



UNHCR
The UN Refugee Agency



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Coronavirus emergency appeal UNHCR's preparedness and response plan (REVISION)



215

COUNTRIES, AREAS OR
TERRITORIES GLOBALLY
AFFECTED BY COVID-19

134

REFUGEE-HOSTING
COUNTRIES REPORTING
LOCAL TRANSMISSION OF
COVID-19

71 million

PEOPLE FORCIBLY DISPLACED
AROUND THE WORLD

\$745 million

NEEDED IN REVISED
FINANCIAL REQUIREMENTS
UNTIL THE END OF THE YEAR

Figures as of 9 May, 2020

On 30 January 2020, the World Health Organization (WHO) declared the novel coronavirus (COVID-19) outbreak a public health emergency of international concern, and a pandemic on 11 March. The coronavirus situation is dynamic and evolving with, as of 11 May 2020, over 4 million cases reported worldwide in more than 215 countries, areas or territories.

In light of the unprecedented impact that the COVID-19 outbreak is having in refugee and IDP situations worldwide and the multiple crises that people already scarred by having been forced to flee are facing in terms of loss of lives, livelihoods and protection, UNHCR had to update its requirements. UNHCR's initial appeal focused on preparedness and emergency response and amounted to \$255 million. Following substantial partner consultations in line with the updating of the Global Humanitarian Response Plan (GHRP), UNHCR is now appealing for an additional \$490 million bringing its revised requirements to **\$745 million**. This will allow UNHCR to protect the most vulnerable from direct and indirect impacts of the virus in countries at high-risk due to its rapid spread, and to scale up life-saving protection and assistance in priority countries. To accommodate these additional requirements, UNHCR's 2020 annual budget will be increased through a supplementary budget of \$404 million.

Cover photo: A Syrian refugee sits inside the Wavel refugee camp, in Lebanon's Bekaa Valley.

Building on the preparedness measures already implemented, UNHCR has focused on its support to national authorities for refugee situations, in line with the Global Compact on Refugees, and on protection, shelter and camp coordination to protect the internally displaced. The revised requirements include measures to combat the immediate socioeconomic impact on people of concern, support national and local authorities with health and medical supplies, and continued outreach to ensure people of concern remain at the center of the response.

The COVID-19 pandemic requires first and foremost a strong public health response. So far, there have not been reports of major COVID-19 outbreaks amongst refugees and internally displaced people. However, UNHCR and its partners are in a race against time to prevent and prepare for an outbreak in camps or settlements, as the virus is

already affecting many countries with large refugee and IDP populations. The pandemic is as well increasingly having secondary impacts such as a significant global economic downturn, and heightened health and protection risks for people of concern.

While States can take vital and evidence-based public health measures to help control COVID-19, these should not be arbitrary, should not discriminate—even indirectly—against people of concern and should be maintained for no longer than necessary. This crisis is a reminder that to effectively combat any public health emergency, everyone—including refugees, stateless persons and IDPs—should be able to access health facilities and services in a non-discriminatory manner.

COVID-19 can be contained, but no one is safe unless everyone is safe. We are only as strong as the most vulnerable among us.

“

The pandemic is inflicting deep wounds across our world. For people who fled wars and persecution, the impact on their mostly hand-to-mouth existence and on their hosts has been devastating. Together with our NGO partners, the UN is determined to stay the course and deliver for refugees, internally displaced, stateless people, and their hosts, and ensure their inclusion in public health responses and social safety nets. The needs are vast, but not insurmountable, and only collective action to curb the threat of the coronavirus can save lives. Timely, generous and flexible response from all our supporters is critical.”

Filippo Grandi

United Nations High Commissioner for Refugees

Overview of priorities



Health and WASH

- Work with ministries of health in affected countries and WHO to ensure people of concern are included in national surveillance and response planning activities for COVID-19 and supporting national health systems, especially at the local level, to respond.
- Undertake risk communication and promote community engagement with emphasis on hygiene promotion, hand washing with soap, respiratory hygiene, care seeking and physical distancing using preferred and accessible communication channels with an emphasis on two-way communication.
- Ensure continued access to essential health services, including routine vaccination, reproductive health services for pregnancy and childbirth, care for children, youth, and older adults, emergency care, and care and support for people with non-communicable diseases and mental health conditions.
- Identify and respond to protection and rights violations that may affect the effectiveness of the health response; and those protection risks triggered or exacerbated by COVID-19 and related measures.



Protection and risk communication

- Work with existing protection monitoring and reporting networks in collaboration with governments, communities and partners to mitigate potential protection risks for refugees and displaced people, including restrictions to access to territory and the right to seek asylum, and ensure continuity of essential protection services, including registration, status determination, documentation, protection counselling, GBV and child protection.
- Leverage existing networks of outreach volunteers and women's, children's and other groups formed and led by people of concern to provide key information on critical sectoral activities and protection needs, as well as provide community-based protection and psychosocial support.
- Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia towards refugees, IDPs and other people most vulnerable to the pandemic by countering misinformation and enhancing awareness and understanding of the COVID-19 pandemic at community level.
- Ensure people of concern have access to timely, relevant and accurate information in applicable language/s and dedicate specific measures to ensure communication and critical protection case management are inclusive and accessible for individuals/communities at heightened risk (older persons, children, youth, persons with disabilities, LGBTI people, ethnic and religious minorities).



Cash assistance, shelter and core relief items

- Ensure people of concern particularly vulnerable to the pandemic receive assistance in the form of core relief items and cash-assistance, including through use of digital and innovative solutions.
- Ensure that cash assistance is designed based on a robust analysis of cash specific protection risks and benefits.
- Provide improved shelter and settlement conditions to reduce density and overcrowded living conditions.
- Improve health infrastructure and provision of health services through building or repurposing health, isolation and quarantine facilities, especially in high-density living conditions most at risk from a spread of COVID-19.
- Coordinate interventions in camps and camp-like settings (including in urban environment and informal settlements) through camp management activities and ensure provision of services and assistance is not adversely affected by the public health measures, in particular quarantine and isolation.



Education

- Supporting schools to remain open where health conditions permit and mitigate the risk of spread of COVID-19 through increased access to WASH and health services and information campaigns.
- Expanding investments in online and offline distance education, or alternative solutions, and ensuring refugee children have access to alternative education arrangements introduced locally.



Venezuelan indigenous Warao refugees and migrants are relocated to a safe space in Manaus, Brazil, amid the COVID-19 pandemic. © UNHCR/Felipe Irnaldo.

Protecting the most vulnerable

Over 80% of the world's refugee population and nearly all the world's internally displaced people are hosted in low to middle-income countries, many of which have weaker health, water and sanitation, as well as social protection systems. Many of them live in camps and camp-like settings, or in poorer urban areas with limited public health facilities and face specific barriers and vulnerabilities that must be taken into consideration when planning for COVID-19 response operations. Many persons of concern are also frequently neglected, stigmatized, and may face difficulties in accessing health, social protection and other services that are otherwise available to the general population.

In many of the countries where UNHCR operates, the COVID-19 pandemic is an “emergency on top of an emergency”,

and worsening humanitarian crises like those in Afghanistan, the Democratic Republic of Congo (DRC), Iraq, Libya, the Sahel, Somalia, Syria, Yemen, and in the North of Central America and the Venezuela situation. In Bangladesh, the monsoon season is again approaching, bringing with it additional challenges. Many Venezuelans and Afghans may feel compelled to return home, risking their lives and putting pressure on already fragile health systems. In regions where healthcare systems are weak, diseases such as malaria, measles and diarrhea pose additional threats. UNHCR is expecting a higher case-fatality amongst people of concern due to poverty, congestion, overcrowded living conditions and limited health and WASH infrastructure.

Access to territory and asylum

To date, UNHCR estimates that 161 States have partially or fully closed their borders to contain the spread of the virus, of which 97 are making no exception for people seeking asylum. While many governments are rightly imposing restrictions on air travel and cross-border movement to contain the spread of the virus, these restrictions can and should be managed in a way that is compatible with international refugee protection. They should not result in closures of avenues to asylum, or of forcing people to return to situations of danger.

Forced return and movement of people is reported in several regions while at the same time, limitations on or discriminatory freedom of movement remain a major concern for people living in internal displacement camps and camp-like settings. Family separation keeps many children apart from their caregivers due to movement restrictions. Attacks on sites as well as heightened tensions and attacks on IDP returnees have been reported in several countries.

Shelter and settlements

Many refugees and internally displaced people live in densely populated areas with inadequate housing or in camps, formal or spontaneous settlements or overcrowded urban shelters and slums. These living conditions compromise health outcomes and increase protection risks (including risks of gender-based violence) making refugees and internally displaced particularly vulnerable to this pandemic.

There is a direct link between the density of living conditions (both inside a shelter and of an overall settlement) and the risk of COVID-19 spreading—the more that living conditions can be improved, through repairing, upgrading and extended existing shelter to reduce density, and providing additional shelter options for the most vulnerable, the better protected the population.

Particular attention should be given to those living in temporary collective accommodation (such as transit and receptions centres) where they are most vulnerable to viral transmission.

Building on its shelter expertise and availability of shelter material, UNHCR has been able to provide shelter options with safe and clean-living conditions, and adequate health and WASH facilities. UNHCR will need more funds to continue to provide this assistance to decongest camps and ensure better shelter conditions. In addition, as many people of concern live in shelters that are not individually provided with hygiene and sanitation facilities, people must leave their homes to access these services.

