GLOBAL HUMANITARIAN RESPONSE PLAN
COVID-19

UNITED NATIONS COORDINATED APPEAL

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Contents

Foreword by the Secretary-General of the United Nations

The world faces a global health crisis unlike any in the 75-year history of the United Nations — one that is spreading human suffering, crippling the global economy and upending people's lives.

COVID-19 is threatening the whole of humanity – and the whole of humanity must fight back. Global action and solidarity are crucial.

The world is only as strong as the weakest health system. This COVID-19 Global Humanitarian Response Plan aims to enable us to fight the virus in the world's poorest countries, and address the needs of the most vulnerable people, especially women and children, older people, and those with disabilities or chronic illness.

> "The world is only as strong as the weakest health system. This COVID-19 Global Humanitarian Response Plan aims to enable us to fight the virus in the world's poorest countries, and address the needs of the most vulnerable people."

Coordinated by the UN's Office for the Coordination of Humanitarian Affairs, it brings together appeals from the World Health Organization and other UN humanitarian agencies.

Properly funded, it will provide laboratory materials for testing, supplies to protect health-care workers and medical equipment to treat the sick. It will bring water and sanitation to places that desperately need it, and enable aid workers to get to the places they are needed.

I appeal to governments to strongly support this plan, which will help stem the impact of COVID-19 in already vulnerable humanitarian contexts.

I also call on all donors and partners to maintain core support to programmes for the most vulnerable, including through UN-coordinated humanitarian and refugee response plans.

To divert funding from humanitarian needs at this time would create an environment in which cholera, measles and meningitis would thrive, even more children would become malnourished, and the narratives of violent extremists would take deeper hold. It would also extend the breeding ground for the coronavirus disease itself.

We cannot afford to lose the gains we have made through investments in humanitarian action and in the Sustainable Development Goals.

At the same time, we are doing our utmost to plan for and respond to early recovery in the countries around the globe that will need it most, so that we achieve a new sustainable and inclusive economy that leaves no-one behind. I have asked United Nations Resident Coordinators and UN Country Teams to support countries around the world in addressing the socio-economic implications of this pandemic, which will require an adequate funding mechanism.

This is a moment for the world to come together to save lives and fight a common threat. The only war we should be waging is the war against COVID-19.

António Guterres
Secretary-General of the United Nations

At a glance

Requirements (US$)

$2.01 billion

At the time of writing, many priority countries are working on or just issuing their revised plans for the COVID-19 response. Funding requirements have not yet been estimated for a number of countries. For this reason, individual country requirements will be provided in the next update of the Global Humanitarian Response Plan (HRP).

Purpose and scope
PP. 8–9

The COVID-19 Global HRP is a joint effort by members of the Inter-Agency Standing Committee (IASC), including UN, other international organizations and NGOs with a humanitarian mandate, to analyse and respond to the direct public health and indirect immediate humanitarian consequences of the pandemic, particularly on people in countries already facing other crises.

It aggregates relevant COVID-19 appeals and inputs from WFP, WHO, IOM, UNDP, UNFPA, UN-Habitat, UNHCR, UNICEF and NGOs, and it complements other plans developed by the International Red Cross and Red Crescent Movement.

NGOs and NGO consortiums have been instrumental in helping shape the plan and conveying local actors' perspectives, and they will play a direct role in service delivery. NGOs will be able to access funding mobilized in the framework of this plan and related country plans through partner arrangements with UN agencies, through pooled funding mechanisms, including Country-Based Pooled Funds, and through direct donor funding.

This ensures complementarity, synergy, gaps and needs identification, and a coordinated response. The Global HRP also complements and supports existing government responses and national coordination mechanisms, with due consideration paid to the respect for humanitarian principles.

The Global HRP identifies the most affected and vulnerable population groups in priority countries, including countries with an ongoing Humanitarian Response Plan, Refugee Response Plan or multi-country/subregional response plan, as well as countries that have requested international assistance, such as Iran. Updates to existing country plans should be initiated to ensure that humanitarian organizations are prepared and able to meet the additional humanitarian needs occasioned by the pandemic. Further updates to these plans will likely be necessary if a major outbreak occurs. In other countries, a humanitarian response plan/Flash Appeal should be considered if they are unable to cope with the emergency.

