in need of humanitarian assistance due to the combined socio-economic impact of the economic and banking crisis and COVID-19.

Challenges and impact to operations

A key challenge is safeguarding critical operations and identifying ones that must continue during the containment and community transmission phase. Select challenges include:

- Over 200,000 jobs have been temporarily or permanently lost, and many more are likely being pushed into the informal sector.
- Significant data gaps for vulnerable Lebanese and lack of coordinated countrywide multi-sector needs assessment.
- A need to regularly review operational modalities and the ability to adjust with availability of flexible funding from donors.
- Increased mental health needs among staff and community.

* A total of \$70.7 million is required for the COVID-19 response in Lebanon.

Liberia New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$57.0M

OF WHICH:

HEALTH: \$17.5 M

NON-HEALTH: \$39.5 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 27 April, Liberia had recorded 141 COVID-19 cases, including 16 deaths, with a CFR of 11 percent. Montserrado county (incl. Monrovia) is at the epicentre of the pandemic, with 91 percent of cases, most occurring in overcrowded areas. Health workers continue to be infected, totalling 32 percent of the current cases. The risk of local transmission remains high, accounting for 95 percent of confirmed cases amid difficulties in complying with physical distancing measures in hotspot communities.

The impact on the healthcare system is substantial with increased efforts towards curbing the risk of rising maternal and neo natal mortality rates. Stigma and fear linger on COVID-19 and health services among communities hampered by the diversion of staff and resources, service reduction and infection of health workers. Liberia presents highest levels of net imports of medicinal and pharmaceutical products and lowest levels of physicians (0.037/1000 population) and hospital beds (0.8/1000 population). These will negatively impact critical health programmes, worsening mortality rates of other diseases as witnessed during the EVD outbreak. Reduced child immunization services in an already under-vaccinated population is of significant concern. Insufficient skilled personnel leave rural facilities without enough staff to care for pregnant women and new-borns, provide HIV-related and essential reproductive health services.

Indirect impacts on people and systems

The pandemic will exacerbate pre-existing vulnerabilities in a country where half the population lives below the poverty line with an already low economic growth rate of 1.4 percent in 2019. Liberia imports 81 percent of its food requirements. Only 11 percent of food is sourced from local production. Prices are expected to continue rising as the country struggles with an inflation that remained high at 20.2 percent at the end of 2019 and further increased to 25.8 percent in February 2020, putting the most vulnerable at-risk. Chronic malnutrition remains widespread where at least 35.5 percent of children under 5 is stunted.

With the heightened economic hardships coupled with the state of emergency imposing country-wide movement restrictions and closure of non-essential businesses, women and children are at heightened risks of SGBV and other forms of violence. Building upon the EVD experience and regional trends, 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 percent) is posing additional challenges to the response due to low WASH facilities and services with less than 1 percent of the population with basic handwashing facilities at home and 97 percent with no handwashing facility.

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 people with disability. The COVID-19 crisis is likely to have a significant impact on the ability of affected populations to earn a minimum income for subsistence with consequent rising levels of food insecurity expected, 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) to drive the response under the leadership of the Minister of Health supported by the national COVID-19 response coordinator. 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). IMS has been activated in most counties with county-level preparedness and response plans; acceleration of risk communication and community engagement including a hand-washing countrywide campaign, data analysis and Infection Prevention and Control, country-wide surge capacity for case management are ongoing.

The humanitarian community is working with the Government to address challenges amid COVID-19 through changing of modalities for intervention to reach those most in need and repurposing of existing funding in response to the pandemic. Some activities in the response will include: emergency social interventions through in-kind food and cash-based transfer modalities; provision of assets and tools to increase agriculture and livestock production; continuation of essential live-saving interventions; capacity strengthening of health and social welfare personnel; and supply chain services. Around 140,000 beneficiaries will be assisted through emergency food distribution and cash-based transfers.

Challenges and impact to operations

The major challenges to the response are inadequate funding for the planned preparedness and response activities and challenges in supply and logistics. The disruption of global supply chains, border closures and restrictions on commercial transport will further undermine the country's capacity to supply, store and transport goods to hard-to-access and remote counties. This will be further exacerbated by Liberia's poor road infrastructure to be further challenged by 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.