Camps and camp-like settings require strong management to monitor and ensure provision of services in line with hygiene and transmission precautions; implement measures limiting physical interactions between residents when using public spaces, communal infrastructures and facilities, as well as mitigate against collateral impact of public health measures on families, high-risk individuals and their protection and well-being.

Health infrastructure and WASH facilities are frequently overcrowded, with many people queuing long periods to use a communal latrine or draw water. Limiting human-to-human transmission, including reducing secondary infections among close contacts and healthcare workers, preventing transmission amplification events, and strengthening health facilities are key priorities. However, critical elements in successfully preventing or mitigating the spread and impact of COVID-19—physical distancing and adequate medical capacity to test, trace and respond—will remain difficult to achieve or in short supply in many camps and similar settlements. To effectively manage large-scale outbreaks in such conditions, adequate preparedness is needed through a multi-sector camp-level or area-based approach to holistically consider existing conditions and plan interventions to reduce COVID-19 risks.



Refugees at Kalobeyei Settlement in Kenya practice social distancing as they wait for two-month supplies of soap, jerrycans and firewood.

Livelihoods and socioeconomic welfare

Since the start of the crisis, 106 countries have adopted new social assistance schemes or other types of networks to protect the most vulnerable. As non-citizens are normally excluded from these types of schemes, UNHCR has, in line with the Global Compact on Refugees (GCR), advocated the inclusion of refugees in national social assistance schemes, while making short term cash grants available to people of concern. These save lives, and can offset other risks such as eviction which, in one country sampled has increased from 5% before the pandemic to 40% in April 2020.

The evidence of the deep and hard-hitting economic impact of the crisis on people of concern is overwhelming. Across the Middle East and North Africa alone, for example, UNHCR and its partners have received over 350,000 calls from refugees and IDPs since

lockdowns and other public health measures came into force, with the majority asking for urgent financial assistance to cover their daily existential needs.

In the Americas, more than 80% of people of concern live in urban centres and are dependent on the informal sector for survival. Quarantine measures mean the vast majority have lost their jobs. In Colombia, a recent needs assessment in Bogota showed that 42 per cent of Venezuelan families have lost their income, have no savings and no access to social safety nets. The desperate situation has contributed to more than 18,000 spontaneous returns to Venezuela and limited the access of thousands of Venezuelans who had previously crossed daily into Colombia to address basic needs.

Previous pandemics such as SARS and AHI resulted in global shocks to food security including increases in food prices, shortages and market chaos. With COVID-19, food supply chains have already faced disruptions due to interruptions in processing, transport and quarantine measures which will reduce the access and availability of foods, possibly creating a “hunger pandemic”. With some 30 million refugees and IDPs depending on food assistance to survive, the impact on such populations could be even worse.

In West Africa, COVID-19 is likely to exacerbate food insecurity, particularly in the Sahel, where it will add to the combined effects of conflict and displacement, and the recent increase in climatic shocks such as recurring droughts and crop pests which have dramatically disrupted crop and livestock production. With humanitarian relief efforts hindered by COVID-19, parts of the region are at high risk of sliding into famine within the next few months. Over 21 million people could struggle to feed themselves between June and August according to WFP.

Older persons

This population is at significant higher risk of complications and death from COVID-19, with those over 80 years of age dying at five times the average rate. The more than 3% of refugees worldwide aged 60 and above are no exception. Nevertheless, to date, health systems in lower- and middle-income countries have been slow to respond to their increased needs and older persons often face barriers to accessing information and services, including health care denied for conditions unrelated to COVID-19, neglect and abuse in institutions and care facilities, and age discrimination in decisions on medical care, triage and life-saving therapies, all of present higher risks for older persons in forced displacement.



A Venezuelan refugee washes his hands at the sink unit he painted at the Tancredo Neves temporary shelter in Boa Vista.

© UNHCR/Allana Ferreira

Women and girls

Implications of the COVID-19 outbreak for women and girls include increased caregiving and household responsibilities, such as having to care for children and for sick family members. This reduces opportunities for education and livelihood activities while also increasing exposure to the virus. In some contexts, the medical needs of male family members are prioritized over the needs of women and girls.

The pandemic is now exacerbating existing GBV risks for displaced women and girls, such as intimate partner violence; sexual violence and harmful coping mechanisms; and sexual exploitation and abuse (SEA) by humanitarian workers as also emphasized by a [UNHCR statement](#). Intersecting forms of discrimination further increase risks of violence for displaced women and girls with disabilities, those living in poverty as well as other marginalized women and girls, for example those with diverse sex characteristics, sexual orientation and gender identities. Displaced adolescent girls are at particular risk of GBV including child marriage.

Reduced access to lifesaving GBV services due to quarantines and closures of services impacts the immediate safety and health of survivors. Vulnerable displaced women may have limited access to official information on health precaution measures and services generally, while living in inadequate conditions.

Women and girls are exposed to particular risks also in terms of the socio-economic impact of the pandemic. They are often disproportionately involved in unpaid care work, which will increase with this health crisis, have fewer savings and are affected by insecure employment, and are highly exposed front-line workers—either professional or voluntary—as women invariably are those who care for the sick.

Nonetheless, displaced women and girls remain at the forefront of the response, advising on their priorities in terms of programme design, informing their communities about the risks of violence against women and girls and providing information on prevention and protective health measures. They are also supporting survivors to access SGBV services.



Refugees at Kalobeyei settlement in Kenya receive two-month rations of soap, jerrycans and firewood.

©UNHCR/Samu el Otieno

Children

With most States having closed schools, refugee and internally displaced children are also at increased risk and need more support to stay safe. Many forcibly displaced children rely on school feeding programmes for their main daily meal. Families, now with children out of school and struggling for income may risk adopting harmful coping mechanisms, such as child labour or child marriage. These same factors have also led to a marked increase globally in instances of domestic abuse, which has a profoundly negative impact on children's development and wellbeing.

Girls, especially those of secondary school age, are likely to be the most affected by the socio-economic impact of COVID-19. Globally, refugee girls at secondary level are half as likely to enroll as male peers. Evidence from Ebola suggests that school closures could significantly worsen this outcome. The Malala Fund's report [Girls, Education and COVID](#)

estimates that if dropouts follow the same rates as post-Ebola, around 10 million more secondary school-aged girls could be out of school because of COVID-19, including 3 million refugee girls.

Border and movement restrictions have increased the separation of children from their families and limited reunification, while home confinement has increased psychosocial distress, increases the risks of domestic violence and reduces the ability of children to seek help. Increased poverty is leading to increasing levels of exploitation of children such as child labour. Access to life-saving child protection services, including case management, shelter and alternative care has been limited and in many settings only able to be provided remotely. Child protection services have increased costs, decreasing capacities yet the need is increasing significantly.

People with disabilities and minority groups

Persons with disabilities are at greater risk of contracting COVID-19. They may have difficulties with basic protection measures such as hand-washing and maintaining physical distancing, and experience greater risks of discrimination in accessing healthcare and life-saving procedures. This may be the case where health care and triage protocols are based on discriminatory criteria, such as assumptions about quality or value of life based on disability, which may be exacerbated for persons of concern with disabilities.

Members of minority groups as well as people deprived of liberty and/or of the right and access to information also experience a higher degree of protection risks and socioeconomic marginalization. The lack of community interaction and delays or cessation of humanitarian programming could leave many of the already vulnerable refugees and displaced people with no avenues to turn to.

In several operations around the world, LGBTI focal points maintain regular contact with LGBTI persons of concern, who may be particularly vulnerable, a [finding confirmed by OHCHR](#).

Many live with compromised immune systems, including some with HIV/AIDS. They are more likely to be unemployed and live in poverty or engage in survival sex and therefore may not be able to fully observe physical distancing measures. When ill, most LGBTI persons are reluctant to seek medical care for fear of discrimination, harassment and abuse. LGBTI persons already live in isolation and may not be able to obtain information on COVID-19 prevention and containment. Physical distancing measures may also exacerbate their mental health and psychosocial wellbeing, while stay-at-home restrictions may also expose them to hostile environments.

What is driving the cost?

UNHCR's first appeal focused on preparedness measures in all locations where refugees, IDPs, returnees, stateless persons found themselves. This included the purchasing of masks, gowns and ventilators to support national and local health authorities as well as the purchasing of personal protective equipment. These items have now been procured and delivered to various operations in the world, including Iran, Bangladesh, Colombia, Kenya, Uganda and Greece. Through this initial large-scale procurement, UNHCR has helped the governments to protect people of concern as well as ensure that UNHCR and NGO staff can continue to operate even in the case of an outbreak. In urban areas, where refugees are spread out amongst the urban population, UNHCR has supported the national health authorities by expanding existing health facilities and provided ambulances, beds, mattresses, ventilators and medical equipment in line with WHO guidelines.

In camp settings, UNHCR has built isolation units, field hospitals and deployed some 1,500 refugee housing units to serve as isolation and quarantine facilities. UNHCR also invested in new technology for remote registration and innovative ways of ensuring a two-way communication with communities. UNHCR has been able to measure its own preparedness for the response, which in the past 5 weeks has increased from 45 % to 85%.

For this new appeal, UNHCR is building on work already done, and on the evidence gathered from its operations with regards to new and emerging needs. While we have yet to witness a large-scale outbreak of COVID-19 among displaced populations, refugees and IDPs, who are in daily contact with UNHCR staff, report their main concerns as linked to increased violence (including gender-based violence) and xenophobia and loss of earnings

in the informal sectors in which they work. Cuts in food rations and pipeline breaks in several countries in Africa, where refugees are dependent on food aid due to restriction in freedom of movement and right to work render refugees and IDPs even more vulnerable.