Humanitarian needs analysis
PP. 10–18

The Global HRP builds on a joint analysis of the immediate health and non-health needs of vulnerable populations, and offers a multi-partner multisectoral response to the pandemic. It does not attempt to deal with secondary or tertiary issues related to macroeconomic effects or more longer-term requirements in various sectors.

Strategic priorities

The Global HRP is articulated around three strategic priorities. Several specific objectives are linked to each priority, detailing the outcomes that the Plan aims to achieve. They are underpinned by a series of enabling factors and conditions.

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

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

Protect, assist and advocate for refugees, internally displaced people, migrants and host communities particularly vulnerable to the pandemic.

Response approach

The response approach is guided by humanitarian principles as well as by inclusivity, gender, protection and community engagement principles.

The importance of involving and supporting local organizations is emphasized given the key role they are playing in this crisis, which is increasingly being characterised by limited mobility and access for international actors.

The logistics, air and maritime transportation services included in this plan will serve the entire humanitarian community, including the UN and NGOs, providing essential support to supply chains and the movement of humanitarian actors.

The public health response outlined in the Global HRP is fully aligned with WHO's soon to be updated Strategic Preparedness and Response Plan for COVID-19, which has a much broader remit than the Global Humanitarian Response Plan.

Coordination mechanisms and monitoring framework

The Global HRP outlines how agency responses are to be coordinated based on existing humanitarian and national/local government coordination mechanisms.

The Global HRP integrates a monitoring framework to provide systematic and frequent information on changes in the humanitarian situation and needs emanating from the COVID-19 pandemic (including for countries not considered in the first iteration of the Plan) and to inform rapid adjustments of the response.

Financial requirements

The financing requirements for the Global HRP over a period of nine months (April–December 2020) are estimated at US$2.012 billion. They represent an initial estimate of the funding required to address the additional needs provoked by the COVID-19 pandemic across all regions, building on, but without prejudice to the ongoing humanitarian operations for pre-COVID-19 emergencies.

Funding for ongoing humanitarian response plans, including preparedness activities related to other disasters, remains the top priority given that people targeted in these plans will be the most affected by the direct and indirect impact of the pandemic.

Many humanitarian response plans are severely underfunded at the time of writing this Global

HRP. Ensuring that they are fully resourced and country teams granted increased flexibility in the approval of modifications is essential to avoid further loss of life and increased vulnerability. They will also be an important stabilizing factor in these fragile contexts.

At the same time, the United Nations, other international organizations and NGOs are doing their utmost to plan for and respond to early recovery in the countries around the globe that will need it most, in order to achieve a new sustainable and inclusive economy that leaves no-one behind. United Nations Resident Coordinators and UN Country Teams will support countries around the world in addressing the socio-economic implications of this pandemic, which will require an adequate funding mechanism.