* A total of \$57 million is required for the COVID-19 response in Liberia.

Mozambique New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$68.2M

OF WHICH:

HEALTH: \$16.0 M

NON-HEALTH: \$52.2 M

Impact of COVID-19

Immediate health impacts on people and systems

The first case of COVID-19 was reported in Mozambique on 22 March 2020. By 30 April 2020, 76 people were confirmed to have COVID-19. The country's capital, Maputo, and the provincial capital of Cabo Delgado, Pemba, are the epicenters of the outbreak in Mozambique.

COVID-19 is expected to heighten the risks of people living with co-morbidities and in challenging living conditions. There are 1.3 million older people in Mozambique, 5 per cent of the population. About 16 percent of women over 60 years of age live alone, increasing their risk of exposure.²⁰ Over 2.3 million people in Mozambique are living with HIV (Prevalence 12.4%), and an estimated 162,000 people are living with TB, of whom 58,000 also have HIV. People living with immunocompromised conditions have poor access to health services, with 50 per cent of the population living more than 20 kilometers from the nearest health facility.²¹ Following Cyclones Idai and Kenneth in 2019, over 100,000 people are still displaced in 76 sites across six provinces. In Cabo Delgado, over 162,000 people have been affected by insecurity, most of whom are living in overcrowded conditions in host communities. Displaced people living in camps, camp like settings, resettlement sites or host communities, are all at heightened risk as their right to information, access to healthcare, hygiene, protection services and livelihoods are constrained.

Prior to COVID-19, multiple disease outbreaks -including cholera and malaria- were already stretching Mozambique's weak health systems and 94 health centers were damaged during the cyclones. IDPs in Cabo Delgado face significant challenges to accessing primary health care. Critical services -such as sexual and reproductive healthcare, immunization activities and continuity of care for HIV, tuberculosis, malaria and cholera- are expected to be disrupted as resources shift to the COVID-19 response, potentially increasing maternal and infant deaths.

Indirect impacts on people and systems

COVID-19 arrived in Mozambique at a time when humanitarian needs were already rising due to consecutive climatic shocks in multiple parts of the country and growing insecurity in Cabo Delgado. Drought, cyclones, floods and violence over the past year have left at least 2.5 million people in urgent need of humanitarian assistance across the country.

The destruction caused by back-to-back disasters and now COVID-19 is escalating an already alarming food security situation and exhausting families' coping capacities. Prior to COVID-19, an estimated 2 million people were projected to be severely food insecure across Mozambique. Households have not yet recovered from the devastation caused by Cyclones Idai and Kenneth that affected over 770,000 hectares of staple crops. At the same time, global disruptions in trade will affect food supply, resulting in lower production, higher import costs and increased prices of food in the markets. Households are likely to exhaust what little savings they had and resort to negative coping mechanisms, including increasing child marriage and transactional sex. Studies have shown that,

following pandemics, there is a decrease in children that return to education and an increased risk of childhood labour and early child marriage. Those with limited mobility, particularly older persons and people with disabilities, are at increased risk from COVID-19 and may face further barriers to accessing life-saving services due to movement restrictions.

Following the country-wide closure of schools on 23 March, 235,000 children are no longer accessing critical school feeding programmes and malnutrition is expected to worsen in the period ahead. An estimated 67,500 children will require treatment for malnutrition in the next nine months. Currently, more than 3,000 children under five are being treated for severe acute malnutrition (SAM) and there have been over 4,000 cases of pellagra (vitamin B3 deficiency) recorded since May 2019.

Response priorities and challenges

Priorities and early achievements

The Humanitarian Country Team in Mozambique has developed an Emergency Appeal for the COVID-19 response, which incorporates both the public health response and action to tackle the most urgent secondary consequences and targets 2.5 million people out of 7.8 million in need. The appeal complements the Government of Mozambique's (GoM) National Plan for Preparedness and Response to COVID-19, which calls for US\$28 million for the public health response, and the Government's Multi-Sectoral Preparedness and Response Plan.