In line with the GCR, UNHCR is working with development actors to advocate for the inclusion of refugees and other persons of concern in social security schemes, while providing immediate and life-saving aid through cash grants to avoid destitute people sliding further into poverty, being evicted or going to bed hungry. Understanding that the inclusion of persons of concerns in emerging new social security schemes will take time, UNHCR is advancing cash payments for up to three months. UNHCR has also advocated with development actors, including financial institutions to ensure host populations receive similar cash grants wherever applicable and feasible.

In the same vein, UNHCR is also focusing on ensuring that refugee and IDP children can continue to learn even when schools are closed. This requires some investment in different systems and new technologies, while maintaining the ongoing running costs, such as paying refugee teacher's incentive even in situations of lock-down. UNHCR has been reaching out to private sector partners to help address this issue.

In addition, UNHCR will also need to continue to procure medical and other equipment in close coordination with the UN Supply chain. Ongoing efforts in the shelter sector to decongest densely populated refugee camps and settlements need to be further scaled up to facilitate a measure of physical distancing. Additional pre-positioning and distribution of CRIs is also required to help refugees and IDPs to get through what is likely to be an extended period with only minimal

humanitarian assistance. Without such efforts COVID-19 will spread more quickly and the capacity of the population to cope will be reduced.

These activities are some of the main drivers of the increased needs. Addressing them now will be cheaper and more cost efficient than allowing refugees, IDPs and stateless to slide

even further behind. If UNHCR does not receive timely funding to help national governments respond, there will likely be a knock-on impact with the risk of losing or limiting recent advancements in the granting of rights for refugees such as the access to work, jeopardizing the gains realized under the GCR.

The added value UNHCR brings

UNHCR is uniquely placed to respond to the challenge presented by COVID-19.

UNHCR's COVID-19 response covers all people of concern—refugees, IDPs, returnees, stateless persons and host communities—and complements the work of governments and other UN agencies. Operating in 134 countries, UNHCR has over 17,400 committed staff members, 90% of whom are in the field and in direct contact with people in need.

It has long-standing relations with governments, UN sister agencies, international and local NGOs, and national health services, as well as with forcibly displaced communities themselves, connections which enable us to take quick action, support partners, and deploy resources to assist people quickly as well as help them help themselves. It has vast experience in emergency preparedness and response, and in working in difficult situations where movements are restricted. UNHCR's expertise and capacity in public health means we can support governments with prevention, coordination and in potentially responding to COVID-19 among forcibly displaced populations, as it has done in previous and ongoing health outbreaks.

In refugee situations, UNHCR leads and coordinates the overall response by humanitarian partners in support of host countries. We already have our experienced teams in the field right now and enjoy the trust of all actors.

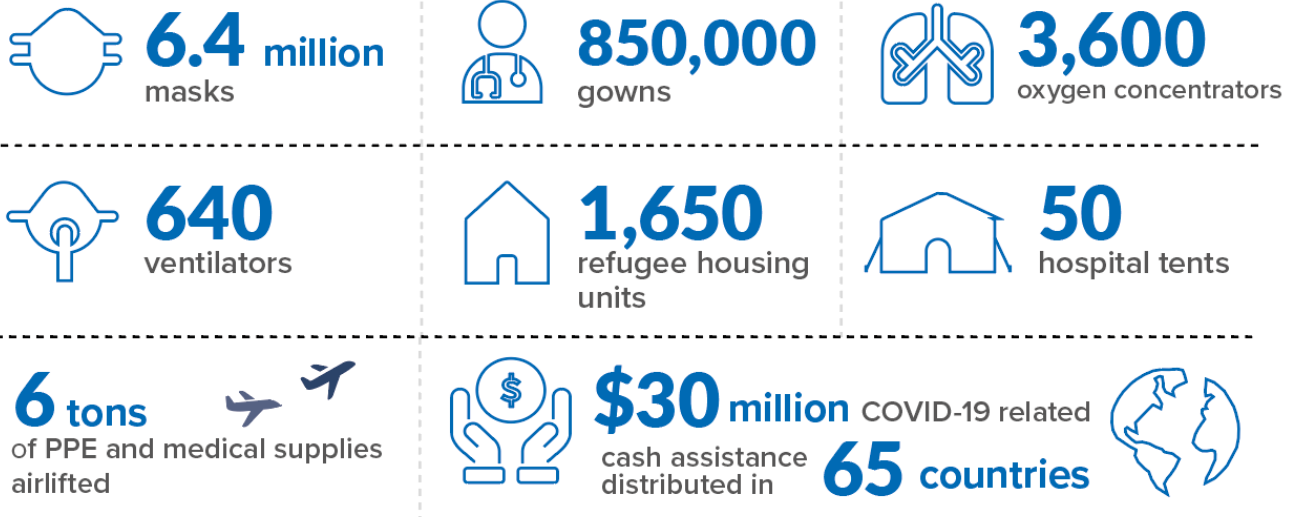
In situations of conflict-induced internal displacement UNHCR leads or co-leads the global and country-level Protection, Shelter, and CCCM Clusters, responsibilities it is fulfilling in the current situation. These include implementing its inter-agency commitments, mobilizing adequate resources and ensuring that protection remains at the center of the humanitarian response.

UNHCR's assistance is available for host communities as well, with the added value of ensuring the host population understands that this assistance comes from the agency responsible for forcibly displaced people thus helping foster social cohesion and preventing inter-communal conflict.

Lastly, UNHCR has an unparalleled network of partners around the world, working with over 1,000 different organizations. Thanks to this network, UNHCR is able to reach people of concern most vulnerable to the pandemic through remote working modalities and close collaboration with communities and partners.

UNHCR's response to date

Among the key items procured to date by UNHCR



Putting people first: Accountability to Affected People

UNHCR's primary goal has been to ensure that all measures taken are aligned with the rights and needs of people of concern, and that they are included in national COVID-19 surveillance, preparedness and response planning and activities.

Throughout its response to the COVID-19 pandemic, UNHCR has been putting the people it serves at the centre and empowering them to be an active part of prevention and response. Physical distancing has required UNHCR to draw on its adaptive capabilities, leverage diverse channels and modalities of communication and rapidly scaling up emerging practices to ensure staff, partners and communities can continue to deliver during this exceptionally challenging time.

Across the globe, UNHCR and partners are leveraging new technology and expanding on

partnerships with people of concerns and host communities through leaders, influencers, volunteers and community-based organizations. In many countries, people of concern have been provided with training and materials to produce face masks and soap to protect themselves and their host communities, they have led awareness-raising campaigns and expanded access to mental health and psychosocial support, and have been engaged in consultations and set up of feedback and response systems, including for confidential and sensitive complaints, such as potential instances of sexual exploitation and abuse. Displaced women are playing a key role in the response. Many young people, including the UNHCR Global Youth Advisory Council, mobilized immediately to respond to the crisis as advocates, volunteers, scientists, social entrepreneurs, and innovators.

Highlights of UNHCR's response to date

Mexico

UNHCR is distributing hygiene kits and expanding its multipurpose cash assistance by delivering targeted assistance for persons of concern facing protection risks. UNHCR expanded the targeted population to 80% of eligible asylum-seekers. Assistance is being determined through processes now managed remotely.

Italy

As part of its "ParticipAzione" programme, UNHCR and INTERSOS launched a digital capacity-building innovation platform for refugee-led organizations on topics such as project management, communication, advocacy and international protection during the health crisis.

Greece

UNHCR is moving over 1,000 asylum-seekers at risk of COVID-19 complications out of overcrowded island centres to safer accommodation in apartments and hotels.

Egypt

Early disbursement of the May multi-purpose cash assistance to 40,449 people was supplemented by an additional 50 Egyptian Pounds per person for hygiene items.

Bangladesh

Following successful testing, UNHCR Bangladesh has shifted to an iris-only (no fingerprint) registration and assistance management strategy. The health and protection sectors are mitigating risks for older persons through strengthened community engagement, enhanced and targeted messaging on how to protect older persons, and modalities for collection of relief items and provision of health care.

Niger

UNHCR and partners have been identifying overcrowded sites and initiated site planning respecting necessary distancing between shelters. In Sayam Forage camp, an additional transit center is being established. Support is also being provided to authorities to set up isolation cells.

Myanmar

To support the national health response, UNHCR has procured four WHO-designed COVID-19 commodity packages sufficient to support an outbreak of 40,000 people with various degree of treatments, including up to 2,000 in ICU.

Ecuador

UNHCR launched HELP ACNUR, a WhatsApp information line. Since its launch on 17 March, some 3,700 cases have been assisted (nearly 80% of whom have been Venezuelans), nearly 6,300 people had registered, and more than 294,000 messages had been sent.

Angola

In Angola, refugee journalists have been trained by UNHCR to lead a mobile radio campaign on COVID-19 prevention.

Yemen

UNHCR has gone door to door with refugees and IDPs across the country to raise awareness about COVID-19, and distributed translated informational leaflets. UNHCR has also distributed hygiene kits and increased its cash assistance in April to both groups to mitigate the risk of job losses and allow beneficiaries to reduce daily movements.

Sudan

UNHCR recently completed the upgrading of a haffir, an artificial lake of 40,000 m³, along with pipes leading to 32 taps close to host and the refugee homes, for the refugee settlement in Dar Batti in South Kordofan.