Priority regions and countries

Legend:
- Humanitarian Response Plans (HRPs)
- Regional Refugee Response Plans (RRPs)
- Venezuela Regional (RMRP)
- Others
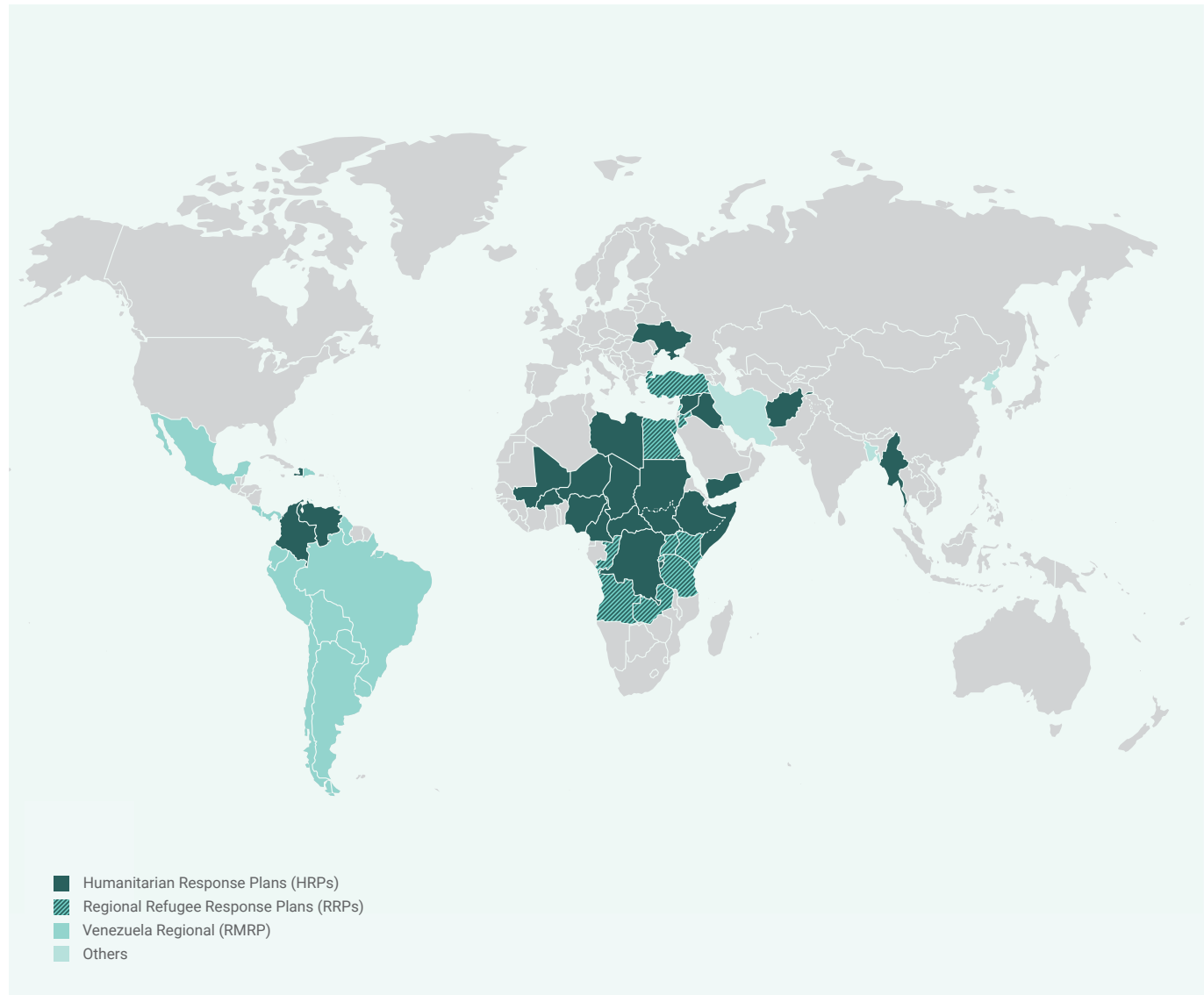
Source: OCHA. **Disclaimer:** The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

* Aruba (The Netherlands) and Curaçao (The Netherlands)

Humanitarian Response Plans
PP. 45–68

Afghanistan	Ethiopia	oPt
Burkina Faso	Haiti	Somalia
Burundi	Iraq	South Sudan
Cameroon	Libya	Sudan
CAR	Mali	Syria
Chad	Myanmar	Ukraine
Colombia	Niger	Venezuela
DRC	Nigeria	Yemen

Regional RRPs
PP. 70–74

Angola	Jordan	South Sudan
Burundi	Kenya	Syria
Cameroon	Niger	Uganda
Chad	Nigeria	Tanzania
DRC	Lebanon	Turkey
Egypt	Rep. of Congo	Zambia
Iraq	Rwanda	

Venezuela Regional RMRP
P. 76

Argentina	Costa Rica	Panama
Aruba*	Curaçao*	Paraguay
Bolivia	Dominican Rep.	Peru
Brazil	Ecuador	Trinidad and Tobago
Chile	Guyana	Uruguay
Colombia	Mexico	

Others
PP. 78–80

Bangladesh	DPR Korea	Iran

> "I see three critical areas for action: First, tackling the health emergency. Second, we must focus on the social impact and the economic response and recovery. Third, and finally, we have a responsibility to recover better."

> —

> **António Guterres**
> Secretary-General, United Nations

BOGOTÁ, COLOMBIA
Aerial view of the military hospital as it gets ready to attend to more cases of coronavirus in Bogotá. *ViewPress/Jennifer Alarcon*

Introduction

COVID-19 is having an unprecedented impact on all countries, both in terms of prompting the scaling of public health preparedness and response and protection of vulnerable populations, and in terms of requiring mitigation of broader social and economic impacts.

