![UNHCR - The UN Refugee Agency]

REPORT ON UNHCR's RESPONSE TO COVID-19

March - September 2020

Above: UNHCR reaches Colombian refugees living in rural communities in northern Ecuador during the COVID-19 pandemic.

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Cover image: Sudanese refugees observe physical distancing while listening to health and sanitation messages over a speaker system at Ajuong Thok camp in South Sudan.

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Updated information on UNHCR's operational response to COVID-19, including regional and operational sitreps and thematic updates, can be found on the Global Focus website **COVID-19 Situation page**.

Introduction

As of the writing of this report, some 29 million people around the world are confirmed to have suffered from COVID-19. This includes some 25,000 people of concern to UNHCR— that is, refugees and other forcibly displaced and stateless persons in 98 countries, of whom 247 have died. In addition, some 280 UNHCR staff have fallen ill, of whom five have lost their lives. Countless others are suffering from the socio-economic impact of the pandemic, none more so than the millions of forcibly displaced whose lives often depend on employment in the informal sector.

In line with UNHCR's emergency policy, the High Commissioner declared a global level-2 emergency on 25 March 2020, while the IASC "System-wide scale-up protocols adapted to respond to the COVID-19 pandemic" were endorsed on 17 April 2020. The IASC Scale-Up declaration allowed for a coordinated humanitarian response, while UNHCR's level-2 emergency declaration allowed it to scale up and adapt its life-saving protection and assistance activities across all regions, prepare and respond to the pandemic across operations worldwide in a coordinated manner, and address the needs of the most vulnerable in close collaboration with governments, partners and people of concern.

Those efforts have had success, where 9.34 million refugees and internally displaced in 151 countries have accessed protection services and over 3.9 million refugees have accessed health services. In many operations, COVID-19 transmission rates amongst people of concern remain similar or lower than among host communities, a testament to the strength of UNHCR's risk communication and public health response. Millions of articles of essential equipment such as PPE have been procured, received as in-kind support, shipped and distributed. Cash has proven essential in the response, with $338 million distributed in total.

However, challenges remain. Testing and tracing remains elusive in the many remote areas in which UNHCR operates. While countries have made tremendous efforts to maintain national education programmes through radio, online and on television, including for refugees and internally displaced people, millions of children and youth are out of school due to mandatory school closures, with dramatic long-term consequences, particularly for girls.

In the early days of the pandemic, faced with extraordinary needs, UNHCR reprioritized and reallocated resources to meet the immediate needs of refugees and IDPs. As the crisis progressed, and the scale of additional needs became clearer and were articulated in the Global Humanitarian Response Plan, UNHCR did everything possible to mobilize resources from its donors—both governmental and private—who responded with generous support, including providing $161.2 million in softly earmarked funding. While the scale of global humanitarian needs grew to over $10 billion, UNHCR made deliberate efforts to ensure its appeals remained focused on the most immediate needs of people of concern and of the people who host them, supported through activities which the Office and its network of partners could reasonably undertake.

While UNHCR remained modest in its assessment of needs, it nevertheless continues to suffer a shortfall in funding for its COVID-19 response, amounting to $283 million or 38% of the $745 million required to meet identified needs.

With COVID-19 still a threat to health systems and populations across the world, and with its socio-economic impacts felt heavily by the most vulnerable in society, including refugees and other displaced people, UNHCR continues to call on its donors—both institutional and private—to show solidarity and support those most in need.

By the numbers

9.34 million
refugees and IDPs have accessed protection services, including GBV and child protection services
151 countries reporting

72%
of countries have reported GBV services have been maintained or expanded
152 countries reporting

3.93 million
refugees have accessed essential health services
62 countries reporting

468,000
women and girls have accessed sexual and reproductive health services
46 countries reporting

265,000
refugees and IDPs have benefitted from mental health and psychosocial support services
68 countries reporting

3 million
refugees and IDPs have received cash assistance
65 countries reporting

2,037
oxygen concentrators have been procured

41.2 million
masks have been procured

2.8 million
gowns have been procured

195
ventilators procured for country support

8,000
refugee housing units have been distributed for quarantine, physical distancing or other covid measures
15 countries

1.8 million
refugee children and youth are out of school
57 countries reporting

750,000
children and youth supported with distance/home-based learning
63 countries reporting

78,940
children have been admitted for treatment of moderate acute malnutrition and **30,700** children for severe acute malnutrition
22 countries reporting

85%
of UNHCR operations have functioning complaints and feedback mechanisms
165 countries reporting

75%
of operations reported reaching all geographic areas inhabited by refugees, IDPs, migrants and host communities with information campaigns about COVID-19 pandemic risks
150 countries reporting

Note on the data: reporting compliance was high and the coverage within this report is broad, with contributions for quantitative indicators received from 181 countries. Which countries reported on which indicators varied by operational relevance, the role of UNHCR with respect to particular populations of concern, the engagement of governments, and the availability of data.

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UNHCR's overarching strategy to deal with COVID-19's impact upon people of concern

The UN Secretary-General launched the UN Comprehensive Response to COVID-19 to save lives, protect societies, and recover better. In its contribution to the priorities of the global coordinated approach, UNHCR pledged the following strategic approach to prepare and respond to the needs of people of concern to it, including:

- Strengthening critical protection, communication and assistance activities to reduce risks to refugees, asylum seekers, returnees, stateless persons, IDPs and surrounding host communities, including harmful coping strategies.

- Together with other UN agencies and the NGO community, ensure efforts to combat xenophobia, discrimination and stigmatization of stateless populations, refugees and others forcibly displaced.

- Undertaking measures that may support prevention of infection.

- Undertaking critical support interventions to ensure access to effective health care.

- Ensuring the basic needs of the most vulnerable are met to reduce the impact of shocks, including in lockdown situations.

- Actively participating in country and district level COVID-19 coordination structures to ensure refugees are included in country-specific national operational plans with estimated resource requirements (such as medicines or supplies).

- Supporting children and youth to continue learning during institutional closures and to return to school on re-opening.

- Advocate and support governments to include refugees and other forcibly displaced in their socio-economic recovery plans and in the UN's efforts to support these plans.

Transforming initiatives: delivering more effectively and efficiently

2020 was supposed to be a milestone year in the High Commissioner's transformative initiatives to make UNHCR more effective and efficient. The most visible was UNHCR's decentralization and regionalization, but there was also reform of the results-based management system, reform of business processes to modernize them, a greater focus on and use of data and evidence in decision making, and the Global Compact on Refugees.

However, COVID-19 brought new challenges and opportunities to the environment in which UNHCR and its partners operate. UNHCR seized opportunities provided by the regionalized bureaux with which decisions could be expedited and devolved. For instance, the bureaux identified COVID-19-related requirements quickly, allowing Headquarters to allocate resources very fast, with corresponding efficiencies in speed in delivery of assistance, and a high implementation rate.

Given the pandemic's global nature, Headquarters brought efficiencies to bear such as economies of scale. Global stockpiles were maintained, supplies prepositioned, and procurement undertaken at scale despite an at times chaotic supply chain. Greater use of data allowed the spread of the pandemic to be tracked, allowing further efficiencies in the response, and technology was used efficiently to enable a response that stayed and delivered, despite 88% of the workforce at one time working remotely.

Here, too, the pandemic has accelerated thinking or initiatives already underway, and brought into focus the feasibility and efficiency of remote working as a future modality—a 'next normal' as it was termed by the Task Force on the Future of the United Nations System Workforce—for an organization such as UNHCR.

Strengthen and support primary and secondary health care and WASH services

Primary and secondary health care

Key achievements or targets met

25,151 reported **COVID-19 cases** amongst people of concern (as of the 27th September)

28,236 births attended by **skilled health personnel (86%)**[1]

78,940 children 6-59 months admitted for treatment of **moderate acute malnutrition**

467,659 women and girls who have accessed **sexual and reproductive services**

613 isolation, quarantine and treatment **centres built / supported**

611 national **health facilities supported** by UNHCR

247 reported **COVID-19 deaths** amongst people of concern (as of the 27th September)

40,711 of **measles vaccine** given

30,699 children 6-59 months admitted for treatment of **severe acute malnutrition**

264,934 people provided with **mental health and psychosocial support**

2,312 additional **community health workers** and other health workers hired

3,935,636 people of concern (girls, boys, women, men) **receiving essential healthcare** services

Number of PPE and medical items procured

42.1 million masks

2,037 oxygen concentrators

2.8 million gowns

380 metric tons of PPE and medical items delivered

[1] Reported in UNHCR's Refugee Health Information System, covering 13 countries.

UNHCR enhanced its support to health services so as to protect health care workers and ensure the continuity of routine health services as well as diagnose and manage suspected and confirmed COVID cases. In camps or settlements this included identification and training of outbreak response teams, referral systems for laboratory specimens and prepositioning laboratory supplies such as transport media, swabs, specimen containers, training of staff in early identification, notification, case management and contact tracing, data collection and analysis and interpretation.

Despite constraints imposed by a highly constrained supply chain, UNHCR responded rapidly and successfully with the supply of essential medicines and supplies to support the management of COVID-19 cases, including PPE for health staff. Over 41.2 million face masks, 2.8 million gowns, 2,037 oxygen concentrators and 195 ventilators were procured for country support through international procurement.

To ensure the food and nutrition needs of refugees in quarantine are met, a checklist was developed to support country operations plan and coordinate with host governments, WFP, and other partners. Increased collaboration in regional bureaux and operations resulted in greater joint support to address these food and nutrition needs.

COVID-19 threatened major disruptions to routine health services and the ways in which people sought to access health care, with adaptations implemented so as to reduce crowds and face-to-face consultations at health centres, clinics and similar. For example, persons with chronic diseases such as HIV, diabetes, hypertension and chronic and severe mental health conditions were provided with three-months medication, and follow-ups were made at home by health staff, by telephone, WhatsApp or online.

Despite all these efforts, however, some disruptions to specific services were noted.

Although facility-based routine immunization services were maintained, the disruption to outreach services had an impact on coverage. Uganda observed drop-out rates from 2–15%, and up to 41% in Kenya at the height of the pandemic. Efforts are being made to engage caregivers to catch up on missed vaccinations including through community outreach.

Challenges met and overcome

With more than 85% of refugees hosted in low- and middle-income countries which often have weak health systems and limited capacity to manage persons with severe disease related to COVID-19, UNHCR focused its health system support on areas that could be scaled up in low resource settings with a combination of clinical and public health responses. These included training of partner health staff in surveillance, case management, including provision of oxygen therapy for those in need, contact tracing, isolation and quarantine and communicating with communities. Where possible, national health services have been supported to provide case management to refugees and host communities. To ensure an integrated and inclusive approach UNHCR advocated inclusion of refugees and other people of concern into national COVID preparedness and response plans and measures to overcome barriers to access health services.

Lockdowns and reduced opening hours of health facilities contributed to reduced utilization of facility-based services in some settings, with reductions in the number of outpatient consultations recorded in 2020 compared to the same time period in 2019. Rwanda experienced an 8% reduction in the cumulative number of outpatient consultations, Uganda a 9% reduction, while data from Burundi and the United Republic of Tanzania showed no change. Of the 13 countries reporting comparable data in the health information systems there was a 9% reduction in inpatient admissions from 65,339 in March to August 2019 to 59,659 during the same period in 2020. This may be due to more stringent admission criteria or people reluctant to access services.

Life-saving medical referrals to secondary and tertiary hospitals were seriously affected in some countries especially during the initial phase of the pandemic when governments imposed lockdowns and travel restrictions. Priority was given to life-threatening emergency cases and many referral hospitals stopped admitting non-emergency cases. This has led to a major backlog of patients requiring elective medical surgeries and specialist care and will require considerable effort to address. In Lebanon, referrals reduced from March to June, with referrals in June 30% lower compared to January. These were mainly related to elective specialist services and did not impact obstetric care services.