For more operational highlights, please see the [COVID-19 page on Global Focus](#)

Strengthening and supporting primary and secondary health and WASH services

The public health response has been critical to pandemic preparedness efforts. As envisioned in the Global Compact on Refugees, UNHCR has supported the inclusion of people of concern into national health services and response plans and strategies. Since the beginning of the outbreak, UNHCR has engaged in monitoring, preparedness and contingency planning, particularly in countries hosting large refugee and IDP populations and with weaker health systems. With disease prevention hinging on firmly entrenched WASH practices, UNHCR and partners are working on the provision of such services in refugee, IDP and host community settings. In the case of COVID-19, the best way to avoid

infection is to wash hands with soap and water. This presupposes, however, that an adequate supply of soap and clean water is available, and UNHCR has thus been increasing provision of these services as well as its community outreach on hygiene best practices across its operations.

Linked to UNHCR's WASH-related activities, UNHCR is supporting governments with infection prevention in healthcare facilities. It has supplied personal protective equipment for health workers and supplies, and increased its stocks of analgesics, intravenous materials, and medications to reduce fever and pain. It is also providing staff training and assessing needs for



Shining the spotlight: Involving refugees in the medical response

Refugees across the world have also been on the front line of the COVID-19 response by putting their medical and nursing qualifications at the service of their host countries, have provided free meals for health workers, and [staffed information centres](#), joining in the [massive volunteering effort](#) in their host communities. UNHCR has been promoting such efforts and strongly advocated for [access to employment](#) and recognition of [skills and professional certificates](#) for refugees.

Several countries in the Americas have now put in place special procedures authorizing the hiring of foreign-qualified health professionals and technicians, including those awaiting licensing or whose certification is yet to be validated by host countries. Where national approaches permit, UNHCR teams are connecting qualified and experienced refugee medics with hospitals and clinics in need of additional personnel to confront the health crisis.

Many refugees and asylum-seekers in Europe have the qualifications, experience and willingness to contribute to COVID-19 responses in their host societies but lack the formal approval by national health authorities. UNHCR is working closely with the Council of Europe to implement innovative approaches, namely the European Qualifications Passport for Refugees, which can help Member States identify and channel skilled refugee medical professionals into national health systems.



© Courtesy of Yasin Jama

Read Mohamed and Yasin's stories:

Refugees from Libya and Somalia offer medical experience to help tackle the coronavirus crisis in France and save lives.



medical equipment, medical supplies, health, isolation, quarantine and referral facilities, and ambulance transportation. UNHCR also stands ready to conduct surveillance, support laboratories, trace contacts, and continue its robust use of information systems to track a potential spread of the virus.

Disrupted manufacturing capacity and border closures have affected supply chains around the world, making it challenging to bring essential medical, sanitation and other supplies to those in need. At a global level, UNHCR is working with UN partners through inter-agency working groups on finding solutions to this challenge, including through air bridges and humanitarian exemptions.

Focusing on protection

Key to an effective protection response is enhanced risk communication and community engagement, the delivery of critical protection services including case management, SGBV and child protection services and registration. Protection monitoring allows for early warning mechanisms and evidence-based engagement with authorities and partners. In the face of the protection challenges posed by the COVID-19 pandemic, UNHCR has employed the multi-stakeholder approach of the Global Compact on Refugees to work closely with national authorities, partners, clusters, and people of concern in more than 130 countries to analyze changes in the protection and operational environment and maintain essential protection and assistance activities.

The COVID-19 outbreak has led to the closure of many international borders, which is having an impact on access to asylum, return to countries of origin in conditions of safety and finding third-country solutions to protection vulnerable individuals. Cases of refoulement have been reported in a number of regions. The High Commissioner has called on governments to manage borders in a way

UNHCR is also providing mental health and psychosocial support through community networks and is supporting individual cases in high distress, managing uncertainty, and anxiety.

UNHCR has been creating prevention and awareness-raising materials in multiple formats—written, audio, online, pictorial, including materials for mass distribution, or for presentation by outreach workers—in appropriate languages, and taking into account the needs of those who cannot read or have cognitive, developmental, or intellectual disabilities.

that protects health, allowing people fleeing war and persecution to access international protection, and to ensure that restrictions are temporary in nature. Practical measures such as health screening and quarantine arrangements are available to ensure that access to asylum is preserved in a manner compatible with border controls and public health concerns.

UNHCR has adapted its registration, documentation, refugee status determination, protection counselling, GBV prevention, risk mitigation and response interventions as well as child protection services. UNHCR also respectively launched and strengthened its community-based protection and child protection communities of practice. Adapting the approach to communication with communities a crucial new project looking at accountability to those affected in the context of COVID-19 is being designed. This project considers the need to focus increasingly also on digital engagement strategies to enhance the risk communication and closing the feedback loop ensuring that the affected communities voices are heard and influence programme design.

Ramping up cash assistance and other assistance

To date, UNHCR has successfully delivered \$30 million-worth of cash assistance. To mitigate the negative effects of COVID-19, UNHCR and partners are exploring expansion and support to national food systems for refugee and IDP hosting areas and cash-based interventions coupled with remote vulnerability assessments to extend existing cash program assistance through increased use of digital cash. Furthermore, in many refugee and IDP camps UNHCR provided food distributions and cash assistance and/ or NFIs to meet other basic needs for two to three-months, in collaboration with WFP. All distributions were provided with new modalities to prevent mass gatherings, ensuring physical distancing and adequate sanitary conditions for refugees, IDPs and UNHCR's workforce.



Wearing a protective face mask, an operator answers queries from refugees over the phone at a UNHCR/World Food Programme call centre.



Shining the spotlight: Overcoming direct access constraints

With direct access to people of concern becoming limited, protection teams are increasingly relying on phones and other technology to maintain regular communication with pre-established community networks and host communities to:

- Undertake protection monitoring in urban, rural settlement (including formal and informal camps), and border contexts;
- Provide people of concern with clear and accurate health and other information, and to receive vital feedback to allow information and other approaches to be optimized; and
- Identify and refer high risk protection cases to UNHCR and/or partner staff working remotely using call centers, voice or phone-based applications.

In other situations where partial access to populations of concern is possible, UNHCR protection teams and partners have identified other workarounds, including expanding helplines and protection hotlines, which allow them to continue to implement the same essential protection activities. How this is done depends entirely on the specific context and capacities of an operation.

In some situations, partner staff (including interpreters) wearing protective gear are able to remain physically present at fixed and/or mobile protection help desks and continue to provide critical information and collect feedback, gather and report on protection trends and receive protection cases, reporting to and consulting with UNHCR and/or partner protection staff by email and phone, as necessary. In other situations, only interpreters in protective gear are able to remain physically present at locations accessible to communities and interviews are being conducted with UNHCR and/or partner staff working remotely by phone.

In still other situations of total lockdown, helplines and other communication channels available to persons of concern are being utilized to both monitor protection trends as well as to set up protection interviews with UNHCR and/or partners staff, including interpreters, working remotely using voice, WhatsApp, Skype, WebEx or other internet-based applications.

Supporting education systems

UNHCR supported continuity of learning for more than 237,000 children in Uganda, Chad, Mali and Burkina Faso. In West Africa, focus was on improved WASH access, replacement school feeding, and providing psychosocial support. In Uganda, UNHCR built on an existing eLearning platform to rapidly curate additional materials against the national curriculum, and make hardware available to students preparing for exams.

UNHCR also focused on making broadcast media such as radio and television accessible to refugee students. In Kenya, in addition to ensuring access to Government educational radio broadcasts, refugee teachers broadcast additional materials through community radio

so students heard familiar voices and have a sense of continuity. UNHCR adapted existing student support to meet the current needs: in Egypt, for example, there was a switch from paying for students to take transport to classes to paying for additional online data instead. In Indonesia, UNHCR learning centres went quickly to online modalities including WhatsApp groups offering lesson materials and encouragement.



A Syrian refugee, with cerebral palsy relies on specialist support provided by UNHCR and partners at his home in Amman, Jordan. © UNHCR/Lilly Carlisle

Coordination and partnerships

UNHCR's response to COVID-19 is driven by a spirit of international solidarity to support host communities and local actors. UNHCR recognized the lead role and mandate of WHO is supporting governments and bringing in technical expertise. In all contexts, including countries with existing humanitarian structures, UNHCR is advocating for using existing coordination mechanisms. UNHCR therefore will support all governments with its expertise in protection, shelter and camp coordination and management either through the RC system or through the IASC cluster approach.

In refugee situations, UNHCR is playing a catalytic role, as outlined in the Global Refugee Compact, to support governments to lead and coordinate the response. In the past month, working with OCHA, UNHCR also coordinated the refugee and refugee and migrant response plans, amounting to \$1.5 billion to assist refugees and migrants in 36 countries (out of the total of 63) in the updated GHRP launched on 7 May 2020.

In humanitarian situations, including internal displacement situations, UNHCR leads the Global Protection Cluster and co-leads the Global Shelter and CCCM Clusters (with IFRC and IOM respectively). The cluster coordination role on the global level have entailed issuing guidance and information to cluster coordinators, ensuring webinars and other mechanisms of rapid information sharing across countries and supporting partners in the field to be able to operate despite confinement measures and other challenges. For example, weekly calls have been held with country-level cluster coordinators to support them on risks identification and analysis, develop COVID-19 protection strategies and specific response modalities for the COVID-19 programming and supported advocacy initiatives and information campaigns on

COVID19 response, including engagement with communities.

Joining complementary expertise, the three UNHCR-led clusters, together with the health cluster, have cooperated on a number of guidelines for humanitarian workers working in camp or camp like settings and as well as guidelines for all actors working in low income settings with fragile health setting.