Humanitarian partners are ramping-up their support to the Government-led response. Through HCT partners, all provincial capitals have established isolation centers and training of rapid response teams have been given at provincial level. Partners also supported prioritization of risky Points of Entry. In the Solidarity Flight that landed in Maputo on 18 April, the Jack Ma Donation provided vital equipment for the COVID-19 response, including: 18,900 swabs and viral transport medium, 18,912 extraction kits, 3800 PPE, 3800 face shields and 10 ventilators. Partners are advocating with Organizations of People with Disabilities to ensure participation and inclusion of disability issues into COVID-19 preparedness and response. Partners are also working with the Ministry of Education and Human Development to mitigate the impact of the epidemic on children's education.

Challenges and impact to operations

There are gaps in reagents for testing for COVID-19 and availability of personal protective equipment (PPE). There is a need to strengthen contact tracing and to increase risk communication to create awareness about COVID-19 at all levels and counteract stigma. At the same time, essential service systems -including for health, nutrition and WASH- were already strained pre-COVID-19 and will struggle to cope with additional pressures. Life-saving care and support to GBV survivors, and sexual and reproductive healthcare, in particular may be disrupted. The cost of maintaining humanitarian assistance -especially food and livelihoods- will likely increase due to COVID-related containment measures.

²⁰ www.helpage.org/where-we-work/africa/mozambique

²¹ www.who.int/countries/moz/areas/tuberculosis/en/index1.html and

https://extranet.who.int/sree/Reports?op=Replet&name=/WHO_HQ_Reports/G2/PROD/EXT/TBCountryProfile&ISO2=MZ&outtype=html

* The Emergency Appeal requires \$68.2 million.

Pakistan New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$126.8M

OF WHICH:

HEALTH: \$29.2 M

NON-HEALTH: \$97.6 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 29 April, over 14,885 people had been infected with COVID-19 in Pakistan, with 327 deaths. Cases have been reported in 115 out of 158 districts. According to the National Institute of Health, the most affected age group ranges from 20 to 49 year (53%). The predictive analysis of expected cases indicate that there may be over 196,000 COVID-19 cases in Pakistan, with 15 per cent becoming moderate to severely ill and 5 per cent becoming critical and requiring ventilators. Currently, there are 52 laboratories in Pakistan with testing capacity for 15,500 people per day. With such limited facilities, most cases are at risk of being undetected.

The biggest humanitarian need is the protection of health workers to ensure they can combat the pandemic and continue to provide essential health care services. The closure of all hospitals and health facilities, except for emergency services, has hampered the continuation of immunizations, preventive health care, pre- and post-natal care and care for other co-morbidities.

Nutrition programmes have suffered due to the outbreak, leaving over 200,000 pregnant and lactating women and 400,000 children among the most vulnerable in need of regular nutrition support in drought affected areas.

Pakistan is the fifth most populous country in the world with 220 million people and the seventh most affected on the list of countries impacted by climate change. The most vulnerable populations expected to be disproportionately affected by the health and non-health impacts of COVID-19 total 6.65 million people which include Afghan refugees, IDPs and returnees, undocumented Afghans and people affected by natural disasters. The pre-existing vulnerabilities of such groups are further aggravated by related stressors, including family anxieties and the disruption of income generation due to physical distancing.

Indirect impacts on people and systems

Containment measures and movement restrictions are devastating the economy. Estimates indicate that Gross Domestic Product (GDP) will drop by 4.64 per cent, followed by a subsequent increase in the number people living below the poverty from 50-60 million to 125 million.

A quarter of the population, some 53 million people, lives below the national poverty line and 84 million people are multi-dimensionally poor. An estimated 40-62 million people are persistently and chronically vulnerable to food insecurity while also being exposed to natural hazards. These populations are at risk of falling into increased food insecurity requiring a scaled-up response by humanitarian partners through both in-kind and cash modalities.

Women and children from the disadvantaged households, home-based workers, domestic workers, daily wage earners (small shops, self-employed persons and families) and especially pregnant women, are among the most impacted during this pandemic.

All educational facilities will remain closed until at least the end of May 2020, resulting in major disruptions to learning.

Response priorities and challenges

Priorities and early achievements

Through COVID-19 National Action Plan, the Government is taking a two-pronged strategy: prioritizing efforts to contain and mitigate the spread of the virus and address the secondary humanitarian and socio-economic impacts, which is linked to the HCT's integrated Humanitarian Response Plan to address the humanitarian impact of COVID-19 on the most vulnerable. The plan aims to target 5.6 million people through to the end of the year.