In South Sudan there was a 51% reduction in children enrolled for treatment of severe acute malnutrition and a 31% reduction in pregnant and lactating women enrolled in supplementary feeding. Similar reductions have been noticed in some other countries. In response, admission criteria were simplified using mid upper arm circumference (MUAC) and mother or family MUAC was initiated to

enroll acutely malnourished children into treatment programmes in countries including Ethiopia, Sudan and the United Republic of Tanzania. Since not all malnourished children will be identified by MUAC screening, UNHCR and partners enhanced community mobilization and awareness raising using remote communication tools (radio, mobile phone, as per context), and enhanced coordination, referral and follow-up mechanisms with health care (especially antenatal and post-natal care) and other community based services / partners. Ethiopia will also move to wireless weighing scales for contactless assessment.

There were also changes in the way food and in-kind assistance was distributed. UNHCR developed guidance on registration and assistance and operations increased physical distancing by reducing crowds, ensured proper handwashing prior to the collection of assistance, ensured referral to health professionals if and where people were symptomatic, developed alternative modalities of distribution (including mobile money where possible), and shifted to non-contact iris scanning for biometric identification where possible.

Guidance regarding the maintenance of sexual and reproductive health (SRH) services was shared and operations adapted service delivery to comply with COVID-19 related restrictions. Of 13 countries reporting comparable data in the health information system, SRH services were able to be maintained in 2020 at similar levels to 2019 with a 5% increase noted in 2020 (262,963 essential SRH services were provided from March to August in 2020 compared to 249,921 in 2019). There were also 9% more deliveries reported in 2020 (28,236 versus 25,329 in 2019) indicating that women were still accessing safe delivery services.

The following changes were made to facilitate continuity of services.

- Maternities were equipped with additional material to allow all pregnant women coming for delivery and other emergency obstetric care and their health providers to wear masks during hospitalization. Health information highlighted continuous priority of facility-based deliveries with skilled birth attendants (this included Bangladesh, Cameroon, Chad, and the United Republic of Tanzania).

- In the initial phase under confinement in Uganda, pregnant women were provided with a special laissez-passer allowing their unhindered access to maternity services.

- Physical distancing required the re-organization of antenatal care and postpartum consultations. These generally overcrowded services were re-organized to allow only small groups of women at a time by increasing consultation days and extending consultation hours (Chad, the Democratic Republic of the Congo (DRC), Uganda, and the United Republic of Tanzania).

- Hotlines for gender-based-violence (GBV) outreach and support were established, including material support (protective masks and hand washing) to ensure re-opening of safe houses (DRC, Ecuador, and across West and Central Africa).

- Crowd avoidance made market-based health promotion activities extremely difficult, but outreach teams increased targeted door-to-door outreach to share essential information on SRH in general and contraception specifically. Health promotion incorporated key messages regarding COVID-19, but also integrated appropriate messaging in view of increased GBV, and the risk of domestic and intimate partner violence (across West and Central Africa).

- Provision of antiretrovirals and contraceptives (pills) was increased to form stocks for several months whenever supplies allowed (South Sudan).

- Community health workers were involved to track defaulters and help supply patients in need with anti-retrovirals.

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Communicating with communities has been critical to ensure timely and factual information on how to protect oneself and one's family, where to go for services, and to promptly dispel myths and misconceptions. With a participatory approach that takes into account age, gender and diversity, UNHCR used a range of methods to communicate with communities such as with information materials, radio spots, help lines, call centres, community outreach volunteers, and community health workers among others, with particular attention to two-way means of communication. 75% of UNHCR operations reported reaching all geographic areas inhabited by refugees, IDPs, migrants and host communities with information campaigns about COVID-19 pandemic risks (112 of 150 countries).

In Lebanon, for example, UNHCR supported the Ministry of Public Health's call center with staff and equipment, and supported the expansion of local government hospitals. Six governmental hospitals across the country were expanded and rehabilitated in order to receive and treat COVID-19 patients and avoid competition for care, with 800 additional beds and 100 additional intensive care unit beds, ventilators, advanced equipment, and medicinal stocks made available.

In Greece, national risk communication messages were translated and disseminated through community outreach, websites and social media. In Zimbabwe's Tongogara refugee camp, UNHCR, partners and the Ministry of Health strengthened COVID-19 awareness among youth and persons with disabilities through structured small group discussions.

Mental health and psychosocial support

UNHCR adapted its activities for mental health and psychosocial support (MHPSS) to the changing context of the pandemic. Staff of UNHCR and partners, in country offices in all regions of the world, developed innovative field practices to continue providing essential MHPSS services to refugees. The adaptations include:

- Community messaging about coping with distress delivered in appropriate languages using contextually relevant dissemination methods.
- Training first responders in psychological first aid (PFA) and basic psychosocial skills as the way people respond to others in distress can make a major difference. In many settings, PFA needed to be adapted to the COVID-19 context in which helpers had to provide support while keeping distance or working remotely, such as through helplines. UNHCR and partners organized trainings around the world for medical personnel, protection staff, outreach volunteers and other frontline workers to build basic psychosocial helping skills to people directly or indirectly affected by COVID-19.
- Increasing capacity to provide psychological therapies for refugees with mental health issues such as depression, anxiety, and bereavement. Movement restrictions and the need for physical distancing meant that group-based therapies had to be temporarily halted or given in adapted forms such as, for example, with smaller group sizes, or through tele-counselling (especially for people with complex needs).
- Ensuring continuous care for persons with moderate to severe mental health conditions including through more extensive use of community-based workers and by adapting facility-based care to prevent infections.
- Ensuring that persons with severe protection risks continue to receive psychosocial support such as through providing GBV survivors with support by telephone or in-person in safe shelters.
- Attention for mental health and wellbeing of refugees supporting others in their community: Many local UNHCR offices and partners have taken measures to provide mental health and psychosocial support for humanitarian responders, including refugees who work as volunteers.

All data collection activities that involve in-person interaction, such as population-based surveys, including standardized expanded nutrition surveys (SENS) are suspended. Considering UNHCR and its partners conduct around 90 nutrition surveys a year around the world, this particularly affects monitoring of the nutrition and related food security and public health status of people of concern. Critically, the surveys allow for early intervention in situations where the health and nutrition situation in children is deteriorating. As an example of compensating for this situation, in Rwanda, a remote nutrition survey was conducted by UNHCR and WFP to fill in the data gap; and in the United Republic of Tanzania, a remote joint assessment mission is planned to do a secondary data analysis using the existed data to understand the nutrition and food security situation.

Testing for COVID-19 at country level is generally centralized at designated laboratories. Samples from suspected cases in refugee camps are collected and transported for testing with a turnaround time of approximately 24-72 hours at best, but which can sometimes be as long as 10 days in some places. This is a challenge for case management and decisions on isolation and contact tracing. Despite the availability of decentralized testing equipment in a number of refugee hosting areas there are insufficient tests, and this because of the lack of tests available globally. UNHCR is actively in the WHO-led global diagnostic consortium determining country allocations and has managed to procure 15,000 tests for decentralized testing but this is insufficient to meet the needs. UNHCR has been participating in the technical evaluation of PPE in the joint UN tender.

As part of its effort to promote a comprehensive and inclusive approach to addressing the needs of refugees and IDPs, UNHCR entered into a tripartite agreement with the African Development Bank and the G5 Sahel to support the COVID-19 response across the five countries of the Sahel region. Funded through the framework of the African Development Bank's COVID-19 response facility, the $20 million will allow the Governments of Burkina Faso, Chad, Mali, Mauritania and Niger to strengthen their national health response to prevent the spread of COVID-19 and limit its social and economic impact in a region already facing a dire humanitarian crisis. Implemented with the support of UNHCR, the project will prioritize activities in areas most impacted by conflict and violence, with a high concentration of forcibly displaced people and limited presence of government institutions. In line with the objectives of the Global Compact on Refugees, this partnership serves as a model for other financial and development entities to explore and engage in addressing the massive needs created by forcible displacement during the pandemic.

COVID-19 is causing challenges for cross border movements of new arrivals or voluntary organized repatriation. Many receiving countries are requiring COVID-19 testing before onward travel to areas of origin or further into the country of asylum. The lack of COVID-19 testing capacity in many countries is limiting the number of returnees at one time, and also hampering efforts for the reception of new arrivals. UNHCR is working with governments to adapt testing strategies and seeking additional support to scale up testing.

SPOTLIGHT: Refugees on the frontlines

Saidul Karim spends his days moving from shelter to shelter along the muddy paths that crisscross Kutupalong refugee settlement in Bangladesh. The families who open their doors to him know him well. He is one of over 1,400 Rohingya refugees trained to go door-to-door in the densely populated camps that house some 860,000 Rohingya refugees, sharing information about health and hygiene, looking out for signs of illness, recording births and deaths, and acting as a bridge between refugee communities and health facilities.

The trust Saidul and other volunteers have built with the families they visit has been critical since the first cases of COVID-19 were detected in Cox's Bazar in May. They have been able to counter rumours circulating in the camps with accurate information and practical advice. Saidul now visits the 150 households in his assigned block every week.

Saidal's story is one of thousands around the world.

In Europe, refugee health workers were involved in national COVID responses, with employment of refugee doctors and health workers increasingly enabled. Across the Middle East and North Africa over 24,000 outreach volunteers worked closely with UNHCR and partners and 66,009 visits were conducted to support families in remote areas and other people with specific needs. In Guatemala, frontline workers were trained on the mental health and psychosocial needs of people on the move during COVID-19, to strengthen identification and referral to available services. Similarly, in Greece, refugees and asylum-seekers were trained as paraprofessionals to address psychosocial needs, bridging national mental health and social services and staffing helplines in Arabic, English, Farsi and Greek, offering psychosocial support, information about COVID-19, liaising with protection services, and providing referrals to psychological or psychiatric specialists. Helping teachers stay in touch with their pupils, tutoring groups were established by refugee volunteers in Cameroon.

These and so many more examples throughout this report testify to how and where refugees and other forcibly displaced people have stepped up their engagement and commitment to their communities, contributing across the range of the response from health, to protection, to education.

Learn more

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Water, sanitation and hygiene

Key achievements or targets met

47,021,000 bars of **soap** distributed

165 persons per **usable handpump / well / spring**[2]

264 persons per **usable water tap**[3]

19 litres of safe water available per person per day[4]

1,451,159 persons per **hygiene promoter**[5]

To facilitate adequate infection prevention and control measures in health care facilities, UNHCR bolstered the water supply, handwashing facilities and soap available. In the East and Horn of Africa and the Great Lakes region alone, 108 health structures designated for COVID-19 response were provided with additional WASH facilities. In the same region, 95 schools were provided with additional hand washing facilities.

Business continuity planning involved operations anticipating potential disruptions to supply lines or access to populations of concern due to lockdowns. Some operations faced restricted movements which meant that teams had to support people of concern remotely. For example, in Djibouti, community members managed the water pumping and distribution activities when access was temporarily restricted.

[2] Reported in 10 countries in UNHCR's WASH monitoring systems for refugee settings.
[3] Reported in 16 countries in UNHCR's refugee WASH monitoring system.
[4] Reported in 22 countries in UNHCR's refugee WASH monitoring system.
[5] Reported in 22 countries in UNHCR's refugee WASH monitoring system.

The amount of safe water made available has been increased as much as possible to allow for increased handwashing. This is not possible everywhere as some locations are water stressed and increased pumping would do long term damage to water resources. In some locations, this has meant a recourse to water trucking. To reduce potential transmission in communities, physical distancing at water collection points has been enforced and pumping and water delivery times adapted to reduce congestion.

Additional handwashing facilities have been installed in critical locations to increase hand hygiene uptake with 3,400 being constructed in DRC alone and 32,421 in the East and Horn of Africa and the Great Lakes.