While all countries need to respond to COVID-19, those with existing humanitarian crises are particularly vulnerable, and less equipped and able to do so. Humanitarian needs may also occur in other countries as a result of excessive pressure on health systems and the overall delivery of essential services, as well as secondary effects on employment, the economy and mobility, the rule of law, protection of human rights, and possible social discontent and unrest.

Humanitarian needs assessments must be adapted to understand the specificities of this new crisis, including using technology that facilitates and accelerates data collection in a context of constrained access to people and need for real-time information in a fast-evolving emergency. While COVID-19 has a greater morbidity and mortality impact among specific vulnerable groups such as the older people, the chronically ill, the immunologically compromised, and people with disabilities, its spread is linked to the rapid circulation of the virus in the general population. The effects of the disease are less severe in most cases in younger and otherwise healthy population groups, but indirect effects of the preventive measures such as confinement, greatly influence the ability of people to secure a basic living. These effects are also overburdening underperforming and stretched health-care systems, and putting pressure on education access and many other aspects that add to the difficulties that existed prior to the pandemic.

Understanding the socioeconomic impacts of the pandemic is crucial, including elements of social cohesion and conflict sensitivity, and gender inequality and gender-based violence. Although needs assessments and analysis are seriously constrained by restricted mobility and avoidance of social interactions, available knowledge should inform a review of existing humanitarian operations, a re-prioritization and adaptation to implement the most urgent actions, and the identification of critical gaps.

Humanitarian and UN Country Teams are currently gathering and analysing information on the situation in-country, and determining how vulnerable people assisted through ongoing operations might be affected, including by potential disruption to the operations themselves. The teams are identifying additional vulnerable groups in need of assistance, introducing new activities, reprogramming some resources and requesting new plans, and potentially even expanding the scope of existing plans. This Global HRP is meant to encompass these adjustments to response in a number of priority humanitarian contexts, and mobilize an initial amount of new resources that are necessary. There will be a combined emphasis on continuing to meet existing humanitarian needs while simultaneously addressing new vulnerabilities that result from COVID-19.

HRPs and other humanitarian plans continue to be under-resourced, and donors are encouraged to help increase funding levels. At the same time, the additional resources covered by this Plan are needed to ensure that gains already achieved in these humanitarian contexts are not lost, and humanitarian needs arising as a direct result of COVID-19 are addressed. These efforts within the framework of ongoing humanitarian operations will complement the broader effort by the international community to address the impact of COVID-19. Resources mobilized through the Global HRP will be used to fund analysis, preparedness and changes to existing humanitarian plans. These will be programmed by UN agencies through their traditional implementing partners, or disbursed to NGO partners through pooled funding mechanisms, or through direct donor to NGO arrangements.

In priority countries where no country-based pooled fund exists, other mechanisms for disbursing resources to NGO partners that possess a comparative advantage in those contexts, through their presence and expertise, will be explored.

Purpose and scope of the Global HRP

The COVID-19 Global HRP is a comprehensive inter-agency response plan that aggregates and updates relevant existing humanitarian appeals from UN and non-UN entities, including WFP, WHO, IOM, UNDP, UN-Habitat, UNFPA, UNHCR, UNICEF and taking into consideration the International Red Cross and Red Crescent Movement. It also integrates inputs from the humanitarian NGO community that has also captured the perspectives of local organizations. The Plan focuses on preparedness and response to the initial immediate and urgent health and non-health needs and response to the pandemic, including to secure supply chains and humanitarian personnel mobility. It does not attempt to deal with secondary or tertiary issues related to macroeconomic effects or more longer-term requirements in various sectors.

It addresses the additional needs from the COVID-19 pandemic building on, but without prejudice to the ongoing humanitarian operations for pre-COVID-19 emergencies. Funding ongoing plans remains an utmost priority given that people targeted in these plans will be the most affected by the direct and indirect impact of the pandemic. Ensuring that humanitarian plans are fully resourced is essential to avoid further loss of lives and suffering, and the aggravation of vulnerabilities. It will also help affected people to better cope with the new emergency and will be an important stabilizing factor in these fragile contexts.