To support and guide a robust protection response, the Global Protection Cluster developed a COVID-19 operational footprint focused on five pillars: safe, dignified, and inclusive health response; protection monitoring and analysis; protection advocacy; protection and rights awareness raising activities and campaigns; Protection service delivery.

The Global CCCM Cluster has established a dedicated [information platform](#). Community reporting mechanisms and referral mechanisms for camps and camp-like settings are being established to ensure two-way communication is maintained despite movement restrictions. Service monitoring in camps and camp-like settings is continuing, where possible, with increasing involvement of site residents through building capacity and remote mentoring. As access to sites remains a challenge, teams enable communities to take partial or full responsibility for management of the sites, should humanitarian workers not be able to access them regularly, while activating robust monitoring mechanisms to ensure minimum standards across sectors continue to be met.

Through the Global Shelter Cluster, UNHCR has mitigated health risks, through activities such as planning and building quarantine, isolation areas and medical facilities, expanding shelters of vulnerable households

to reduce overcrowding and improving inadequate shelter conditions. Emphasis has also been placed on decongesting and reducing human density in settlements to maintain social distancing and reduce transmission. Particular attention has been given to disseminating guidance for high-density settlement conditions so that infrastructure planning that facilitates a health response is available to all partners.

As co-chair with UNICEF of the IASC Results Group 2 on Accountability and Inclusion, UNHCR has contributed to the collection and sharing of COVID-19 related resources on AAP, PSEA and inclusion through the [IASC website](#). As the Champion for Combatting PSEA, the High Commissioner has led the discussions on this within the IASC Principals' meeting and new tools and information material has been developed to assist country teams to mitigate the risks of PSEA.

As outlined in the COVID-19 GHRP revision, UNHCR is coordinating the global refugee response through established coordination mechanisms. In countries with a refugee response plan, coordination mechanisms under UNHCR leadership will be used in close coordination with WHO, and with IOM in countries where this is also a migrant response plan.

In countries with “mixed situations”, where there is a presence of both refugees and IDPs the joint UNHCR-OCHA Note on Mixed Settings will be used. This Joint Note lays out the respective roles and responsibilities of the Humanitarian Coordinator and the UNHCR Representative, and the practical interaction of IASC coordination and UNHCR’s refugee coordination arrangements, ensuring that coordination is streamlined, complementary and mutually reinforcing.

Country-level coordination

To better respond to COVID-19, UNHCR has reprioritized activities, including those it undertaken jointly with partners. While relying on existing partnerships and the strong ties between UNHCR and international NGOs which alongside UNHCR staff have the capacity to stay and deliver, UNHCR has also paid increasing attention to local actors and first responders whose critical role in this crisis cannot be overestimated. Particular attention has been paid to refugee-led responses and organizations who have stepped up to ensure a first response.

At field level, UNHCR advises the UN humanitarian and country teams of the protection situation, on the technical expertise and operational activities of the shelter sector and the importance of communicating with communities.

The protection clusters have gradually adapted response modalities and service delivery, strengthening engagement with community networks, leaders and grass root organizations. Field clusters have all advocated respect of protection principles; explored cash modalities and associated risks; adapted to monitor protection risks and responses; and adapted mechanisms through which humanitarian actors interact with people of concern and ensure accountability.

At the country level, CCCM cluster members provide guidance and capacity building to local authorities and communities on issues such as stigmatization and discrimination, management of isolation centers, and death management.

In line with the principles in the Global Compact on Refugees, UNHCR is working with development actors, the private sector, local authorities, faith-based organizations, refugee-led organizations, women-led organizations and academia to support the emergency response. Pledges made at the Global Refugee Forum are being accelerated and country offices have concrete examples of relevant pledges that could be fast-tracked, outlining the practical application of the Compact in the pandemic and its impact on burden and responsibility sharing, protection and inclusion in national systems.

Partnerships with NGOs and private sector partners

UNHCR is working with many NGO partners to rapidly scale up and adapt interventions in support of national efforts, and to address complex protection risks. Together with NGO partners, in many operations UNHCR is realigning and reallocating resources to find flexible, pragmatic solutions that allow UNHCR and NGO partners to stay and deliver together. Since the outset of the pandemic, UNHCR has organized weekly NGO consultations, with an average of 100-200 participants each week, to discuss critical issues and ensure a smooth flow of communication. Sessions have been led by UNHCR as well as by international NGOs and focused on topics such as protection, preparedness, supply chains, and localization. WHO and WFP have both generously agreed to bring their respective expertise to these consultations and exchange with INGOs on the specific challenges of COVID-19 in displacement settings and on issues of mutual concern.

UNHCR aims to work with existing NGO partners, where possible, providing them with the flexibility needed to make adjustments in their activities given physical distancing measures and travel restrictions. In addition, UNHCR is working with NGO partners to address shared challenges such as the need for humanitarian exemptions, supply chain and other logistical issues, and duty of care for humanitarian workers.

In responding to this unprecedented challenge, the partnerships that UNHCR has with the private sector are proving critical. Businesses, foundations and individuals can play an increasingly key role in donating and fundraising for refugees and displaced people; using their communication channels and platforms to raise awareness and advocate for the inclusion of the most vulnerable in the COVID-19 response; and engaging with employees and stakeholders.



UNHCR partner staff distribute COVID-19 leaflets to Syrian refugees at Gawilan camp in Dohuk, Kurdistan Region of Iraq.

© UNHCR/Rasheed Hussain Rasheed

Key priorities and areas of intervention



Strengthen and support primary and secondary health care and WASH services

UNHCR will enhance inpatient and outpatient services, increase capacity in the camps, settlements and host communities assessed to be at highest risk, and will continue to supply and distribute urgent medicines and medical supplies including personal protective equipment. UNHCR will also reinforce its partners' capacity in both prevention of and response to a COVID-19 outbreak, including recruitment of additional staff and allocation of funds for hazard and overtime pay.

Learning from past outbreaks such as Ebola and responding to clear evidence from operations about concerns expressed by communities, UNHCR recognizes the importance of supporting culturally appropriate burial practices in line with public health recommendations. UNHCR will also strengthen mental health and psychosocial responses to increased anxiety, distress and consequences of loss associated with this pandemic. Protection considerations (including GBV risk mitigation) will be mainstreamed throughout health and WASH interventions.

Along with partners including WHO, UNHCR will work with ministries of health to undertake assessments of national health system readiness. It will also contribute to multiagency support to address identified gaps including in national testing and laboratory capacity; advanced care for people with severe respiratory symptoms including oxygen therapy; treatment of secondary bacterial infection; physiotherapy; and other aspects of case management, surveillance and contact tracing and referral systems.

In camps and settlements UNHCR will support epidemiological surveillance using its Health Information System where it is in place; alert notification, and case investigation and case-reporting following WHO and national guidance. UNHCR will also train rapid response teams, health staff, community health workers on case definitions, isolation procedures, referral mechanisms for suspect cases, and contact tracing.

Using an age, gender and diversity mainstreaming approach, UNHCR public health and WASH activities will conduct early and ongoing assessments to identify essential information about at-risk populations and adapt communications appropriately. UNHCR will establish or reinforce two-way means of communicating with communities to allow opportunities to explore concerns, address misconceptions, and adapt messaging.

Access to WASH services will become even more critical in COVID-19-affected areas, particularly in slowing the rate of the virus' spread. UNHCR is enhancing water and sanitation capacity at hospitals, clinics, reception and transit facilities, women's centres, schools and other communal facilities. These include accessible handwashing facilities, enhanced water supply, sanitation, as well as adapted management of medical waste.

UNHCR will also increase its outreach campaigns and communication with communities on prevention, physical distancing and general hygiene practices, including a broad distribution of hygiene materials.

UNHCR will also renovate and enhance health facilities to facilitate flow and reduce congestion and identify or construct isolation and case management facilities.



Strengthen risk communication and community engagement, critical protection services, including case management, protection monitoring, GBV and child protection services, and registration

UNHCR will maintain and strengthen core protection activities, prioritizing those at heightened risk such as women, children, the older persons and persons with disabilities. Using remote mechanisms if necessary, UNHCR will step up its protection monitoring activities, including at borders, to assist States in meeting humanitarian standards and ensure that the needs of all those seeking international protection are taken into account, the principle of non-refoulement is respected and the forcibly displaced are not arbitrarily detained.

UNHCR's advocacy and support to states will also continue to focus on ensuring processing of asylum claims while also protecting public health; monitoring that restrictions on freedom of movement are not arbitrary nor discriminatory and that restrictions on rights are maintained for no longer than necessary; advocating for and facilitating equal access to national health services; preventing, and addressing risks of violence (including GBV) and of discrimination, marginalization and xenophobia towards refugees, IDPs, stateless persons and other vulnerable groups.

UNHCR will also enhance critical case management, including assistance to survivors of GBV, unaccompanied and/or separated children, and other emergency protection cases, through the provision of mental health and psychosocial support and/or legal advice.

Women, older persons, survivors of gender-based violence, children, youth, persons with disabilities, persons with underlying health conditions (such as persons with tuberculosis or living with HIV/AIDS) and LGBTI persons are particularly at risk in the context of the COVID-19 pandemic in different ways.

UNHCR operations will maintain contact, either directly or through community members or partners with these specific groups to inform protection risk mitigation approaches and assistance. Where protection measures are put in place by the authorities to stop the transmission of COVID-19, UNHCR will advocate to ensure that special considerations are given to address these specific factors of risk (be they physical, cultural, security, psychosocial, sanitary or other) and needs, including care for older persons or children, and that procedures are in place for reuniting separated families.