In Bangladesh, where water quantity is less of an issue, 70,000 household level 'tippy taps' were distributed. In the Americas, water access was improved for people with special needs and spontaneous returnees in the Bolivarian Republic of Venezuela, along with 20,000 hygiene kits.

Hygiene messages are being crafted based on the latest information regarding COVID-19 and the delivery of messages is being adapted to reduce the potential for transmission, with operations finding innovative ways to communicate key messages to communities. In South Sudan, for example, refugees wrote and recorded songs about COVID-19 and broadcast them over local radio.
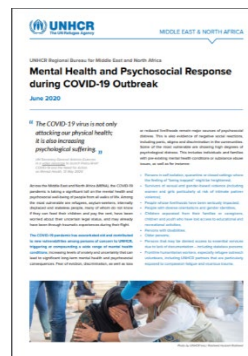
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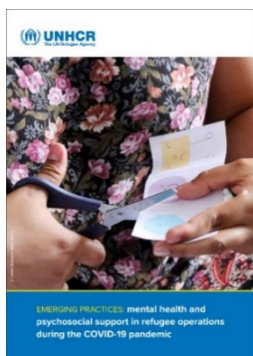
Emerging practices: mental health and psychosocial support in refugee operations during the COVID-1 9 pandemic

Emerging practices: WASH and COVID-19 field practices

Middle East and North Africa: Mental health and psychosocial response during COVID-19

Challenges met and overcome

UNHCR and both operational and implementing partners have focused their response on two major axes: first, on ensuring adequate WASH services in health care facilities and other institutions. Second, and critically, providing sufficient quantities of water, soap and handwashing stations to people of concern to facilitate hand hygiene given its function as a critical barrier to disease transmission generally and COVID-19 specifically. UNHCR developed and disseminated technical guidance on WASH for camps and settlements highlighting the need for action on several fronts: in health care facilities and institutions, WASH for infection prevention and control, physical distancing, risk communication and community engagement, and planning for business continuity.

Strengthen risk communication and community engagement, critical protection services and registration

Key achievements or targets met

9,339,543 people who have **accessed protection services**
151 countries approved

72% of countries where **GBV services** are maintained or expanded in response to COVID-19
52 countries reporting

85% of countries inhabited by IDPs, refugees and migrants with **feedback and complaint mechanisms** functioning
165 countries reporting

43% of countries reporting **instances of xenophobia, stigmatization or discrimination** of people of concern related to COVID-19
173 countries reporting

75% of countries where areas inhabited by refugees, IDPs, migrants and host communities are reached by **information campaigns about COVID-19** pandemic risks
150 countries reporting

UNHCR storymap on how the pandemic has impeded efforts to protect the displaced and affected their access to basic rights, **here**.

Access to international protection

To combat the spread of COVID-19, States legitimately restricted international movement of people to protect public health. In April 2020, 167 States had implemented full or partial border closures, with 90 providing no exceptions for people seeking international protection. By September, those figures had dropped to 156 and 75, respectively. States that have maintained exceptional access for asylum-seekers serve as positive examples for those with stricter approaches.

UNHCR has emphasized how States can safeguard public health while ensuring access to territory and protection for those in need, including through use of quarantine, reasonable limitations on free movement, and flexible or alternative arrangements for asylum claim registration, issuance and renewal of documents, and processing of individual cases. UNHCR operations have appealed to States' interest in managing arrivals in an orderly, protection-sensitive and effective fashion.

Allowing asylum-seekers to lawfully enter and be registered at borders, followed by appropriate quarantine or movement restrictions, has facilitated control of infection more effectively than the irregular movement and entry at unofficial border points. UNHCR has worked with State authorities to adapt the registration of new asylum applications by mail, phone, email, and online so those seeking protection are still able to do so. More than 107 States have adapted registration procedures for new applicants. Colombia for example has remotely registered 57,741 individuals (73% women) since the start of the pandemic, ensuring that they are able to access critical services.

While 31 countries have announced derogations from their human rights international obligations since the start of the pandemic, nine have subsequently lifted their states of emergency and associated derogations.

Acknowledging that States may, in extreme circumstances, derogate temporarily from certain human rights, UNHCR has recalled non-refoulement is a non-derogable right constituting the cornerstone of international refugee protection. As such, non-refoulement prohibits non-admission and rejection at borders that could expose refugees or asylum-seekers to the risk of persecution, torture, or inhuman treatment or punishment. In those countries where states of emergency have expired, operations are advocating the reduction or removal of far-reaching restrictions as the rationale for their promulgation no longer applies.

Challenges met and overcome

The COVID-19 pandemic has exacerbated protection concerns in humanitarian crises by exposing refugees, asylum-seekers, IDPs, host communities and stateless persons to new threats. Despite a range of challenges, UNHCR has worked with communities of concern, governments, and partners to deliver essential services including through remote modalities all the while ensuring the rights of people of concern are respected and their voices heard. Life-saving protection actions include individual assistance and advocacy for rights, registration and documentation, specialized services to children, older persons and persons living with disabilities, case management for survivors of gender-based violence and referrals to medical care, psychosocial support, security, and legal aid.

Access to asylum

Some countries entirely or partially suspended asylum, resulting in lack of access to safe reception conditions. Other States, however, introduced early adaptive measures for the automatic or remote extension of validity of asylum documents, the safe submission and receipt of asylum applications, and the use of online interviews or adjustments to facilities in accordance with public health guidelines. While many of these adaptive measures required technical capacity, others did not and only required political will (such as amnesty or the automatic extension of documents' validity). At least 112 State asylum systems are now fully (58) or partially (54) operational while only 19 are not; most States continue to provide asylum-seekers with information about ongoing suspension or resumption of the asylum process, including any precautionary measures.

Examples include operations in the Middle East and North Africa which adjusted their RSD procedures and set up remote processing methodologies under strict conditions and requirements set out at regional level, with a view to maintain access to protection and durable solutions, while preserving integrity. The Ghanaian government introduced an online appointment system for asylum registration and case interviews. Asylum-seekers can, moreover, request the renewal of documents online through social media, text messages, email or by telephone.

Other examples come from Ecuador where, in March 2020, asylum authorities launched a new remote system to register asylum applications, conduct interviews, and notify asylum decisions. In the Americas more widely, 108,058 people returned to the Bolivarian Republic of Venezuela from or through Colombia as of the end of September. Other borders, such as the Mexican-Guatemalan, are witnessing increasing movements. Meanwhile, asylum applications are on the rise in Mexico, with 26,255 claims lodged as of 18 September. In Peru a remote system launched last June has registered 30,280 asylum-seekers.

In Europe, many countries maintained access to territory and asylum or quickly re-established such access following brief suspension, including through innovative practices. UNHCR issued Practical Recommendations and Good Practice to Address Protection Concerns in the Context of the COVID-19 Pandemic in Europe which compiles and highlights European States' good practices. The Office also issued practical considerations for remote interviewing in Europe. UNHCR, as co-chair of the Issue-Based Coalition on Large Movements of Population Displacement and Resilience (Europe and Central Asia region), also released key messages and recommendations providing concrete guidance for Resident Coordinators and UNCTs to ensure the inclusion of migrants, refugees, IDPs, stateless people and vulnerable communities in the socio-economic assessments and response plans.

As State practice shows, it is possible to continue enabling access to asylum and documentation during the pandemic. At the same time, while countries adapt asylum procedures, procedural safeguards—including access to legal aid—must also be ensured. Simultaneously, States must quickly and fairly address the backlogs of cases that have accumulated during the pandemic as they resume processing asylum applications. Without such planning, the risk is high that quality will diminish and waiting times will escalate resulting in serious protection risks, including heightened vulnerability of people of concern.

Informing and engaging communities

Early in the pandemic, restrictions on movement and the near-complete shutdown of economic activity impeded people's access to services and UNHCR's ability to deliver protection and solutions. Operations across all regions altered their modus operandi by leveraging existing community-based structures as well as technology to ensure two-way communication and access to accurate information among people of concern.

Community and religious leaders, outreach volunteers, and members of women's and youth groups translated, adapted and disseminated culturally appropriate and understandable information through, for example, social media, going door-to-door, bicycling to isolated communities, assembling in small groups, or using megaphones and loudspeakers. Most country operations undertook information campaigns in support of government efforts, reaching remote or otherwise hard-to-reach areas inhabited by refugees, IDPs, and stateless persons; 85% of countries reported having functioning feedback and complaints mechanisms (165 countries reporting).

Although many operations prior to the pandemic embraced information technology to communicate more efficiently with people of concern, COVID-19 boosted those efforts, which have sought to ensure uninterrupted communication and engagement with communities and individuals globally. Operations bolstered call centers with integrated voice response in target languages and established 24/7 protection hotlines to take calls, followed by interventions aimed at safeguarding access to rights and services.

Country offices built capacity to staff these helplines remotely with home-based operators and third-party interpreters. With limited access to people of concern, email queries grew significantly requiring technological innovation to provide rapid response. Operations reached millions of people through bulk SMS texts, audio and text WhatsApp messages. Chatbots were developed to automatically respond to common questions, and communication trees deployed to propagate accurate information across community networks. Two-way communication via social media proliferated on Twitter, Instagram, Trello as well as dedicated Facebook, Kobo, and UNHCR helpline pages in multiple languages, including sign.

Statelessness and COVID-19

Stateless people are also facing increased economic hardship because they frequently live in precarious situations and depend on the informal sector for their livelihood. Moreover, as many States require national identification to access medical services, stateless persons in those countries are often denied testing, treatment, and other social services. Central Asian countries, however, have taken a fully inclusive and non-discriminatory approach to stateless persons in terms of testing and treatment. Kenya and Thailand are also providing testing and treatment to stateless persons.

The suspension of birth registration in some countries has raised the risk of statelessness for newborns there, particularly those of minority groups. The trend is somewhat positive in terms of the number of countries that have declared civil registration services essential and moved towards innovative ways to ensure birth registration can continue and the validity of nationality documentation can be renewed or the timeline for renewal extended. Burkina Faso and Côte d'Ivoire, for example, have resumed issuance of civil documentation. Many States, including the Islamic Republic of Iran, are relaxing deadlines for registration of vital events. Likewise, many States such as Costa Rica, Italy and the United Kingdom are allowing online submission of applications for statelessness and interviews to be conducted remotely.

All platforms enabled UNHCR to spread timely and accurate health information while countering myths, misinformation, stigma, and xenophobia. Operations disseminated risk-mitigation, prevention and hygiene messages, statistics on the coronavirus, host government directives and policies related to the pandemic, as well as the rights and responsibilities of people of concern. They gained access to updated information on referral pathways to essential services, contact details, opening hours, appointment systems, and complaints mechanisms. People of concern also received information on protection risks related to COVID-19, including on evictions, GBV, child protection, and protection from sexual exploitation and abuse.

As concrete examples, in the Middle East and North Africa, UNHCR's investments in community-based protection to enhance inclusion and participation of all communities'

members proved vital. Over 900 community centres remained open, with some periods of suspension during COVID 19. Community-led initiatives, targeted visits and digital communication tools were expanded to reach vulnerable people, over 24,000 outreach volunteers worked closely with UNHCR and partners, and 66,009 visits were conducted to support families in remote areas and other people with specific needs. Some 614,000 people were reached though WhatsApp groups, outreach volunteers, and mass communication campaigns in Syria.

In Italy, a national hotline number was made available in 36 languages and a multi-lingual information portal—'JUMA'—provides refugees and asylum-seekers with access to information on COVID-19 in 15 different languages, as well as health advisories, regulations and movement restrictions, administrative procedures and available services.