The UN health response has been aligned with the pillars of the WHO's Strategic Preparedness and Response Plan. Examples of activities include:

- Developed and shared information, education and communication material (IEC) material on physical distancing and orientation guidelines for frontline workers in local languages in all provinces.
- Collaborating with the Polio Eradication Initiative (PEI) 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 programs.
- Development of an Infection Prevention and Control (IPC) strategy that includes the training of over 10,000 health workers, provision of materials and other supplies and conducting IPC assessments at over 200 health facilities and quarantine sites.

Challenges and impact to operations

Nationally led health responses have suffered from several challenges: isolation and quarantine facilities are inadequate in number and they lack human resources, technical expertise, supplies and equipment.

The disease surveillance system is weak; e.g. the Severe Acute Respiratory Illness/ Influenza Like Illness (SARI/ILI) sentinel surveillance, which could be used in this pandemic, is not fully functional. Sexual and reproductive health service delivery is expected to be severely impacted, contributing to a rise in maternal and newborn mortality,

From a humanitarian standpoint, the COVID-19 response is taking place in the context of climate vulnerabilities and a refugee response: a series of climatic shocks combined to make those already facing social exclusion and vulnerability due to poverty and displacement, more acutely vulnerable to the virus and its impacts.

* A total of \$126 million is required for the COVID-19 response in Pakistan.

Philippines New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$96.2M

OF WHICH:

HEALTH: \$23.2 M

NON-HEALTH: \$73.0 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 29 April, a total of 8,212 confirmed COVID-19 cases including 558 deaths have been reported in the Philippines. Almost 65 per cent of deaths had one or more comorbidities, like diabetes, hypertension, or cardiac disease. Out of the total confirmed cases, 54 per cent are male, with the most affected age group being 30-39 years.

As a lower middle-income country, the Philippines exemplifies the challenges of a health system in transition. The COVID-19 epidemic is adding strain to an already overwhelmed health system in a country with ongoing measles, dengue and polio outbreaks. Responding to COVID-19 may also divert attention and resources for sexual and reproductive health services. Shortages of PPE, ventilators, testing supplies, intensive care and other critical equipment is affecting the ability of health facilities to treat COVID-19 patients. Some hospitals in the National Capital Region have stopped accepting patients as they reached full capacity and/or were unable to provide adequate protection for their staff. The infection rate among healthcare workers - around 13 per cent of total confirmed cases in country - is among the highest in Asia Pacific.

The risk 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 restrictions between Mindanao and Metro Manila.

Stringent physical distancing measures and community quarantine have affected polio outbreak response activities and vaccination campaigns are being postponed. There are concerns that at least two million children below two years old might not be protected from vaccine preventable diseases this year.

Indirect impacts on people and systems

The Government has adopted enhanced community quarantine and physical distancing measures including the suspension of schooling, prohibition of mass gatherings, home-isolation whereby movement is limited only to access basic necessities, travel restrictions and a curfew.

According to the Central Bank of the Philippines economic growth is forecasted to decline from 6 per cent in 2019 to between zero and minus one per cent in 2020. More than two million workers have been affected, mainly by temporary closures of establishments, such as manufacturing, hotel, food and other tourism-related sectors. These numbers do not include the substantial number of workers in the informal sector, particularly affecting women.

The home quarantine may cause a surge in domestic violence and the Commission on Human Rights has urged the Government to ensure GBV survivors can access legal aid and medical and psychological services.

Response priorities and challenges

Priorities and early achievements

Authorities moved quickly and with determination to halt the spread of the outbreak. The HCT COVID-19 Response Plan was mounted in support of government response efforts and targets 5 million of the most vulnerable people living in COVID-19 hotspot areas as well as those displaced in Mindanao that will require multi-sectoral humanitarian assistance.

The overall objective of the Plan is to support the government in containing the spread of the outbreak and deterioration of living conditions of those most vulnerable or at risk in affected areas. The response approach is to front-load humanitarian interventions in the first few months before transitioning in the early recovery mode until the end of the year. To ensure the realization of this nexus approach, HCT partners are mounting an inclusive and coordinated response plan, pulling together capacities of UN agencies, international/national NGOs as well as members of civil society, including the private sector.