To meet obligations under its Accountability to Affected People (AAP), UNHCR will continue to strengthen communication and community engagement to ensure access of people of concern to information regarding COVID-19 and to confidential feedback mechanisms (including for reports of sexual exploitation and abuse (SEA) and discriminatory practices in accessing services), ensuring that UNHCR's response is informed by community feedback. UNHCR will share regular and accurate information that is understandable, accessible and adapted to the needs and priorities of different community members, and counter derogatory, xenophobic or demonstrably false messaging or narratives.

Registration remains a critical component of refugee protection during the pandemic and UNHCR has recommended that operations continue registration activities where no viable alternative is possible. Whilst registration is an important priority, all measures will be taken to decrease the risk of contracting and transmitting COVID-19 during

these activities. As an example, electronic means of communication will be put in place where feasible, and social media and hotlines will be used to disseminate information outside of UNHCR and partners premises.

Remote registration, as well as self-registration will also be used, while seeking to maintain the ability to establish and anchor identities.

For this to take place efficiently, new equipment will be needed such as telephones, the deployment of self-service applications, and internet capacity connectivity will need to be sufficient to access proGres and videoconferencing tools.

Additionally, self-registration solutions which connect and are interoperable with PRIMES systems will need to be developed and implemented quickly.

UNHCR will also continue to integrate mental health and psychosocial support (MHPSS) within its health and protection activities, including through community messaging about coping with distress, capacity building of MHPSS community-based staff, training first responders in psychological first aid, and ensuring care for and protection of people of concern with severe protection risks and mental health conditions through remote and direct support.



UNHCR and World Food Programme staff carry out a distribution of food, hygiene kits and relief items for refugees at Kakuma camp in Kenya, while encouraging physical distancing. © UNHCR/Samuel Otieno

Gender-based violence and violence against children

Women and girls of concern to UNHCR are likely to experience distinct challenges and risks associated with the COVID-19 pandemic, and as such the outbreak might exacerbate already existing risks of GBV. Confinement is expected to increase risks of intimate partner violence for displaced women and girls, while worsened socio-economic situation will expose refugee women and girls in particular to increased risks of sexual exploitation by community members as well as humanitarian workers. In parallel, access to regular GBV services is likely to become challenging for survivors.

Implications of the COVID-19 outbreak for women and girls might include increased caregiving and household responsibilities such as having to care for sick family members and handle additional childcare demands. This can in turn limit women and girls' access to services, including critical health services. Increased caregiving responsibilities might also limit access to and time available for education and livelihood activities and as such increase vulnerability. Inadequate living conditions of vulnerable female-headed households might increase the risk of infection.



Shining the spotlight: Supporting survivors of gender-based violence and violence against children

UNHCR's lifesaving programmes for women and girls subjected to violence have been evolving. In some locations, they are managed remotely by case workers with the support of trained community volunteer networks who disseminate information on services within their communities. Displaced women remain involved at the forefront of the response, actively participating in community decision-making structures, informing their communities about the risks of violence and providing information on prevention and protective health measures as well as GBV services. UNHCR is also distributing emergency cash assistance to support survivors and women at risk.

Child protection services have also been adapted during the COVID-19 response. Case workers are providing remote case management to children at risk and their caregivers when relevant, while community volunteers disseminate information on services within communities.

In Malawi for instance, 14 refugee-led community-based organizations (CBOs) serve as focal points within the community for referral to GBV services. Child-friendly information on health recommendations in the context of COVID-19 as well as on how to seek help through CBO volunteers was also distributed.

In Kenya, radio shows are conducted within refugee camps. In April, the messages focused on risks of intimate partner violence, denial of resources, psychological abuse, female genital mutilation, and forced marriage for child survivors. After the shows, refugee women and girls reported having gained knowledge and the confidence to approach GBV service providers; having been assured through radio of the principle of confidentiality and having been updated on services available. Empirical data shows that number of survivors reaching out for support increases after radio shows.

The meaningful participation of women in community structures and decision-making fora related to COVID-19 will continue to be promoted to ensure decisions reflect the priorities of women. UNHCR will continue consulting with women and girls (and other groups at heightened risks of GBV) on current risks (including SEA) preparedness plans and proposed interventions while addressing barriers faced by women and girls to access services.

UNHCR and its partners will also continue to scale up their response interventions. In particular, GBV case management and other response programs will be adapted, including through remote assistance, while also enhancing accessibility for survivors with disabilities. Prevention messages on GBV risks, gender equality and updated information on available GBV services will be disseminated within communities. Information will address the needs, priorities and concerns of women, and girls in relation to COVID-19 and GBV in a manner that is accessible to all women and girls (including those with disabilities).

Advocacy with relevant line ministries is being undertaken to ensure GBV services are designated as essential and are accessible to those forcibly displaced. UNHCR will also promote partnerships with women-led organizations.

UNHCR will also promote the integration of GBV risk mitigation actions (as outlined in the IASC GBV Guidelines) in the interventions

related to COVID-19 implemented by all sectors/clusters.

UNHCR will continue to work with partners to address the increased risk of violence against children. This includes scaling up communication on positive parenting practices and providing child friendly information on services. Child protection case management services have been adapted to provide remote counselling where possible and ensure the provision of essential in person services for emergency cases. UNHCR will continue to work with partners and authorities to adapt the identification and referral of victims of violence, reinforcing linkages with health and other essential service providers and providing more online opportunities for reporting. UNHCR has worked to maintain access to shelters and scale-up and adapt alternative care services for children in need.

For instance, in Lebanon the child protection sub-working group developed procedures to maintain child protection case management services during movement restrictions and online coaching and supervision was provided to case workers. UNHCR will also pursue cash transfers to mitigate risks of exploitation of girls and boys, including in the labour market.

As SEA is known to increase in public health emergencies, SEA prevention and mitigation considerations must be maintained within all activities undertaken in response to COVID-19 while survivors of SEA will continue to receive support through existing child protection and GBV services.



Ramp up cash assistance, reinforcing shelters, and provide core relief items in congested collective settings, including urban contexts

Over 65 UNHCR operations have launched new COVID-related cash assistance and/or adapted existing cash assistance to meet the urgent needs and mitigate some of the socioeconomic impacts. UNHCR will continue to build on its existing cash assistance mechanisms by ramping up cash payments to existing recipients, especially those most vulnerable and affected by economic shocks, to assist them in weathering the storm and to serve as an economic stimulus for affected areas.

Where digital means are in place, cash assistance will require only a limited interaction of UNHCR and partner staff—an important consideration given the risks that in-kind assistance distribution presents to staff and partners. Where digital means are not yet in place, UNHCR will invest in shifting its delivery mechanisms from cash-in-hand to digital and electronic options, including mobile banking in remote camp locations, and

cardless ATM withdrawals in urban areas, such as was done in Ecuador, and is currently being undertaken in Rwanda.

With overcrowded shelters and settlements posing a major risk for the spread of COVID-19, UNHCR will identify and implement targeted actions to expand congested settlements, provide family shelters to the most vulnerable living in crowded collective accommodation and improve the conditions in existing shelters of particularly vulnerable households in key locations.

Moreover, as population movements across many borders continue, UNHCR will enhance reception and shelter facilities in critical border locations. UNHCR will continue trying to identify land where isolation and quarantine spaces can be built to protect overcrowded settlements, and provide shelter assistance to install or repurpose hospitals and health, isolation and/or quarantine facilities.



Shining the spotlight: Expanding cash assistance remote registration and assessment



Refugees at Kakuma camp in Kenya await a distribution of food, hygiene kits and relief items, while practicing physical distancing.

Across key operations, including Bangladesh, Ethiopia, Zambia and Malawi, UNHCR has piloted contactless biometrics through a newly developed BIMS iris scanner. This provides for the continuation of a range of services, such as disbursing cash-based assistance.

In Peru, for example, UNHCR has entirely switched to remote registration and assessment procedures to reduce the transmission risks of COVID-19. While continuing to provide cash to existing beneficiaries through pre-paid cards, UNHCR and partners are also increasing the use of mobile money to reduce COVID transmission risks and enable new beneficiaries to receive assistance despite the significant movement restrictions in place.

Coordination of interventions in planned camps and settlements, especially related to COVID-19 will be strengthened and adapted to ensure continuous provision of services and assistance even if movement restrictions prevent access for humanitarian workers, including through enhanced localization efforts and identification of focal points for key sectors and overall management from among the refugee and IDP populations. UNHCR will also provide technical advice to the local authorities on protection-sensitive management of quarantine and isolation facilities when located in camps and camp-like settings or when temporary collective accommodation (reception/transit centers) is transformed into such facility.

As COVID-19 increasingly affects refugee and IDP hosting areas, funds are needed for UNHCR to build up stocks of core relief items in its network of seven emergency stockpiles.

While suppliers in China and other countries in Asia are up and running, there are nevertheless supply-chain disruptions for some key commodities, supplies and essential items. UNHCR will consider alternatives to normal supply chains to ensure continued delivery of supplies, including local procurement options.

To address the socioeconomic impact of COVID-19 in the longer term, UNHCR will continue working with the World Bank and other actors to ensure that the ramping up of cash assistance can be linked to financial inclusion of refugees and that development actors increase their support for cash assistance and other social inclusion schemes for nationals to ensure social cohesion.

Protection considerations (including GBV and child protection risk mitigation) will be mainstreamed throughout cash assistance, shelter and core relief items interventions.