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In West and Central Africa, teachers, community health workers, and hygiene promoters in Eastern Chad reached more than 128,000 refugees (96% of the refugees in the province). In Sudan, 54,000 refugees received risk communication on awareness, health promotion, infection prevention, and stigmatization. An assessment conducted subsequently showed that 96% understood the prevention messages received, including where to go to for assistance if they develop COVID-19 symptoms. In Colombia assistance was provided to more than 20,000 Venezuelan refugees, returnees, and IDPs via 47 helplines. In the DRC, humanitarian partners reached more than 1.5 million refugees, IDPs and members of host communities through COVID-19 awareness-raising across the country via group discussions, flyers, and door-to-door messaging, with an additional estimated 700,000 reached amongst refugee, IDP and host communities through radio programming.

Connectivity remains a significant challenge, especially in remote and conflict-affected areas. In Chad, Libya, Niger, and Yemen, poor connectivity hampers the ability to ensure vulnerable communities are kept informed. Connectivity issues also restricts the capacity to monitor rights violations and manage the

COVID-19 response. In Myanmar, an internet ban was in place for several months in central Rakhine State, while the internet was inaccessible in Ethiopia for three weeks in July. To reach those without access to such technology, COVID-19 public service announcements were instead broadcast using more ubiquitous means such as radio and TV. For example, in Burkina Faso a daily COVID-19 news programme for IDPs and host populations was broadcast on 37 radio stations in local languages.

During the pandemic, refugee, IDP and other affected communities played a critical role in taking actions to enhance their own protection. UNHCR operations benefited greatly from being able to communicate and work with their established networks at the community level, both to operationalize and coordinate their protection response as well as monitor the rapidly changing protection situation for people of concern during the pandemic. Prioritizing investment from the onset of emergencies in community-based approaches to protection as well as in effective accountability to affected people mechanisms, in all refugee, IDP and mixed situations in which UNHCR engages, will continue to be key areas of work going forward.

Xenophobia, stigmatization, and discrimination

UNHCR operations in 45 countries have documented COVID-related incidents of xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons. Displaced and other marginalized groups have been accused of spreading the virus since the outbreak of the pandemic in early 2020. Xenophobic messages on social media or in the news has led to violence and discrimination against non-nationals including incidents of eviction, denial of medical service, or expulsion from hotels. Engagement with affected

communities has been critical in mitigating the impact both of the virus itself as well as new protection risks. For example, UNHCR Colombia launched the online campaign *Somos Panas* to combat xenophobia and discrimination against refugees while UNHCR in Zambia is working with the Government to dispel fears and clarify misperceptions among host populations regarding COVID-19 outbreaks. UNHCR is also working with States to ensure that COVID-19 related policies do not have discriminatory effects against forcibly displaced persons.

Response to gender-based violence

The pandemic has impacted people of concern differently based on age, gender, and diversity. In many countries, forcibly displaced women and girls have been disproportionately affected, and gender-based violence has increased throughout the pandemic. Countries in all seven UNHCR regions and in 24 of 26 field protection clusters and GBV Areas of Responsibility (AoRs) report increased incidence of GBV, including a surge in domestic and intimate partner violence. There are also reports of a rise in harmful practices against girls such as female genital mutilation and child marriage, which have been reported in 15 out of 26 field protection clusters and GBV AoRs.

Service providers adapted existing referral pathways and bolstered community-based protection mechanisms. Protection staff in countries such as Kenya, Pakistan, South Sudan, and Zambia created or expanded 24/7 multi-language hotlines that are key entry points for survivors. Throughout Colombia, protection partners established 29 information kiosks and GBV focal points providing orientation, case follow-up, psychosocial, and legal support for GBV survivors by phone and email. Many operations like Lebanon broadened their network of community outreach volunteers who serve as a safe and trusted means to refer GBV survivors to services. Protection actors in Syria have conducted virtual trainings on GBV for community volunteers and hotline staff. Since the start of the pandemic, this outreach has contributed to awareness raising of available sexual and reproductive health services, which were accessed by 467,659 women and girls, who benefited from a range of services, including, when needed, medical care to survivors of rape. In Greece, community referrals were facilitated through social media networks. UNHCR operations in Zimbabwe and Mozambique distributed SIM cards and phone credit to community mobilizers to ensure survivors have access and referral to vital protection services. In Burkina Faso, UNHCR launched mobile clinics and GBV mobile teams to provide medical, psychosocial, and legal support services to survivors of GBV in remote and insecure areas. These clinics, organized in consultation with local authorities, allowed survivors to receive care within 72 hours and improved communities' mechanisms for identifying and referring GBV cases.

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# Ensuring access to protection and education for children

Child protection risks escalated across operations: 23 of 26 field protection clusters and child protection AoRs report an increased occurrence of incidents or heightened risks of violence against children because of COVID-19 measures. With full consideration of the factors of age, gender, cultural, religious identity and education level, child-friendly messages are designed in consultation with parents, caregivers and with the children themselves, and delivered through posters, songs, story-telling and drama. UNHCR protection partners supported community-based mechanisms to protect children, including child protection committees, parenting groups, adolescent clubs, community volunteers, sports and child friendly spaces, and life-skills education groups.

In Mexico, protection partners developed child-friendly information materials on COVID-19 and supported recreational activities during the lockdown. In Afghanistan home-based and door-to-door psychosocial support kits for children and families were accessed by 100,724 people in the first half of this year. In Chad, protection staff mobilized community

child-protection networks, preschool teachers, and mother-teacher-associations to conduct door-to-door sensitization of the coronavirus. In Bangladesh, Ecuador, Pakistan, and Ukraine, procedures for remote case management include assessments and counselling sessions for children. Protection partners in Ukraine increased emergency assistance to unaccompanied and separated children to cover basic needs and rent. In Ecuador and Ethiopia, monitoring of care arrangements continue to take place through phone calls and the mobilization of community volunteers. In Egypt, Ethiopia, Lebanon, Uganda and the United Republic of Tanzania, Best Interest Procedures take place through remote coaching and supervision, and stipends were granted to cover communication and transportation costs.

While out of school, children are exposed to further risk of armed recruitment and forced labor (reported in 17 out of 26 protection clusters). Protection partners have thus been working to ensure education programmes can reach children living in some of the most vulnerable communities.
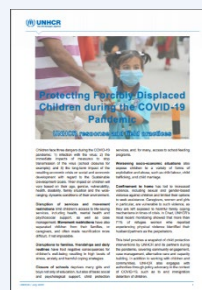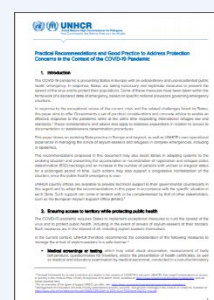
Further reading
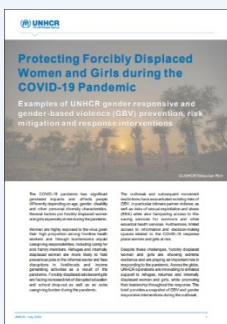
Protecting Forcibly Displaced Women and Girls during the COVID-19 Pandemic

Protecting Forcibly Displaced Children during the COVID-19 Pandemic

Supporting community leadership in response to the COVID-19 pandemic

Practical Recommendations and Good Practice to Address Protection Concerns in the Context of the COVID-19 Pandemic in Europe

UNHCR's stepped-up IDP approach during COVID-19

For the protection of IDPs and their host communities, COVID-19 is a crisis within the crisis. Like refugees and stateless persons, IDPs have been disproportionately impacted by the pandemic, which is worsening the existing protection and socio-economic concerns they had and creating new ones. While active COVID-19 cases are reported in 26 out of 32 countries where protection clusters operate as of August 2020, 80% of operations report escalating conflict and/or political instability. Intensifying violence and conflict, as well as violations of international humanitarian and human rights laws since the outbreak of COVID-19, have triggered new internal displacement impacting hundreds of thousands of people, in particular in Africa and the Middle East, undermine efforts to curb the spread of COVID-19 and reduce safe access to life-saving humanitarian services.

Internally displaced people may face risks which are specific to their displacement in the context of COVID-19, aggravating existing vulnerabilities or creating new ones. Among them are the following:

- Impact on health: as IDPs are frequently located in crowded conditions in camps, camp-like settings or urban slums, this can accelerate the spread of the virus, in particular in locations where water and sanitation services are not adequate. In addition, IDPs may face challenges in accessing national health systems, including due to the lack of documentation, lack of availability of services, and possible discrimination.

- Impact on the socio-economic situation: loss of livelihoods, including daily labour opportunities, leaves IDPs who were previously able to meet their own needs vulnerable to exploitation and abuse. Those who continue to work, often as day laborers or in the informal sector, expose themselves to the risk of becoming infected with COVID- 19.

- Impact on protection: flight due to continuing conflict and persecution may be further hindered due to pandemic-related movement restrictions. This may also affect the ability of IDPs from voluntarily returning and reintegrating in locations of origin. In addition, tensions between host and IDP communities may arise due to the worsening local economic conditions, existing xenophobia, and a new competition over resources.

Given the pandemic-related complexities in addition to those with which IDPs were already confronted before, UNHCR recommended the UN Secretary-General's High-Level Panel on Internal Displacement consider four imperatives that underlie the main risks for IDPs, especially those displaced due to conflict and persecution. These include:

1. Amplification of the Secretary-General's appeal for a global ceasefire as conflict is a root cause of internal displacement, and a ceasefire will potentially prevent further displacement and offer solutions for some IDPs.

2. IDP inclusion in national programs and social safety nets responding to the socio-economic impact devastating already impoverished IDP households.

3. Urge states and development partners to ensure that IDPs are included in state-led initiatives benefiting from international financial support.

4. Advocate against forced return to insecure places of origin, as this cannot be undermined on the basis of exceptional measures within the response to the pandemic.

To mitigate the impact of COVID-19 on IDPs, UNHCR stepped-up its IDP approach such as in Burkina Faso where it provided direct operational support to regional health authorities to strengthen their prevention and response capacity. Activities included in-kind support for the purchase of medicine, medical equipment and supplies, as well as provision of hand-washing stations and housing units to allow for isolation and quarantine. Strengthening community awareness for the prevention of COVID-19, UNHCR partnered with Fondation Hirondelle (FH) to produce a short daily COVID-19 news program for IDPs and host populations, broadcast through 37 partner radios across the country, including in local languages such as Fulfudé and Moré.

In Mozambique and Somalia, UNHCR supported the dissemination by community protection workers and IDP leaders respectively of door-to-door messages on COVID-19 prevention and access to services in IDP neighbourhoods. In Ukraine, UNHCR advocated the preservation of freedom of movement at checkpoints between government and non-government-controlled areas, at least to ensure continued crossing on humanitarian grounds. In Iraq, UNHCR supported IDP families' access to basic hygiene items through cash assistance. The disbursement initiated in April, facilitated over 65,260 IDP families to access assistance through their e-wallets. A target of over 80,000 IDP families largely residing in 37 UNHCR managed camps is planned.

In DRC, the Protection Cluster and CCCM Working Group jointly advocated additional land close to current displacement sites in Ituri and North Kivu provinces, as well as for the successful inclusion of IDPs in the national COVID-19 response plan. In line with the UN-coordinated response, UNHCR

enhanced its operational response to COVID-19 through partnerships with local NGOs in Sudan, which have been critical in boosting operational response efforts at a time where mobility is challenging. In Colombia, UNHCR has provided authorities with refugee housing units and tents to establish isolation areas in IDP sites and field hospitals across the country.

Throughout the pandemic, UNHCR and the Global Protection Cluster have also continued to directly support the work and advocacy efforts of the Special Rapporteur on the Human Rights of IDPs, especially during her interventions on COVID-19 and the protection of IDPs in the media, within the IASC and in the context of the GP20.