The HCT COVID-19 response includes interventions to earthquake-affected people in North Cotabato and Davao del Sur and to conflict-affected population in Mindanao to address their specific needs due to the pandemic.

Challenges and impact to operations

Response operations will take place in the context of pre-existing vulnerabilities brought about by conflict and natural disasters. Conflict-affected IDPs, particularly in Mindanao, will remain most at-risk, given the cramped living conditions in transitory sites and limited access to water, WASH facilities and health-care. The 'peace dividend' from the 2019 creation of the Bangsamoro Autonomous Region of Muslim Mindanao (BARMM) may not be reaped if the COVID-19 outbreak makes the lives of Bangsamoro people worse, as it may trigger further violence and displacement. Further, the peace negotiation between the Government and the New People's Army remains fragile, despite their commitment to the COVID-19 cease-fire.

The Philippines is one of the most hazard-prone countries in the world. Averaging over 20 cyclones per year and a high likelihood of earthquakes and volcanic eruptions, it is likely that additional mid-scale disasters will occur in the coming months, compounding effects of the COVID-19 emergency.

Physical distancing has resulted in decrease or suspension of non-critical field missions and the suspension of several humanitarian activities due to restrictions on assemblies.

Movement restrictions provide challenges. In most cases, access to communities can be negotiated with individual local governments, particularly in areas where organizations have relief activities.

* A total of \$96.2 million is required for the COVID-19 response in Philippines.

Sierra Leone New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$60.5 M

OF WHICH:

HEALTH: \$16.8 M

NON-HEALTH: \$43.7 M

Impact of COVID-19

Immediate health impacts on people and systems

As of April 28, 104 cases of COVID-19 had been confirmed, more than 75% in the district that includes the capital of Freetown. WHO models estimate that 20 percent of the population may contract the virus, in the context of a severely constrained health system, despite new measures enacted following the 2014-2016 Ebola outbreak. With more than 47.7 percent of the population food insecure, one-third of children chronically malnourished, and 57 percent of the population living in poverty, the country is particularly vulnerable to shocks. Urgent actions are needed to contain the virus and mitigate negative impacts.

COVID-19 could overwhelm an already weak health system and reduce services for endemic health concerns such as malaria, tuberculosis, and malnutrition. Maternal and child mortality rates are among the highest worldwide, and there are only 3 physicians and 50 nurses/mid-wives for every 100,000 persons. The capacity and necessary medical equipment to manage severe acute respiratory illnesses due to COVID-19 is also extremely limited and the upcoming rainy season, often associated with an increase in respiratory illness may favour transmission. Sierra Leone's safe water supply is 58 percent.

Indirect impacts on people and systems

GDP could drop by minus 2.5 percent in 2020 due to serious disruptions in trade, tourism and services, sectors that comprise nearly 40 percent of GDP. Trade disruption will reduce the supply of food and essential commodities and increase inflation, already at an annual rate of 15.6 percent. Formal manufacturing and services jobs are virtually non-existent, leaving most people employed in the highly vulnerable informal sector. Market sellers rely on daily turnover to provide for their families, and most of them are women.

The agriculture sector, more than half of GDP, could face adverse shocks as movement restrictions limit crop cultivation. Both locally grown and imported rice had a 28 percent price increase from March 2019 to March 2020, while prices of other essential commodities were already increasing. More than 1.3 million people are estimated to be food insecure; with around 73,500 persons under Emergency category by June-August 2020.

School closures and lockdown measures raise education and protection concerns, particularly for women and girls who also due to socio-economic norms may not have access to services and decision-making. Without additional support to the health sector, maternal health services and nutrition support for children, pregnant and lactating women will be reduced. The already high rate of teen pregnancy, (30 percent bearing children by age 18), could increase if family planning services are not maintained, like during the Ebola outbreak. Migrant and mobile populations, people with disabilities, and urban slum dwellers are also highly vulnerable to social impacts.

Response priorities and challenges

Priorities and early achievements

With support from WHO, the Government developed a COVID-19 Prevention and Response Plan covering surveillance, laboratories, case management, communication, logistics, data management and security. Rapid activity scale-up is needed, including for regional case management trainings, test kit procurement, contact tracing and quarantine activities. Supplies are severely lacking for infection prevention and control and to equip laboratories and facilities being established as treatment centres.