The Global HRP outlines how these measures are to be coordinated and implemented in countries with existing humanitarian response plans and operations, including Humanitarian Response Plans (HRPs), regional Refugee Response Plans (RRPs), the Regional Refugee and Resilience Plan (3RP) for the Syria crisis, the Regional Refugee and Migrant Response Plan (RMRP) for the Venezuela crisis, and the Joint Response Plan for the Rohingya Humanitarian Crisis (JRP), as well as a limited number of other priority countries. Updates of these country plans should be initiated to ensure that humanitarian organizations are prepared and able to meet the additional humanitarian needs anticipated from the outbreak. Further revisions of the country humanitarian plans will be necessary if a major outbreak occurs. In other countries, a humanitarian response plan/Flash Appeal should be considered if they are unable to cope with the emergency, taking into account factors such as a formal request for international assistance by the Government, the capacity of existing mechanisms to coordinate the response, the scope of the assistance required. Consultations with organizations partnering in the Global HRP will take place on a monthly basis or more frequently if appropriate, to decide on the issuance of a humanitarian response plan in these countries.

The Global HRP complements and supports existing government response plans and national coordination mechanisms, with due consideration paid to the respect of humanitarian principles.

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[1] At the time of writing, a formal set of criteria to decide on the inclusion of a COVID-19 affected country without an ongoing humanitarian response plan, has not been agreed upon at IASC level. Criteria may include the incidence and mortality rates, presence of dense camp/camp-like settings of forcibly displaced people or migrants, capacity of the Government to respond and request for international assistance, for example.

Humanitarian needs analysis

This section provides an overview of the humanitarian needs provoked by the COVID-19 pandemic in countries where a humanitarian response is already taking place, while also considering contexts where a humanitarian response may be required in the near future as a result of excessive pressure on health systems and other essential services, as well as secondary effects on livelihoods, employment, the economy and mobility, and possible social discontent and unrest.

The analysis does not aim to inform individual country response plans for this new crisis, but rather to contribute to the adaptation of existing responses. The analysis also does not encompass an in-depth macroeconomic review of the pandemic impacts, which is the remit of specialized entities such as the World Bank and other multilateral development entities.

The COVID-19 pandemic is an unprecedented public health emergency affecting all countries worldwide. While the scope of the epidemic differs between countries, the disease rapidly propagates in the vast majority of them, affecting an increasing number of people. Although to date few cases have been reported in countries with humanitarian response plans, this situation has the potential to change very quickly.

Some of the earliest affected countries such as China may be reaching a plateau with an observed decrease in the number of new cases, but they remain at risk of the importation of cases from other countries. An increasing number of countries have taken drastic isolation measures to avoid or delay the increase of cases. The effectiveness of these measures, however, greatly depends on the strength of the health systems and the ability of Governments to enforce policy decisions.

In countries facing pre-COVID-19 humanitarian needs, these measures are impacting the delivery of humanitarian assistance by limiting the movement of goods, aid workers and beneficiaries, and disrupting transportation services and domestic and international trade. The number of international aid agencies' staff is decreasing as a result of entry/exit restrictions. These effects are highly problematic as conflict and other disasters are not stopping for the disease, and humanitarian assistance remains imperative. This requires increased partnership and support to national and local staff and organizations that are equally impacted but retain a greater capacity to operate locally than international agencies, provided they receive the necessary resources and are able to act.

The majority of countries with an ongoing humanitarian response have weak health systems and governance combined with poor basic service delivery. This will severely constrain their ability to prevent the spread of the epidemic and provide health care to infected people, as well as sustain health services to the general population, including sexual and reproductive health services, mental health and psychosocial support, and overall management of non-communicable diseases. The effects of the pandemic on people and institutions are compounded by pre-existing drivers of humanitarian needs such as conflict or civil unrest, disaster, poverty and inequality – including gender inequality and discrimination – environmental degradation, food insecurity, malnutrition, poor health, water and sanitation infrastructure and services, low education levels, limited social safety nets or social assistance, unequal access to information and others.