UNHCR and protection cluster partners are particularly concerned about the severe impact the pandemic is having on the already fragile socio-economic situation in which IDPs live and on their psychological distress. Harmful coping mechanisms are forecasted to escalate. The economic down-turn created by the pandemic is drastically reducing IDPs' ability to cope with their daily challenges, particularly the most vulnerable amongst them, making them vulnerable to abuse and exploitation, with few safe alternatives. In response to these multifaceted challenges, protection actors have worked alongside IDPs to ensure the most vulnerable, in particular older persons and persons with disabilities, have access to healthcare, that two-way communication is effective even where IDPs cannot be reached in person, to respond to gender-based violence and child protection, to address risks of eviction and identify those most in need of livelihood assistance, and, to continue to monitor and analyze evolving contexts to inform advocacy efforts.

Global cluster leadership

The **Global Protection Cluster (GPC)** and national protection clusters have worked to advocate for the rights of 191 million people in need of assistance, of which 104 million were in need of protection services and assistance, in 32 humanitarian operations. This included 15 in Africa, seven in the Americas, five in the Middle East and North Africa, four in Asia and the Pacific, and one in Europe.

The GPC developed a Global Operational Footprint highlighting the importance of protection activities and services during the pandemic, the exacerbation and emergence of multiple protection risks and negative harmful coping mechanisms due to the outbreak and identifying critical protection activities and services to be provided across field operations.

The GPC focused on building and communicating the latest evidence on protection, including its COVID-19 dashboard and regular 'Situation Reports' pulling together the latest data from national clusters to report on global protection trends, along with analysis from across the cluster membership. The GPC also created key messaging that has been endorsed by the IASC system to put protection firmly at the heart of the COVID-19 response, along with hosting a series of donor briefings and advocacy towards member.

Working with Humanitarian Country Teams, the GPC is revising protection strategy guidance and published the HCT Protection Strategies Review along with its annual review of the Centrality of Protection Review 2019. This takes a collective look at how the system has been able to move from declarations of the Centrality of Protection to its operationalization in varying degrees.

The GPC organized the Global Protection Forum, a series of webinars and events spread across the last four months of 2020, that examine contemporary and emerging protection challenges from wide ranging perspectives of protection service providers, humanitarian, peace and development partners, academics, and UN Member States. The sessions will be brought to a close by a High-Level Event that will bring partners together to take a comprehensive look at how the humanitarian community is positioned to address protection needs of the world's most vulnerable going into 2021.

The **Global Shelter Cluster's** coordination role has entailed issuing guidance and information to cluster coordinators, supporting development and exchange of guidance and standard operating procedures among national cluster peers, as well as supporting partners in the field to operate despite confinement measures and other challenges.

A dedicated COVID live page and dashboard was created on the Global Shelter Cluster website compiling IASC and shelter-related guidance from different countries and organizations in multiple languages. This included guidance on key issues such as considerations on tenure security and an advocacy paper containing five ways shelter and settlement programmes can mitigate the spread of COVID-19. In addition, the Global Shelter Cluster has maintained support to country level clusters including through regular webinars on how to mitigate COVID-19 through shelter activities and advocacy, with the Cluster Coordinator participating in the regular Global Cluster Coordinators' group calls on COVID and in all UNHCR COVID task force meetings.

The **Global CCCM Cluster** has assisted field actors with highlighting the particular vulnerability of IDP sites to pandemics. The Cluster's efforts have aimed at ensuring that, to the extent possible, measures to prevent and respond are in place in IDP sites, and that adequate response and referral plans are in place in collaboration with health actors. Country-specific guidance was developed in Iraq, Syria and Nigeria.

The non-medical implications of COVID-19 have also been very much present in the Cluster's response . The Cluster established a dedicated webpage where CCCM advice on key actions to take in IDP sites is provided, along with the best practices and COVID-19 measures in field level clusters to overcome non-medical challenges represented by the decreased level of access due to movement restrictions and reduced capacity of the IDPs to access livelihood and labour market.

The Cluster also conducted four webinars on COVID-19, including on Sphere standards, community engagement and participation, remote training, and adapting CCCM activities to urban and informal settings.

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

Key achievements or targets met

$338,970,113 total monetary value of **cash assistance distributed** (as of August 2020)

3 million people **benefitting**

54 contracts with financial service providers

97 countries with **cash-based intervention** (CBI) programmes, of which

63 with over **$100,000** expenditure

Cash-based assistance post distribution monitoring

3.1 million people **benefitting** (Q1 + Q2) of which

1.3 million as a result of **COVID-19-related activities**

Globally, UNHCR recorded a 6.8 % increase in cash assistance between January-August 2019 and January-August 2020. Proportionately, the East and Horn of Africa and the Great Lakes and the Southern Africa regions saw the largest increases, both over 30% as compared to August 2019 expenditure. The Middle East and North Africa, the East and Horn of Africa and the Great Lakes, and Europe regions saw the largest increases in monetary (absolute) terms.

Cash has proven to be an efficient means of getting assistance to affected refugees and IDPs fast, providing protection, empowering families to meet their basic needs, and mitigating some of the negative socio-economic impacts of COVID-19. UNHCR operations have adapted existing cash assistance, introducing new approaches and technology, designing new cash grants and targeting criteria to assist new vulnerable populations, developing exit strategies, increasing the use of digital payments, adjusting systems and complaints and feedback mechanisms and, where appropriate, aligning cash assistance with the government social assistance.

In Malaysia, for example, UNHCR provided urgent cash assistance to hard-hit urban refugees, with some 80% of recipients having experienced loss of income during the movement control order in Malaysia. Some 85% of respondents received the cash in time to meet their most urgent essential needs, with food, rent and utilities being the top expenditures. More than 30% felt that UNHCR's cash assistance had significantly improved their living conditions while over 60% highlighted that cash assistance had reduced their feelings of stress.

Another example comes from Jordan, which hosts close to three quarters of a million refugees, most living outside of camps, the majority of whom are vulnerable and unable to independently maintain a dignified life. UNHCR Jordan's unconditional monthly basic needs cash assistance is thus a lifeline for many, and has proven crucial in reaching people by remote. Cash delivery is enabled by the innovative banking delivery systems already in place, supported by beneficiary authentication designed to prevent fraud, and by measures ensuring physical distancing and hygiene measures during distribution and payment. Post-distribution monitoring results suggest that the distribution modalities of the monthly cash assistance generally work well: found that over nine respondents out of ten received the assistance on the day they were expecting it and were able to collect it at an ATM close to their place of residence. The feedback on service delivery is broadly positive, and the helpline well-known. Like in previous years, and in line with empowering refugees and IDPS to decide how they spend the cash based on their own priorities, the majority use the monthly cash assistance to pay for rent and food, and for survival during lockdowns when unable to access other sources of income.

In Ecuador, UNHCR hotlines have provided assistance to 17,628 cases (77% of them Venezuelans, and 19% Colombians). A little over half the calls were requests for cash assistance to help meet essential needs, such as food or housing. Since March, UNHCR has provided almost 14,000 households with cash via a remote system, applying qualification criteria that was widened as a result of the health crisis. The second most common request via the hotlines was for legal assistance to address questions about asylum procedures and access to migratory alternatives.

Following the restrictions and measures put in place by many governments to curb the spread of COVID-19, many refugees were unable to engage in their regular casual work, leaving them vulnerable with challenges to meet basic needs. An example of how cash mitigates this, in Uganda, WFP and UNHCR are jointly providing one-time cash assistance to all urban refugees in Kampala through mobile money. Joint post-distribution monitoring (PDM) demonstrates that over 74% of refugees were able to withdraw the assistance within one kilometre from their home. Overall, refugees spent their money on immediate basic needs: food, rent, utilities, hygiene items, and health being the largest expenditure categories, with the monitoring highlighting that expenditure on hygiene items increased significantly.

While cash assistance has helped refugees and IDPs cover some of their basic needs, major gaps remain. The situation is concerning for refugees due to their often-limited rights (such as restrictions on freedom of movement, right to work, access to land etc.), which in turn affects their ability to meet their needs. The available results from the 13 countries having conducted PDMs during COVID-19 suggest that 74% of the refugees can meet only half or less of their basic needs while over 40% of the respondents stated that they could not even meet half of their basic needs[6]. 83% of surveyed households, ranging from 48 to almost 100%, engaged in one or more negative coping mechanisms to meet their basic needs, representing an increase from pre-COVID.

Challenges met and overcome

Cash has come into its own in this crisis as a modality of assistance which is rapid, hygienic, and innovative.

The COVID-19 response has demonstrated that UNHCR is fit for purpose to deliver cash rapidly, and at scale. In collaboration with governments and other partners, more than 65 UNHCR operations have launched new cash initiatives and/or expanded existing cash assistance, reaching some 3 million vulnerable people.

Expenditure and use of cash
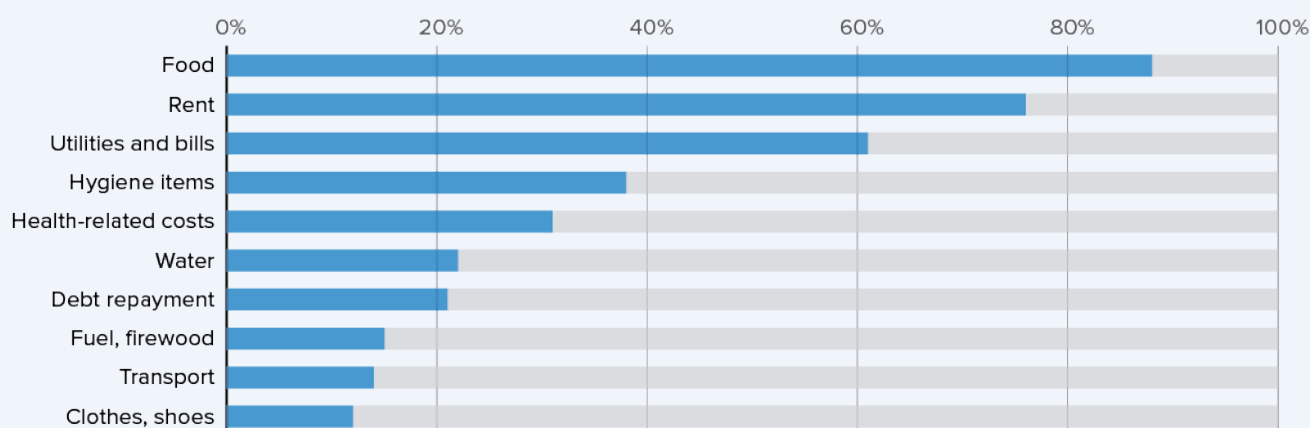
Because one person can spend the funds in multiple areas, they overlap. Therefore, percentages do not add up to 100.

[6] Angola, Cameroon, Central African Republic, Chad, DRC, Ethiopia, Kenya, Malawi, Nigeria, Uganda, South Sudan, the United Republic of Tanzania and Zambia.

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Shelter and settlements

Key achievements or targets met

743,635 people of concern reached with **shelter support**[1]

362,691 people of concern supported with shelter-related **core relief items**[1]

151 number of buildings (exluding shelters) **constructed or renovated**[1]

Decongesting and reducing human density in shelter and settlements to maintain physical distancing and reduce transmission, UNHCR and partners worked to improve the living conditions of people of concern though repairing, upgrading and extending existing shelters to reduce density and providing additional shelters for vulnerable families, implementing activities through a cash modality as a multi-purpose cash response where feasible.

Emphasis has been placed on decongesting and reducing human density in settlements to maintain physical distancing and reduce transmission. UNHCR has developed and disseminated guidance for high density settlement conditions so that infrastructure planning that facilitates a health response is available to all partners.

[1] Cumulative data from SIP and sitrep Reports from Afghanistan, Angola, Bangladesh, Burkina Faso, CAR, Chad, DRC, Ethiopia, Jordan, Kenya, Malawi, Mauritania, Myanmar, Niger, Nigeria, Rwanda, South Sudan, Syrian Arab Republic, Uganda, United Republic of Tanzania, Yemen.