There is also a socio-economic plan to assist vulnerable and affected populations, encompassing food security, livelihood support, psychosocial support, education, logistics and supply of critical goods and services. A national social safety net system is being developed to provide income to extremely poor households during economic disruptions. Food support would target locked-down communities and severely food insecure people through either in-kind food distribution or cash-based transfers.

Challenges and impact to operations

Although some of the response measures are already in place, capacity and equipment gaps in the health system should be addressed immediately. More training is needed to engage persons at the district level for surveillance and other activities. Personal protective equipment for health workers will need to be urgently procured and imported, 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 390,000 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 be revived so they are ready to implement when market and other conditions are met.

Curfews and travel restrictions could impact service delivery by humanitarian organizations; however, UN agencies have to-date arranged special passes allowing for program-related movement.

* A total of \$60.5 million is required for the COVID-19 response in Sierra Leone.

Togo New

COVID-19 REQUIREMENTS*

REQUIREMENTS

\$19.4M

OF WHICH:

HEALTH: \$3.3 M

NON-HEALTH: \$16.0 M

Impact of COVID-19

Immediate health impacts on people and systems

As of 29 April, 109 confirmed cases of COVID-19 were reported, including 7 health workers. Four regions are affected: Maritimes, 80%; Central, 18%; Plateaux, 1% and Savanes 1% with local transmission concerning 33% of cases. Free care and a toll-free number for infected people has been set up, but the common nature of symptoms and poor access to the mobile network hamper reporting and monitoring. Given limited health services, the redeployment of resources to manage COVID-19 will negatively impact on access of vulnerable groups (pregnant women, PLWHA, and populations with underlying health conditions) to adequate healthcare.

The national response to COVID-19 includes surveillance at points of entry, establishment of coordination mechanisms for crisis management, closure of borders (land, air and sea), and establishment of a care center for infected persons at the regional health center in the capital city Lome. Challenges however remain with only one approved functional treatment center, a single laboratory, lack of necessary PPEs and inadequate WASH facilities in health centers. Surveillance at the points of entry is also limited by inadequate resources.

Indirect impacts on people and systems

An estimated 3% fall in GDP will negatively impact public finances and household consumption. Restrictive measures will hit the agricultural sector that provides more than 20% of export earnings and employs over 80% of the rural population. This will in turn impact food availability and household purchasing power. Limiting agriculture and subsistence activities of the informal sector (3,341,763 persons including 52.7% of women) leaves the vulnerable households without livelihoods. Without access to other social safety programmes, incidences of GBV and other protection concerns are expected to increase.

COVID-19 related restrictions impact all sectors: critical vaccinations (measles and polio), malnutrition, and malaria campaigns are hampered. Fear of infection may jeopardize maternal and child health, and misinformation. In addition, media hype could increase stigmatization and human rights violations of marginalized groups.

School closures have impacted over 2.7 million children, 91,000 of which received school meals, and will erode some educational gains. Chronic malnutrition (23.8% in 2017) will be impacted by difficulties in accessing inputs." According to "Cadre Harmonisé", 534,200 people are under 'pressure' (CH phase 2) and 5,900 'in crisis' (CH phase 3) between June-August,²² with 38% increase in cases of acute malnutrition by end 2020.

Only 45,1% of the population has access to potable water in rural areas; only 20% has access to handwashing facilities with soap and water.

Most of health care facilities lack access to water, sanitation and hygiene to allow proper infection prevention and control (respectively, 58% and 25% of health centers have access to clean water, 25% and to improved sanitation facilities). Only, 30% of health centers have access to an effective waste management system.

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 physical distancing and a significant number suffering from chronic diseases and risk factors for COVID-19.

Response priorities and challenges

Priorities and early achievements

In support of the Government response plan, the UN developed a country preparedness and support plan. Numerous interventions remain necessary to address COVID-19's direct effects: preparing populations for measures to decrease risks; deterring and testing all suspected cases; preventing, suppressing and interrupting transmission; provision of safe and effective clinical care and scale unessential health services and systems.