Shining the spotlight: Adapting existing shelters to support the responses in the Americas

UNHCR has been working to support national authorities by providing refugee housing units (RHUs). Quick and easy to erect, RHUs have enabled the creation of contingency areas for health facilities to improve storage and creation of changing rooms for health staff, as well as isolation facilities for COVID-19 patients. They have also been key in helping to decongest high-risk collective sites, including transit centers.

To date, more than 2,100 RHUs have been provided in 60 locations throughout the Americas.



Staff building protector zones in the integrated assistance centre in Maicao, Colombia. The structure, when completed, will serve as a protective facility for children of Venezuelan refugees staying in the camp.



Support education systems

School closures have disrupted education for almost 8 million refugee children and youth, and the implications for displaced and stateless children are numerous. These include increased risk of drop-out once school resumes, nutritional and food security gaps as school feeding programmes are suspended, and protection risks when children are not in school during the day.

Girls, especially those of secondary-school age are particularly at risk. Globally, refugee girls at secondary level are half as likely to enroll as male peers, and evidence from Ebola suggests that school closures could significantly worsen this outcome. Some global estimates suggest that if dropouts follow the same rates as post-Ebola, around 10 million more secondary school-aged girls could be out of school because of COVID-19. When applied to refugee girls globally, up to 3 million could drop out.

As national governments and UNHCR operations respond to school closures and the impact of the pandemic on education, UNHCR will support schools in their efforts to remain open, where health conditions permit, and mitigate protection risks posed by school closures through expanded support services such as school feeding schemes, continuity of learning and mental health and psychosocial support programmes at home where possible, and protection against violence.

Continued payments of teacher incentives, student fees and cash-for-education programmes during school closures will be key to both protection activities and continued to support refugee's livelihoods. UNHCR will continue to expand its investments in connected education and the accessibility of these to refugees. This may include developing off-line solutions by developing platforms for teachers and parents to adapt to new teaching modalities through online platforms, such as those developed in Jordan for refugees and host



Shining the spotlight: Supporting continued access to education during the coronavirus

To support continued access to education opportunities, UNHCR has been working closely in partnership with national governments to develop virtual learning platforms, such as in Jordan. In other areas, UNHCR has invested in the distribution of educational materials and resources to support home-based learning, such as in Niger, South Sudan and Ghana. In the Dadaab refugee camps in Kenya, home to over 200,000 refugees, community radio is being used to help ensure that children do not miss out on learning.



A Somali refugee teacher gives an English lesson to grade five pupils over the radio system at Dadaab camp in Kenya.

communities. Where accessibility is challenging, UNHCR will invest in the distribution of educational materials and resources to support home-based learning, including school materials and radios (Niger), self-study packs (South Sudan), and e-readers (Ghana). In other operations, UNHCR will continue to invest in the use of broadcast opportunities such as instant messaging and video-conferencing, as well as using radio and television broadcasts to support home-based learning.

UNHCR will monitor and support continued access to tertiary education for refugees, in particular those who are part of the Albert Einstein German Academic Refugee Initiative (DAFI), to ensure they can be assisted in case of closures of universities, student

accommodation, or need to access online materials from home. Some DAFI graduates are already active in the fight against COVID-19.

Protection considerations (including GBV risk mitigation) will be mainstreamed throughout education interventions.

UNHCR will continue to play a key role in advocating for and ensuring the inclusion of refugees in national response plans to ensure the continuity of learning. In certain operations, UNHCR is also expanding its use of cash assistance for increased data connectivity to allow access to national educational resources. As this pandemic has the risk of deepening existing inequalities in education, early action is needed more than ever to minimize the risk of refugee children and youth being left behind.



Medical staff at UNHCR's partner Caritas prepare medicines for delivery to vulnerable refugees in Amman, Jordan. © UNHCR/Mohammad Hawari

Funding the response

As of 6 May 2020, UNHCR's coronavirus emergency appeal raised recorded and pledged contributions of \$227 million – an extraordinary generous level of funding – against requirements of \$255 million. This left a funding gap of \$28 million, or 11% of requirements. With the revised requirements of \$745 million, this funding gap has now grown to 70%.

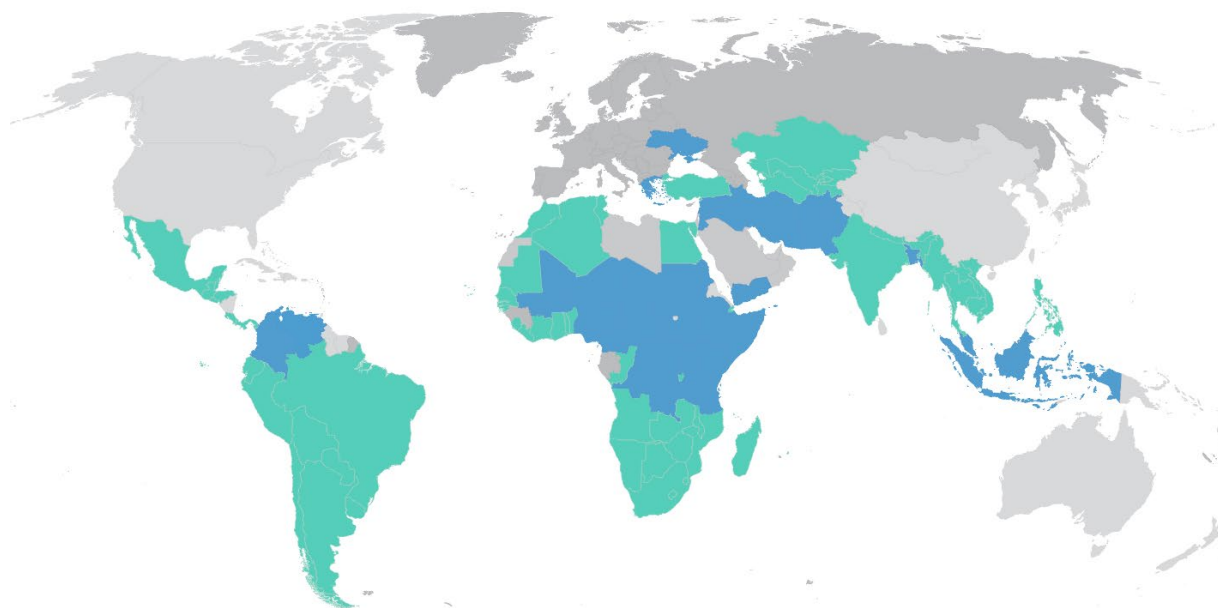
Governments and the European Union contributed the most funding against the initial appeal, with \$212 million (94% of contributions). Softly earmarked funding to the COVID-19 situation comes to \$104 million (46%), while \$122 million (54%) is tightly earmarked to specific countries and below. Asia and the Pacific received the most earmarked funding (\$50 million), with the Middle East and North Africa second (\$36 million).

Unearmarked funding has been invaluable in the response to date. It greatly facilitates UNHCR being able to kick-start an emergency response, bolster forgotten or under-resourced crises, and enable the fullest possible implementation of programmes. Unearmarked funding enables UNHCR to plan and manage its resources efficiently and effectively as it supports all programmatic areas—including innovation for the future of the Office's response—and has a positive impact on the the future of the Office's response—and has a positive impact on the many achievements of the Organization, contributing to the collective success in every life that is transformed and saved.

For example, unearmarked funding has allowed UNHCR to kickstart procurement of PPE, essential medicines and medical equipment. Given global supply and transport challenges, unearmarked funds have been used for air and other transport, especially to deliver speedily to operations where land and maritime borders are congested or closed. Unearmarked funding has also contributed to a global approach to protection, for instance making possible remote registration to support the filing of asylum claims and access of asylum seekers and refugees to assistance. Supporting refugees impacted by the economic downturn with cash assistance to meet their basic needs has been possible through use of unearmarked funding. It has also enabled operations improve health facilities, expand isolation facilities, and train health workers on COVID-19 diagnosis and management.

UNHCR has recorded \$391 million in unearmarked contributions this year to date. Flexible funding is truly a lifeline, both for urgent situations and under-funded operations, which will likely be the first to lose out if resources are shifted to fight the pandemic.

Revised funding requirements



● Countries covered under initial appeal

● Countries covered under revised appeal

UNHCR is appealing for **\$745 million** in scaled-up or new activities to support prevention and response efforts in refugee sites and host countries.

For this revision, UNHCR is focusing in particular on the following countries assessed as high-risk, taking into account the priority countries outlined in the Global Humanitarian COVID Appeal.

- **East and Horn of Africa and the Great Lakes** | Burundi, Djibouti, Ethiopia, Kenya, Rwanda, Somalia, South Sudan, Sudan, Tanzania, Uganda
- **Southern Africa** | Angola, The Democratic Republic of the Congo, Malawi, Mozambique, the Republic of Congo, South Africa, Zambia, Zimbabwe
- **West and Central Africa** | Burkina Faso, Cameroon, Chad, the Central African Republic, Côte d'Ivoire, Ghana, Liberia, Mali, Niger, Nigeria, Senegal
- **The Americas** | Argentina, Brazil, Bolivarian Republic of Venezuela, the Caribbean, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, and Peru
- **Asia and the Pacific** | Afghanistan, Bangladesh, India, Kazakhstan, Kyrgyzstan, Myanmar, Nepal, Pakistan, Philippines, Indonesia, the Islamic Republic of Iran, Malaysia, Tajikistan, Thailand
- **Europe** | Greece, Turkey, Ukraine
- **The Middle East and North Africa** | Algeria, Egypt, Iraq, Jordan, Lebanon, Mauritania, Morocco, Syria, Tunisia, Yemen

As the situation evolves, priority countries will be continuously revised and updated, with UNHCR assessing and responding to emerging needs in an agile manner and looking to maximum flexibility in terms of pre-defining interventions and areas where resources are allocated.