Supporting emergency shelter, UNHCR has deployed 58,000 tents reaching more than 400,000 people of concern with emergency shelter support. A total of 8,800 refugee housing units were deployed or repurposed in 15 countries where they have been used in a variety of shelter and health-related purposes to support the COVID-19 response.

So as to distribute assistance in a way that avoids spreading COVID-19, operations have adopted procedures to adhere to physical distancing standards and limit large gatherings of people. For instance, in the new Bele settlement for South Sudanese refugees in the DRC, UNHCR ensured door-to-door distributions of food and CRIs to avoid crowds and limit potential human to human transmission. In Cox's Bazaar, Bangladesh, UNHCR examined how to safely resume additional COVID activities, while at the same time continuing to limit the footprint of staff and partners on the ground in line with public health considerations and the principle of "do no harm." UNHCR partners managed to safely distribute one tarpaulin per household to 67,194 refugee families , or 75% of UNHCR's refugee population of concern, over seven days in August. Similarly, in Honduras, 200 individual kits were delivered to LGBTI community-based organizations to mitigate the disproportionate impact suffered by the LGBTI population in accessing basic goods and services due to COVID-19 movement restrictions.

The fear and stigma at times associated with COVID-19 led to increased vulnerabilities in some sites, with local communities fearing IDP areas were associated with a higher risk for uncontrollable COVID-19 outbreaks. In some specific cases, tensions between IDP and host communities were reported. To mitigate this, responding agencies ensured local communities were equally involved in the measures and planning in IDP areas.

Further reading

Emerging field practices: UNHCR cash assistance and COVID-19 (1)

Emerging field practices: UNHCR cash assistance and COVID-19 (2)

UNHCR cash assistance and COVID-19: Main findings from post-distribution monitoring

Challenges met and overcome

The shelter needs arising from pre-existing drivers, including conflict and civil unrest, disaster and seasonal events such as floods and drought are being compounded by the effects of COVID-19. Travel bans and restriction of movement is leading to a reduced humanitarian presence and hindering the provision of much needed humanitarian shelter assistance to vulnerable populations. Overcrowded shelter and settlement conditions remain an unfortunate reality for many crisis-affected people, posing considerable challenges to attempts to reduce the transmission of COVID-19. The consequences of COVID-19 are forcing shelter and settlement responses to re-prioritize activities to the detriment of durable and transitional shelter solutions and it is likely to also affect funding capacity for essential life-saving winterization activities later in the year. The economic impact and limitations in transport of goods is leading to a reduction in the availability of basic NFIs as well as construction material supply and an overall increase of prices of these essential items for the sector.

Support education systems

Key achievements or targets met

1,791,777 children and youth **out of school** due to mandatory school closures

744,745 children and youth supported with **distance/home-based learning**

During the height of school closures more than 90% of the world's children enrolled in formal education, including refugees, were not attending schools and universities were also closed in most countries. Schools remain closed in many refugee-hosting countries, with gradual re-opening planned for the last quarter of 2020. A survey of over 1,000 refugee-hosting schools serving just over a million children showed that as of June only 28% of schools were in session.

Many governments quickly mobilized emergency distance and remote learning programmes. However, COVID-19 has highlighted the digital divide that exists, with a recent survey by UNICEF showing that up to a third of learners from poor and marginalized communities were unable to access online and home-based learning modalities. Many refugees did not have either the connectivity or hardware to access national responses to ensure continuity of learning. As a result, UNHCR has worked with teachers, private sector partners and communities to try and facilitate access to the same materials and content as their host country peers or provide additional support to students impacted by school closures.

Currently, almost 2 million refugee children and youth are out of school due to mandatory school closures, attempting to learn from home through national programmes delivered through radio, television and the internet. UNHCR has worked to ensure that families have access to these programmes, supporting 744,745 children and youth with distance/home-based learning.

In Mali, for example, UNHCR distributed 11,000 solar powered radios to refugee and host community students, and in Croatia and the Russian Federation laptops and mobile phones were provided to children in reception centres. In both Malawi and Kenya community radio stations were used to broadcast lessons for students. UNHCR Kenya procured recordings of lessons broadcast by the national Ministry to be broadcast on community radio stations in camps as broadcast signals do not reach these areas. In Uganda additional tablets with pre-loaded content supplementing existing connected education programmes were provided to refugee students. Refugee teachers have remained in contact with students through WhatsApp, providing recorded lessons and sharing content in operations such as Kenya and Indonesia. Printed learning materials were distributed with the support of UNHCR in Bangladesh, Chad, Malaysia, Mauritania, and South Sudan and small tutoring groups were established by refugee volunteers in Cameroon. UNHCR leveraged its expertise in the delivery of connected education programmes to support ministries of education in Jordan and Uganda in the development, roll-out and hosting of online learning platforms, and supported education ministries in Chad, Mali and Niger design national response plans.

Preparing for school reopening

UNHCR is part of the global Save Our Futures campaign for equitable access to quality education thorough protecting education finance and ensuring the most vulnerable, including refugees, are not left behind. At national and regional levels, UNHCR is following the lead of host governments on decision-making around school reopening and using the opportunity to 'build back better'. UNHCR is also a member of the UNESCO-convened Global Education Coalition and has contributed to inter-agency frameworks for the re-opening of schools and guidance for practitioners in crisis-affected contexts.

Challenges met and overcome

In line with "Refugee Education 2030" the inclusion of refugees in national response plans and ensuring that refugees have meaningful access to support programmes has been a key element of the COVID-19 response. Whilst there have been some successes, ensuring that refugees are able to access continuity of learning whilst schools are closed has been challenging for a number of reasons including lack of connectivity, broadcast signals not reaching areas where refugees live and families not having access to the required hardware. UNHCR has worked to ensure that refugee teachers and educators—who are often not part of the national system—are paid and supported, so that they in turn can continue to engage students and communities. UNHCR has worked on two related strands around supporting education systems: ensuring continuity of learning and preparing for school reopening.

A survey which collected data from 28 countries and almost 1,000 refugee-hosting schools found that around half of all schools had not received guidance on re-opening and safe operating protocols from the national authorities. The majority of these schools lacked basic cleaning equipment and supplies required for compliance with international guidance on controlling infection in schools. The ratio of handwashing points to learners in schools was well in excess of UNHCR guidance with on average 275 learners using a single handwashing station and rising as high as 700 in some countries. The survey also highlighted acute shortages in the number of latrines in schools where the ratio for latrine access is more than double the recommended number of students, with an average of 76 girls per latrine against a standard of 30. Few facilities exist for hygienic, dignified menstrual health management which can negatively impact girls' attendance. Urgent action and support is needed to reverse years of under-investment in school WASH infrastructure and to ensure that schools hosting refugees and those supported by UNHCR in camps and settlements can comply with protocols for safe operation.

In spite of these efforts, refugee children are likely to have fallen behind their peers academically and will need support to catch up lost learning opportunities and may be at risk of having missed key examinations or being insufficiently prepared for national examinations that will determine progression to the next academic level. The risks to children of missing out on further education are considerable, especially for girls, children with disabilities and children from families with extreme vulnerabilities. The risks of not resuming education or dropping out completely, are higher for lower secondary-aged refugee boys and girls, who are particularly vulnerable to negative coping mechanisms such as child labour, child trafficking, recruitment into armed forces, and child marriage.

Further reading
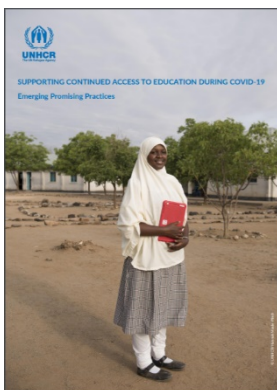
Emerging practices: Supporting continued access to education during COVID-19 (1)

Emerging practices: Supporting continued access to education during COVID-19 (2)

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Transition from immediate to long-term responses

Across Africa, the Americas and the Middle East, hundreds of thousands of refugees are in need of urgent financial assistance to cover their daily subsistence since lockdowns and other public health measures came into force. In Colombia, Ecuador and Peru, economic conditions as a result of lockdowns have already forced tens of thousands of Venezuelans to return. In Rwanda, most of the 12,000 urban refugees have lost their livelihoods. In late August, 59% of refugee families in Costa Rica reported steady work-related income streams as of the end of July, a staggering decrease from 93% before the pandemic hit.

A fifth of Nicaraguan refugees said they do not know where they will live the next month. The socio-economic impact of the COVID-19 pandemic has hit Nicaraguan refugees and asylum seekers in Costa Rica particularly hard,

with over 75% of respondents to a humanitarian assessment conducted in July and August reporting they are only able to eat once or twice a day. Before the pandemic, only 3% of refugees reported eating once a day or less, thanks to effective local integration initiatives in Costa Rica. However, that number has now grown to 14% according to the assessment, conducted to help Costa Rican authorities address the needs of the more than 81,000 Nicaraguans who have sought international protection in the country. Given these stark results, UNHCR is concerned that pandemic-related hunger could force especially vulnerable Nicaraguans to return home. Nicaraguan refugees and asylum seekers elsewhere in the region—in countries including Panama, Guatemala and Mexico— have also reported facing hardships including the loss of livelihoods, eviction and hunger.

In Lebanon, which was already facing an economic downturn before the pandemic, over half of refugees surveyed by UNHCR in late April reported having lost livelihood mechanisms, such as daily labour opportunities. Among the refugees consulted, 70% said that they had to skip meals. The impact of the pandemic on refugee women has been particularly profound, with almost all who had been working indicating that their sources of income had been disrupted. Other issues reported included evictions, heightened tensions with host communities and an increase in negative coping mechanisms.

As a short-term response, the scale up in cash assistance to refugees and internally displaced was a quick and efficient modality to enable people to meet their basic needs and mitigating some of the negative socio-economic impacts. In Costa Rica, for example, refugees holding work permits who lost their jobs because of lockdowns, have been eligible for temporary monthly cash transfers.

UNHCR is stepping up its livelihoods response to help bridge immediate assistance with longer-term economic recovery plans. High-level advocacy to ensure refugees are included in the responses of other humanitarian and development actors such as governments, private sector, UN Country Teams and civil society is taking place. Refugee inclusion in impact assessments by the World Bank and national statistical bureaux is informing context-specific responses, for example in Ethiopia, Kenya and Uganda. Similar efforts are ongoing in Albania, Bangladesh, the CAR, Iraq, Jordan, Lebanon, Moldova, Montenegro, Morocco, Romania, Serbia, South Africa, Thailand, Turkey, Ukraine and Zimbabwe, and with a range of partners from governmental research institutions to UN agencies. In Iraq, Jordan and Lebanon, UNHCR and the World Bank are conducting a joint study on the socio-economic impact of COVID-19, funded by the JDC, to be published by the end of 20202. Results from all these assessments are being used to inform relevant responses, with efforts to include refugees in multi-agency socio-economic response plans and launch joint resource mobilization proposals through UN Country Teams and inter-agency responses, for example in Angola, Argentina, Bolivia, Eswatini, Iraq, Jordan, Lebanon, Mauritania, Paraguay, Tunisia, Uruguay and Zimbabwe.

Challenges met and overcome

Refugees have been disproportionately impacted by the socio-economic consequences of the pandemic and have been among the first to lose their livelihoods. This is not surprising considering that even before the pandemic, 70% of refugees had no or limited right to work, 66% had restricted freedom of movement and 47% restricted access to bank accounts. With lockdowns and more restrictive freedom of movement measures in place, income-generating opportunities disappear, and what little savings people had have dried up. As a result, refugees are unable to cover their basic needs and are resorting to negative coping mechanisms. Many who have earned self-reliance over the years, particularly in urban settings, risk losing it. Many refugees have seen the business they run or work for forced to close. The impact of the pandemic on refugee women has been particularly profound, with almost all who had been working indicating that their sources of income had been disrupted. Other issues reported included evictions, heightened tensions with host communities and an increase in negative coping mechanisms.