To address the indirect effects of COVID-19, actions will be focused on the ability of most vulnerable and affected people (45 000 households) to access food supply, to ensure continuity of prevention, essential health services, and set up supply chain for emergency response. Meanwhile, partners are carrying out WASH activities; sensitizing refugees and migrants on COVID-19 risks and protection measures, installing handwashing facilities and distributing protection kits; providing GBV-related psychosocial and medical services; and engaging community medical workers.

Challenges and impact to operations

As restrictions impact on supply chains, stock management at the global level could seriously affect the availability and distribution of food supplies, health related, as well as aid inputs. Delivery times are now up to 45 to 60 days or more. This could impact on food access, maternal and child health and universal access to health, and reverse recent progress, with a detrimental impact on access to basic social services.

The number of people in a fragile situation is expected to increase, most of whom are also affected by floods and the upcoming rainy season might worsen conditions and lead to the review of the humanitarian plan. Limited capacity of the country in emergency management can also hamper timely assistance.

²² Analysis of the "Cadre Harmonisé-IPC.

* A total of \$19.4 million is required for the COVID-19 response in Togo.

Annex D

Provisional Sector Breakdown

US\$
m= million

	CCCM	Coordination	Early Recovery	Education	Food Security	Health*	Logistics	Multisector
UNSPECIFIED								
Global Support Services								
HRPS	61.3m	25.3m	64.2m	191.3m	710.4m	963m	93.6m	56.4m
Afghanistan		0.5m		2.1m	21.5m	21.7m	12.6m	
Burkina Faso		0.2m		4m	11.8m	15m		
Burundi		0.0m		9.9m	5.3m	0.0m	12.4m	0.0m
Cameroon		2m	1m	25m	9.3m	23m		4.4m
CAR				10.1m	66.1m	4m	2m	
Chad	0.5m	2.8m		2m	54.5m	6m		
Colombia		0.3m	19m	3.6m	22.8m	131m		
DRC	8.6m			23.1m	117.8m	49.2m	0.1m	
Ethiopia				10.2m	32.6m	100m	59.7m	
Haiti		0.0m		0.0m	0.0m	0.0m	0.0m	
Iraq	24.2m	0.0m	10.2m	2.6m	21.2m	65.4m		43m
Libya		13.5m		0.0m	0.0m	0.0m	1m	0.0m
Mali		0.0m		8.7m	4.4m	10.1m		
Myanmar		0.0m		3.5m	5.1m	18.1m	2.8m	
Niger		0.0m		4.9m	39.4m	1.9m		
Nigeria	7m		13.3m	15.8m	104.4m	54.5m		
oPt				1.2m	11.8m	19.1m		
Somalia	5.1m		0.0m	0.0m	54.2m	71.1m		0.0m
South Sudan	0.7m	0.3m		20.1m	63.5m	21m	2.7m	
Sudan								
Syria	8.1m		20.7m	27.4m	37.8m	158m	0.4m	5.1m
Ukraine		0.0m		1.2m	9.2m	16.6m		4m
Venezuela					2.7m	40.9m		
Yemen	7.2m	5.8m		4.4m		101.6m		
Zimbabwe				11.5m	15.1m	35m		
NEW PLANS	2.9m	2.4m	21.8m	22.2m	144m	176.6m	26.8m	
Benin		0m		0.5m	3.2m	10.9m	1.5m	
Iran			10m	1.3m	2m	64.4m		
Lebanon								
Liberia				3m	20m	17.5m	4.5m	
Mozambique	0.9m	0.7m		5m	15m	16m	3m	
Pakistan				4m	45m	29.2m	8.5m	
Philippines	2m	1.7m	6.9m	2.7m	33.5m	23.2m	0.6m	
Sierra Leone			4.9m	4.5m	19.6m	12m	6.2m	
Togo				1.1m	5.7m	3.3m	2.5m	
OTHER PLANS		4.6m			35.8m	95.7m		
DPRK		4.6m			5.8m	23.9m		
Rohingya JRP					30m	71.8m		
RRPs			60.1m	49.2m	350.4m	291.2m		
Burundi Regional						36.5m		
DRC Regional						94.7m		
Nigeria Regional						0.0m		
South Sudan Regional						77.4m		
Syria Regional			60.1m	49.2m	350.4m	82.6m		
RMRP			23.3m	9.7m	188.7m	132.4m	10.5m	
Venezuela Regional			23.3m	9.7m	188.7m	132.4m	10.5m	
GRAND TOTAL	64.2m	32.2m	169.4m	272.3m	1,429.4m	1,658.9m	130.9m	56.4m

*The "health" financial requirements listed in the financial requirements tables on pages 7, 70 and 72 include COVID-19 health activities that may draw funding from one or more sectors. The "health" column depicted in this table on sectoral funding requirements only includes funding requested in the "health" sector.