The best way to support UNHCR's appeal is through unearmarked or softly earmarked contributions supporting the global COVID-19 prevention and response efforts. Such flexible funding at global level will be key in allowing a timely emergency response to the evolving needs wherever required. It will allow UNHCR flexibility to allocate funds across regions and operations according to priority needs, and will also allow for support to Headquarters in its cross-cutting work to strengthen advocacy, improve protection, bolster coordination and communication efforts, and support the regional and country offices on the front line of the response.

REQUIREMENTS BY REGION AND OPERATION		
REGION	OPERATION	REQUIREMENTS (US\$)
EAST AND HORN OF AFRICA AND GREAT LAKES \$126,208,183	Burundi	5,386,845
	Djibouti	1,912,685
	Ethiopia	34,984,324
	Kenya	11,024,422
	Rwanda	3,044,755
	Somalia	7,124,084
	South Sudan	19,778,951
	Sudan	13,625,236
	Tanzania	3,470,029
	Uganda	25,856,852
SOUTH AFRICA \$31,240,303	Angola	1,282,335
	Congo	2,296,080
	Democratic Republic of the Congo	16,895,332
	Malawi	1,326,968
	Mozambique	939,180
	South Africa*	2,745,000
	Zambia	4,630,981
	Zimbabwe	1,124,426
WEST AND CENTRAL AFRICA \$69,189,402	Burkina Faso	12,711,375
	Cameroon	12,552,050
	Central African Republic	9,053,703
	Chad	10,300,133
	Cote d'Ivoire	350,000
	Ghana	500,000
	Liberia	1,320,000
	Mali	8,018,000
	Niger	7,445,213
	Nigeria	4,168,928
	Senegal*	2,770,000
ASIA AND THE PACIFIC \$96,298,522	Afghanistan	11,085,150
	Bangladesh	25,487,008
	India	2,077,500
	Indonesia	3,536,871
	Iran (Islamic Republic of)	16,199,400
	Kazakhstan*	270,000
	Kyrgyzstan	470,000
	Malaysia	4,526,273
	Myanmar	8,900,000
	Nepal	1,461,200
	Pakistan	19,256,030
	Philippines	450,000
	Tajikistan	440,000
Thailand*	2,139,090	

REGION	OPERATION	REQUIREMENTS (US\$)
EUROPE \$28,332,500	Greece	6,795,000
	Turkey	19,040,000
	Ukraine	1,697,500
	Regional activities	800,000
THE MIDDLE EAST AND NORTH AFRICA \$272,730,986	Algeria	8,350,128
	Egypt	10,188,000
	Iraq	35,722,944
	Jordan	79,960,000
	Lebanon	85,128,747
	Mauritania	2,208,595
	Morocco	975,000
	Syrian Arab Republic	4,416,572
	Tunisia	3,246,000
	Yemen	42,535,000
AMERICAS \$93,178,782	Argentina*	1,220,079
	Brazil	16,220,000
	Caribbean	6,211,785
	Colombia	17,308,201
	Costa Rica	3,300,000
	Ecuador	17,050,000
	El Salvador	1,700,000
	Guatemala	902,800
	Honduras	2,700,000
	Mexico	3,730,535
	Panama*	1,925,000
	Peru	13,033,132
	Venezuela (Bolivarian Republic of)	7,642,250
	Regional activities	235,000
	Field operations sub-total	717,178,678
	Business continuity	27,821,322
	GRAND TOTAL	745,000,000

*South Africa multi-country office (MCO) also covers Botswana, Comoros, Eswatini, Lesotho, Madagascar, Mauritius, Namibia and Seychelles.

*Senegal MCO also covers Benin, Cape Verde, Gambia, Guinea-Bissau, Sierra Leone and Togo

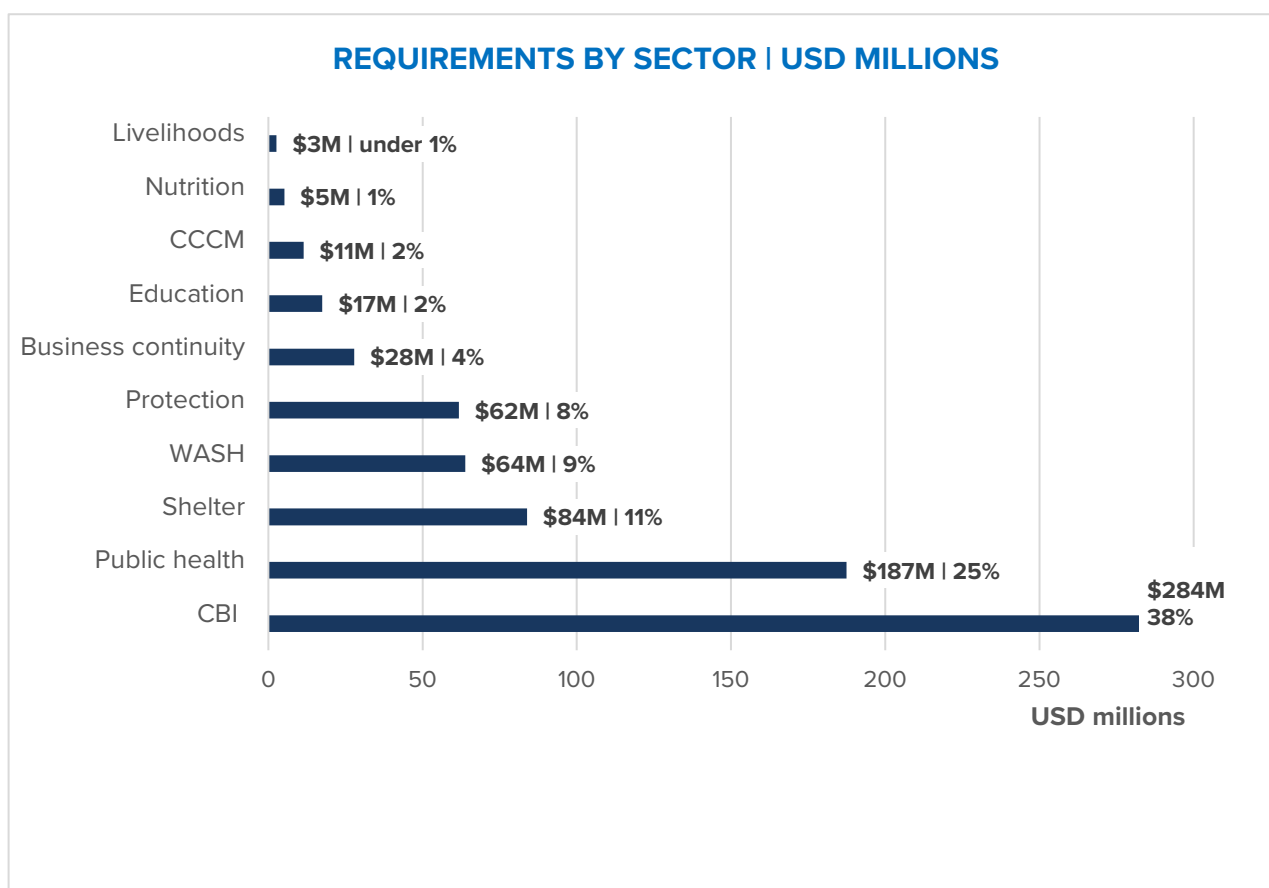
*Kazakhstan MCO also covers Turkmenistan and Uzbekistan

*Thailand MCO also covers Cambodia, LaoPDR and Vietnam

*Argentina MCO covers Bolivia, Chile, Paraguay and Uruguay

*Panama MCO covers Belize

REQUIREMENTS BY SECTOR	REVISED REQUIREMENTS (US\$)
CBI	283,644,167
Public Health	187,470,506
Shelter	83,838,187
WASH	63,828,902
Protection	61,749,084
Education	17,499,160
CCCM	11,403,141
Nutrition	5,163,686
Livelihood	2,581,843
Business Continuity	27,821,322
TOTAL	745,000,000



Resources and links



The primary responsibility for response to COVID-19 lies with governments, supported by WHO and other partners with technical expertise. UNHCR's interventions are in line with WHO guidance and aligned with the revised COVID-19 Global Humanitarian Response Plan. Under this Plan, UNHCR has focused on the third strategic priority: protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic. UNHCR's operational response will be fully embedded within national strategies and guided by ministries of health and WHO.

Where the humanitarian programme cycle is implemented, the Resident Coordinator/Humanitarian Coordinator and the Humanitarian Country Team lead the response with WHO providing lead support and expertise on public health issues in consultation with national authorities. In countries covered by a refugee response plan, the existing coordination mechanisms

will be used under the overall leadership of UNHCR in close coordination with WHO.



[Revised
COVID-19
Global
Humanitarian
Response Plan](#)



[UNHCR Global
Focus COVID-
19 Situation
page](#)



[Inter-
agency
COVID-19
data portal](#)



[WHO
COVID-19
situation
dashboard](#)

UNHCR staff and Brazil's Operation Welcome Task Force assist in transferring Venezuelan refugees and migrants with suspected or confirmed COVID-19 to the temporary treatment centre at a shelter in Boa Vista, Brazil.



CORONAVIRUS EMERGENCY APPEAL

UNHCR'S PREPAREDNESS AND
RESPONSE PLAN (REVISION)

As of May 2020