Ongoing advocacy is underway to ensure refugees are included in national social protection, with a number of countries already including refugees in social safety nets, and others extending social protection schemes to reach informal workers. Inclusion in national social protection schemes is being seen in, Armenia, Republic of Congo, Mauritania, South Africa, Turkey, Uruguay, and the European Union to name a few.

The pandemic has seen the emergence of opportunities and good practices. Refugee employment and entrepreneurship in high-demand sectors is being facilitated through collaboration with governments, private sector and development actors. Employment of refugee doctors and health workers has been enabled throughout Europe and Latin America, while in Mexico the recognition of qualifications is in process. The European Qualifications Passport for Refugees (EQPR), issued by the Council of Europe in partnership with UNHCR, is steadily gaining acceptance among authorities and higher education institutions in Council of Europe Member States. It has proved a powerful tool for supporting refugees' skills validation and access to employment and higher education in the health sector and beyond. Moreover, refugee production of essential items such as community masks in Armenia, Bangladesh, Cameroon, Egypt, Jordan, India, Kenya, Malaysia, Pakistan, Uganda and others is utilizing the MADE51 partnership model with local social enterprises to reach local and international markets.

Enhancing access to finance a is a critical enabler for economic recovery. On the credit side, UNHCR has established partnerships with 21 financial service providers (FSPs) in 14 countries, offering them support through socio-economic data sharing, advocacy and logistics. Six of these FSPs have received capital at zero-interest by Kiva, through their microfinance crowdfunding platform. Kiva established partnerships with additional 6 FSPs to extend their loan products to refugees. Over 17,000 refugee borrowers have been served by the 12 FSPs using Kiva's capital. UNHCR is monitoring the actions taken by FSPs to support refugee borrowers during these difficult times, such as through restructuring or refinancing loans, repayment moratorium, temporary suspension of operations and promoting digital services. Positive steps in this direction have been taken by FSPs in Brazil, Cambodia, Ecuador, Jordan, Kenya, Lebanon, Peru, the Philippines, Rwanda, Uganda, and in several European countries.

To support the inclusion of the most vulnerable populations in livelihood activities and to improve their self-reliance, UNHCR, the World Bank's Partnership for Economic Inclusion and 13 non-governmental organizations are scaling up the "graduation approach" through the Poverty Alleviation Coalition. Of the 35 countries targeted by the Coalition, funding is confirmed in Bangladesh, Ecuador, Jordan, Kenya, Peru, Somalia and Mozambique, for which the main donors are PRM, GIZ, GAC, DFID, EU Trustfund and DEVCO, Novo Nordisk Foundation and OSF.

Further reading

Emerging practices: Livelihoods, economic inclusion and COVID-19

Partnership and coordination

UNHCR is working with a range of partners to respond to the COVID-19 pandemic: governments, UN agencies, international and national non-governmental organisations, civil society members, faith-based organisations and refugee-led organisations and a host of other entities.

Recognising that this pandemic has consequences beyond the immediate health needs, UNHCR from the outset of the emergency worked with WHO and partners to issue specific guidance on how to ensure assistance reached all people of concern, including those living in camp and camp like

settings. UNHCR also immediately undertook targeted risk communication in multiple languages, including sign languages, to reach refugees and people with disabilities, and worked within several inter-agency framework to ensure a coordinated approach.

More specifically, UNHCR strengthened its partnership and coordination approach through the following methods during COVID-19 to ensure that refugees, IDPs, stateless persons and other people of concern continue to receive the protection and assistance they need while being safeguarded from the negative effects of COVID-19.

In terms of partnerships, UNHCR focused specifically on:

1 Supporting host governments to include people of concern in national health responses and providing concrete financial, medical and technical assistance.

2 Advocating the rights and targeting of assistance to refugees, internally displaced, as well as stateless persons.

3 Localization and partnership reforms to ensure flexible funding to partners and first line responders, including national non-governmental organisations, civil society actors and refugees themselves.

4 Supporting UN Country Teams in identifying the protection impact of non-inclusion of IDPs in health, WASH and other services.

5 Advocating the inclusion of a specific strategic priority to address the protection and assistance needs of people of concern in the COVID-19 Global Humanitarian Response Plan (GHRP) and ensuring the inclusion of refugees in the Secretary-General's report on responding to the socio-economic impacts of COVID-19 as well as, wherever feasible, in the socio-economic response plans of host governments and the development sector.

To better support governments with the health response, UNHCR and WHO signed a Memorandum of Understanding in May 2020. The work on this MOU predated the pandemic, as its main aim is to ensure refugees are included in national health responses in line with the Global Compact on Refugees. The pandemic, however, underlined the need to urgently strengthen support to governments beyond the humanitarian phase of a refugee influx.

Combined with the MOU, UNHCR also signed up to the Solidarity Response Fund, receiving $10 million to strengthen its work in several countries. The cooperation with the Fund helped UNHCR address urgent needs such as risk communication and community engagement around hygiene practices; procure medical supplies and establish isolation units in refugee settings in several countries, primarily in Africa and the Middle East. The Fund, a first-of-its-kind, allows individuals, companies, and organizations all over the world to directly contribute to WHO's global response to help countries prevent, detect and respond to COVID-19.

In terms of advocacy, UNHCR joined with IOM and OHCHR to issue specific guidance, including through the Secretary-General's policy brief on people on the move and through the development of human rights indicators for UN country teams. UNHCR also joined with WHO, IFRC and IOM to work on specific guidance for all humanitarian workers on how to combat COVID-19 in camps and camp–like settings. This guidance was distributed to all humanitarian agencies through the Inter-Agency Standing Committee (IASC).

Recognising the need for further localization, beyond the commitments of the Grand Bargain, UNHCR agreed to co-lead the IASC working group on localization. In August 2020, UNHCR signed an MOU with IFRC, focusing specifically on how to work more closely with Red Cross and Red Crescent Societies as well as support and strengthen their extensive volunteer network to deliver assistance to those in need.

Underpinning the work with other agencies, was UNHCR's own reform of its partnership project agreements, the main aim of which is to lessen bureaucracy and ensure a strategic approach with UNHCR's main partners based on trust and complementarity. Frontline workers, including refugees themselves, and national and international NGOs, play a critical role in providing vital humanitarian assistance and protection. To ensure partners are able to stay and deliver during this pandemic UNHCR was the first UN agency to take specific measures to minimize administrative hurdles and expedite the disbursement of funds to NGOs. These included greater flexibility for partners to manage their budgets within agreed outputs (increased from 20% to 30%), the early release of instalments, extended implementation and liquidation periods and simplified partnership selection. To date, about $1.3 billion has been committed to partners, and of that $1 billion has been disbursed, much of it for activities which are COVID-related. Part of the overall transformative initiatives undertaken by UNHCR, the Office aims to embed increased flexibility measures into its partnership agreements in future. UNHCR as well engaged other UN agencies in the further development of the UN Partnership Portal, which aims to ensure a harmonised approach to NGO partnership selection amongst UN agencies.

UNHCR was as well actively involved in the development of the GHRP, a coordinated and comprehensive humanitarian response to the COVID-19 pandemic. In addition to coordinating the input from the 36 countries with an ongoing inter-agency refugee response plan, UNHCR also highlighted the needs of all refugees, IDPs and stateless persons beyond the 63 GHRP countries. The total budget for the refugee response included not only the UNHCR budget of $745 million, but of all partners contributing to refugee response plans. The RMRP for the Venezuela situation, the 3RP for the Syria refugee situation and the Joint Response Plan for the Rohingya were all updated with significant internal reallocation of resources. UNHCR also highlighted the achievements and challenges related to key protection issues in the GRHP progress reports, and supported OCHA with the development of the GHRP indicator and monitoring framework to ensure that the inclusion and access to assistance for all people of concern in the GHRP. Complementing the GHRP, UNHCR shared more detailed information on its plans and requirements in its own COVID-19 supplementary appeals.

To mitigate the socio-economic impact of COVID-19 for people of concern and to provide a better recovery as soon as possible, UNHCR contributed substantively to the [United Nations Framework for the immediate socio-economic response to COVID-19: Shared responsibility, global solidarity and urgent action for people in need](#).

From the outset of the crisis, with the aim of strengthening coordination and partnerships beyond the funding arrangements, UNHCR held global weekly online consultations with NGO partners on COVID-19 preparedness and response in refugee and IDP situations. The objective of these consultations was to create a space for regular dialogue between UNHCR and NGOs on challenges and for sharing of good practices on emerging responses to the COVID-19 pandemic.

In September 2020, UNHCR organized a roundtable with Religions for Peace, a global, multi-religious movement representing the world's faith institutions and traditions, and which comprises 90 national and six regional Inter-Religious Platforms. The main outcome of this roundtable was the commitment to form a Multi-Religious Council of Leaders to strengthen efforts to address the root causes of conflict and displacement, and to support peacebuilding, inclusion and reconciliation efforts.

Building on the 19 weekly consultations with the NGO community since the outset of the pandemic, the 2020 Annual NGO consultations on 29 and 30 September 2020 were organized around the theme "Responding to Pandemics". These consultations are co-organized with the International Council of Voluntary Agencies and were held virtually for the first time, in four different languages and across seven time zones. The consultations gathered some 200 NGO participants, representing 117 different organizations, and included 64 international NGOs, 41 national NGOs, and 12 refugee-led organizations. The consultations placed refugees and frontline responders at the center and highlighted best practices regarding protection, community engagement, resilience and inclusion. Throughout the consultations, front-line responders and refugees provided examples of the successes and challenges they have faced during the first six months of the pandemic. Given the specific focus on refugee-led organizations, outreach was made to all regional offices to ensure diverse and regional representation of partners. The consultations will feed into the High Commissioner's Dialogue on Protection Challenges, focusing on "Protection Challenges in Pandemics". A concrete commitment made by UNHCR during these consultations was to develop a framework for cooperation with refugee-led organizations.

The comprehensive regional protection and solutions framework to address forced displacement in Central America and Mexico (MIRPS)

Building upon regional consultations in March, MIRPS States have sought to ensure the inclusion of displaced persons within their respective national responses to the COVID-19 pandemic, strengthening inter-institutional coordination and partnerships. While the pandemic has impacted the implementation of MIRPS national response plans, States have taken steps to ensure the continuity of existing service provision to people of concern while seeking gains against several commitments and pledges. These have included; ensuring medical assistance to people of concern under the same conditions as nationals; managing consultations, appointments, and requests for the renewal and issuance of documentation remotely and online; and where possible, including persons of concern within social assistance programmes and expanding shelter and protective quarantine services. Consideration is being given to their inclusion within medium term socio-economic recovery plans.

The MIRPS national technical teams reviewed current needs in strengthening their national asylum systems with the support of the UNHCR-OAS Technical Secretariat. MIRPS countries identified specific areas in need of bilateral cooperation, which are presented to the MIRPS Support Platform Presidency, currently held by Spain. The most common request was the exchange of experiences on the integration of technology for refugee status determination, which is particularly relevant in the COVID-19 context when offices provide their services via internet and helplines.

Funding UNHCR's coronavirus programmes

In the early weeks of the COVID crisis, operations acted quickly to take stock of the pandemic's impact on populations of concern to UNHCR. From an initial emergency appeal of $33 million in early March, UNHCR increased its 2020 requirements to $745 million under the Global Humanitarian Response Plan revision issued in May, mirroring the rapid spread of COVID and the scale of the resources needed to protect refugees and others of concern to UNHCR from the impact of the virus.