US\$
m= million

	Nutrition	Protection	Refugee Response	Shelter/NFI	WASH	Unspecified	Grand Total
UNSPECIFIED						1,005m	1,005m
Global Support Services						1,005m	1,005m
HRPS	152.3m	256.7m	76.2m	194m	438.8m	207.4m	3,491m
Afghanistan	21.1m	9.3m		4.3m	15m		108.1m
Burkina Faso	2m	5m		4m	18m		60m
Burundi	2.5m	3.8m	0.0m	0.0m	2.8m		36.7m
Cameroon	4m	13.5m	3m	1.1m	13.4m		99.6m
CAR	6.1m	3.1m		31.5m	30m		152.8m
Chad	10m	2m	11.3m	8.3m	2.1m		99.5m
Colombia		3m		5.7m	11.7m		197m
DRC	17.9m	24m	3.6m	18.7m	24.8m		287.8m
Ethiopia	29.8m	13.9m	31m	15.4m	30m		322.6m
Haiti	0.0m	0.0m		0.0m	0.0m	105m	105m
Iraq		71.2m		7.6m	18m		263.3m
Libya		3.5m		2.3m	3.7m	14.9m	38.8m
Mali	4m	9.8m		3.5m	5.5m		46m
Myanmar	1.5m	2.7m		6.9m	5.4m		46m
Niger	5.4m	13.1m	5.6m	2.1m	4.2m		76.6m
Nigeria	12.7m	21.9m		12.3m	18m		259.8m
oPt		1m		3.3m	6.1m		42.4m
Somalia	4.5m	10.6m	4m	7.1m	19.9m		176.4m
South Sudan	4.5m	15.3m	16.1m	2.8m	70.1m		217.2m
Sudan						87.5m	87.5m
Syria	10.9m	12.8m		33.2m	69.9m		384.2m
Ukraine		4.9m		0.4m	11m		47.3m
Venezuela		0.6m		6m	22m		72.1m
Yemen	9.6m	5.3m	1.2m	16m	28.2m		179.1m
Zimbabwe	5.8m	6.6m	0.4m	1.5m	9.1m		84.9m
NEW PLANS	26.9m	43.2m		8.8m	59.3m	70.7m	605.5m
Benin	0.3m	0.3m			0.5m		17.2m
Iran	0.3m	6.6m			4.8m		89.5m
Lebanon						70.7m	70.7m
Liberia	2m	6m			4m		57m
Mozambique	3m	2m		8.6m	14m		68.2m
Pakistan	11.5m	17.7m			10.9m		126.8m
Philippines	6.2m	3.6m		0.2m	15.5m		96.2m
Sierra Leone	3.4m	5.3m			4.8m		60.5m
Togo	0.2m	1.6m			4.9m		19.4m
OTHER PLANS	4m	1.7m			15m		156.9m
DPRK	4m				1.4m		39.7m
Rohingya JRP		1.7m			13.6m		117.2m
RRPs		21.6m	0.0m	13.2m	207.9m		993.6m
Burundi Regional					29m		65.4m
DRC Regional					61m		155.7m
Nigeria Regional			0.0m				0.0m
South Sudan Regional					51.4m		128.8m
Syria Regional		21.6m		13.2m	66.6m		643.8m
RMRP		30.3m		29.3m	14.5m		438.8m
Venezuela Regional		30.3m		29.3m	14.5m		438.8m
GRAND TOTAL	183.2m	353.5m	76.2m	245.4m	735.6m	1,283.1m	6,690.8m

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

We are in the fight of our lives.

We are in it together.

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

António Guterres,
Secretary-General, United Nations