The $745 million was maintained through subsequent revision of the GHRP. The additional resources will allow UNHCR to counter the direct and indirect effects of the virus on the most vulnerable until the end of 2020 in 70 high-risk countries. To accommodate these additional requirements, UNHCR's 2020 annual budget was increased through internal reallocations and a supplementary budget of $404 million.

Funding to UNHCR's COVID-19 supplementary appeal by month and by type of funding

Budget: $745 million | Funds available: $460 million | 62% funded

Legend: Softly Earmarked, Earmarked, Tightly Earmarked
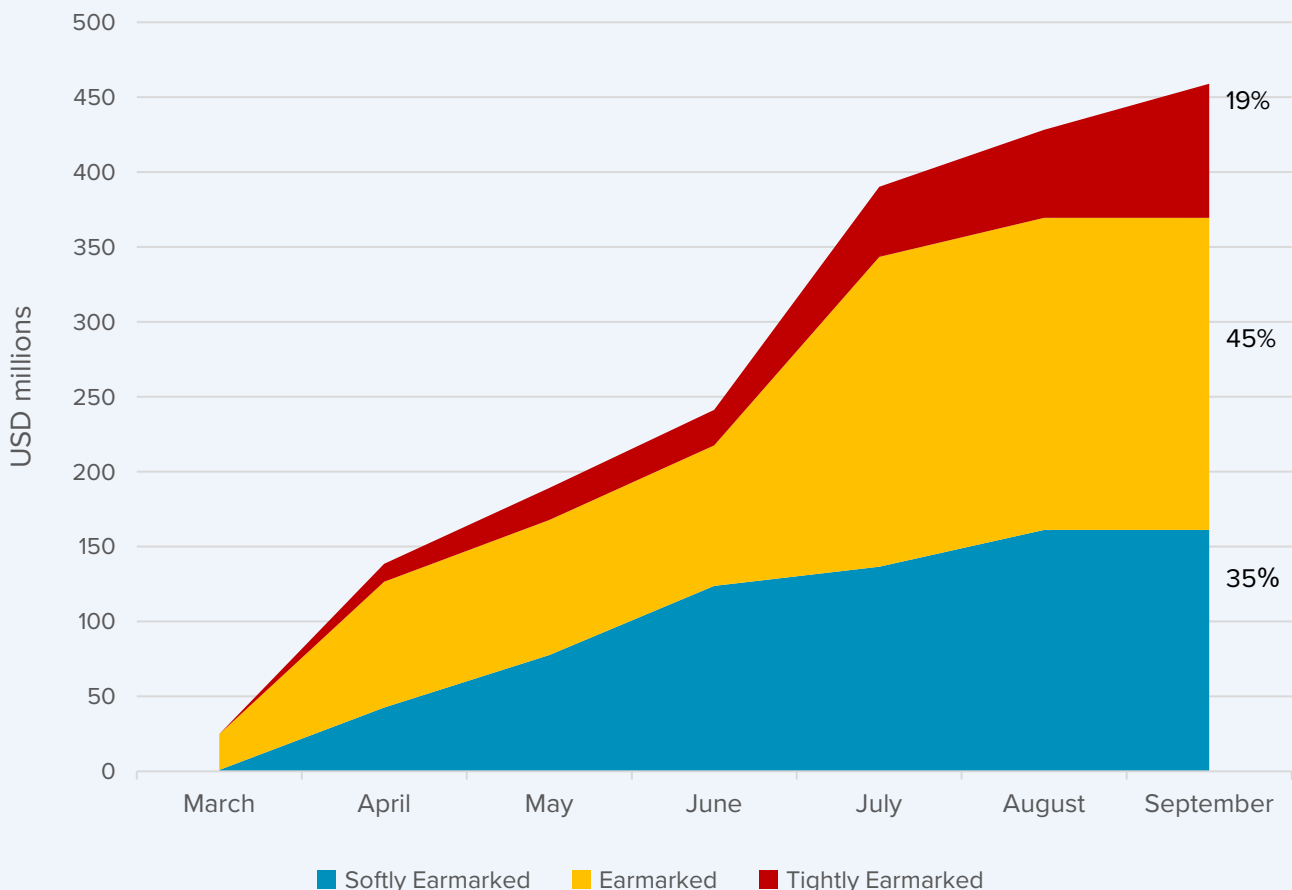
The response to UNHCR's appeal has been timely and generous. As of 1 October, funding stood at over $460 million, or 62% of requirements. Contributions came from 26 governments, the European Union, the African Development Bank, CERF and pooled funds, as well as from the private sector. Although the public sector accounts for 91% of the total, significant support was received from private sources, including corporations.

The largest donor to the appeal is the United States Government, whose contribution represents 25% of the appeal's total requirements. Other significant donors are Germany (8% of requirements), the European Union (6%), the United Kingdom (3%) and Japan (3%).

A complete and continuously updated list of donors is available from the funding update on the Global Focus COVID-19 situation [page](#).

The majority of the funding arrived in the four months following UNHCR's initial appeal. In addition to its timeliness, support has also been of high quality: more than 35% of contributions ($161.2 million) are softly earmarked, meaning funds can be used in any of the countries in which UNHCR has scaled up its protection and assistance. Noteworthy contributions of this type were received from Canada, Denmark, Germany, the United Kingdom, and the United States. Other government donors whose contributions for COVID are softly earmarked include France, Iceland, Ireland, Jersey, Liechtenstein, Norway, and Sweden.

From the private sector, 45% of contributions were softly earmarked. Private donors responded to UNHCR's COVID-19 appeal with $55 million in confirmed contributions and pledges. Over 84% of the income came from companies, foundations and philanthropists, with an important gift in-kind from Unilever constituting the largest contribution, and 16% from individual donors, contributing mainly through digital channels. In addition to financial and in-kind donations, many private sector partners supported UNHCR to raise awareness among their stakeholders and to amplify communications and content about refugees through their platforms, such as Microsoft, H&M and others. The positive response to the COVID-19 emergency appeal helped drive the substantial growth of UNHCR's private donor income in 2020, becoming the emergency appeal best-funded from the private sector ever for UNHCR, together with the Europe refugee crisis in 2015-2016.

A further 45% ($208.3 million) is earmarked to specific operations which donors identified and prioritized in collaboration with UNHCR. The United States and Japan were the largest donors in this category. Of the total contributions to the COVID appeal, only 19% of the total recorded contributions and firm pledges are tightly earmarked. This is some 54% lower than the share of global resources which are tightly earmarked for sectoral activities at the global level, demonstrating recognition of the need to provide flexible funding in response to the ongoing crisis. Softly earmarked and country-level earmarked contributions were received quickly with over $340 million received by July.

As in other emergencies, several donors played a critical role in UNHCR's response to the pandemic before the initial appeal was even issued. Unearmarked funding was used for the first urgent procurement of personal protective equipment and other essential items, allowing operations to mobilize swiftly even as requirements were being assessed and finalized. As the ability to react quickly and robustly under such circumstances is critical to safeguarding refugee lives, UNHCR is particularly grateful to donors of core unearmarked funding.

Through 1 October, 60% of resources allocated to the field for COVID-related activities have been implemented, a high rate made possible by the early operational start and the High Commissioner's determination that UNHCR, confronted with the grave threat to communities around the globe, should 'stay and deliver'.

The flexibility of the support received has allowed UNHCR to deliver life-saving assistance across a range of sectors, as detailed in the adjacent table. A breakdown of how funding was apportioned by region also follows.

Of note is that 10 of the operations covered by the appeal have not received any earmarked contributions, and the needs of 25 operations, including Argentina, Burundi, Costa Rica, India, Indonesia, and Mozambique are less than 25% resourced by such contributions. Without flexible funding, these imbalances must be covered by unearmarked contributions.

Allocation of resources by area of intervention

Area/Sector	Allocation	
Health	37%	
Basic and Domestic Items	31%	
Services for Persons with Specific Needs	8%	
Sanitation and Hygiene	6%	
Reception Conditions	5%	
Shelter and Infrastructure	4%	
Water	2%	
Education	2%	
Food Security	1%	
Others	6%	

Contributions by region, including tentative allocation of softly earmarked funds

Tightly earmarked · Earmarked · Softly earmarked · Gap

UNHCR
The UN Refugee Agency
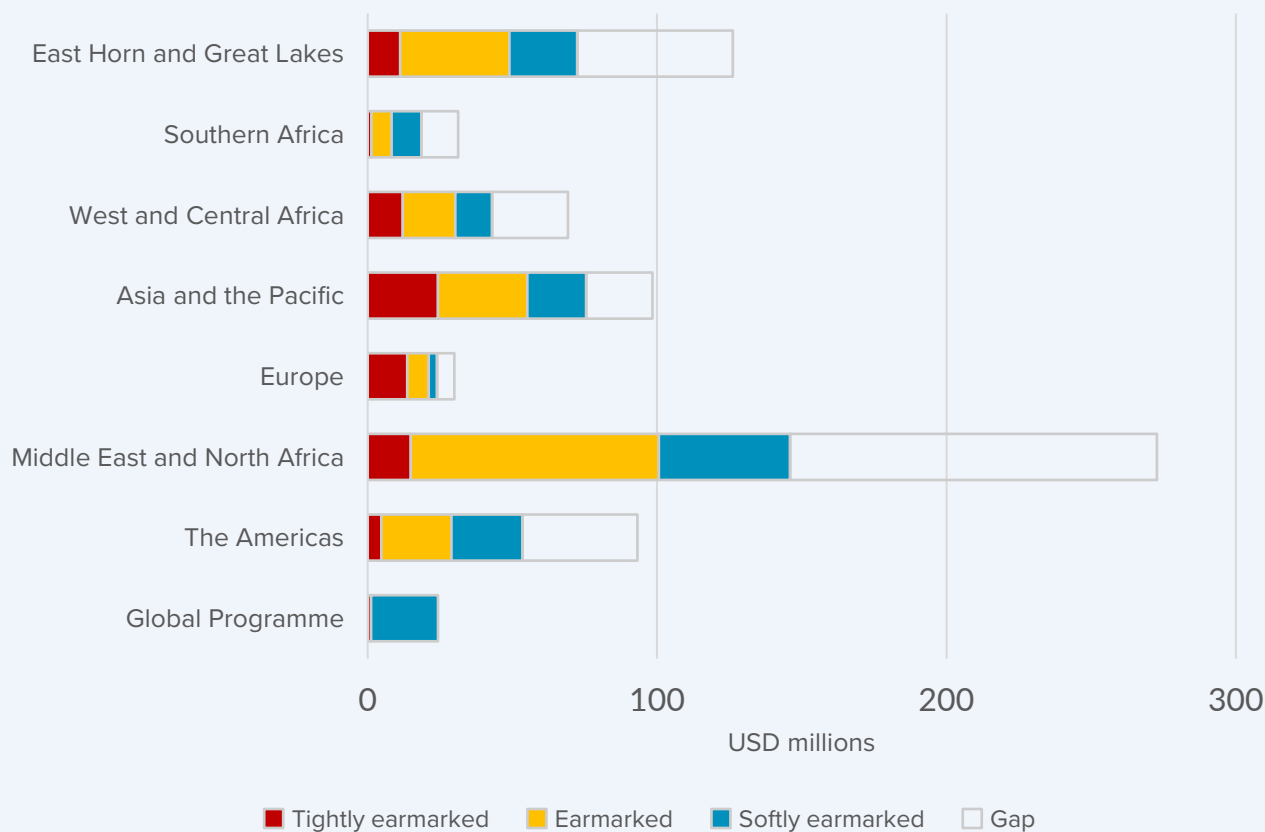
UNHCR
P.O. Box 2500
1211 Geneva 2
Switzerland

For information and inquiries
please contact:
DRRM
hqfr00@unhcr.org
HQGARS@unhcr.org