Negative feedback loops can also happen, as people who are struggling even more to meet their basic needs due to the pandemic, may ignore prevention measures or seek to bypass imposed mobility restrictions. Lack of awareness and information about COVID-19 can weaken social cohesion and spur violence, discrimination, marginalization and xenophobia. Access restrictions already applied to humanitarian actors may also be exacerbated.

Existing humanitarian response plans formulated prior to the COVID-19 outbreak must be revised, adapted and re-prioritized to address the additional needs the pandemic is causing, both health- and non-health-related. It is essential to sustain the response to pre-existing humanitarian needs while augmenting and complementing it to address the additional requirements from the pandemic. At the same time, the restrictions to supply chain and travel will impose some scaling back of the response, and decisions at field level will be needed on which interventions should be prioritized in these circumstances.

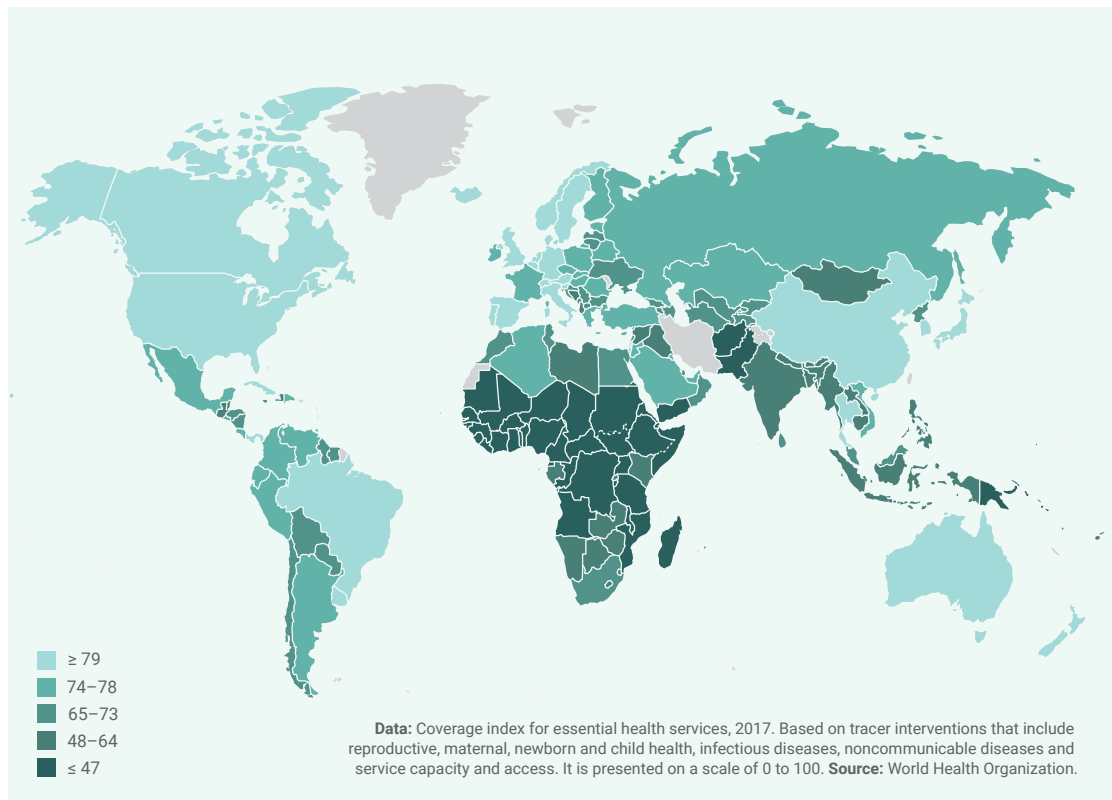# Public health impact of the COVID-19 pandemic

Health effects on people

COVID-19 has become a major pandemic. In a span of just 11 weeks from January to mid-March 2020, the virus has progressed from a discrete outbreak in Wuhan, China, to clusters of cases in many countries, and then to a pandemic with most countries reporting cases, and many experiencing significant outbreaks. Thus far, overall fatality rates have been higher than 3 per cent, and considerably higher for older people and those with underlying health conditions. The virus is also affecting the health of younger adults.

At the beginning of March, COVID-19 was primarily a disease of the northern hemisphere. Sporadic cases and even clusters, however, are now being reported from almost all countries in different climatic zones of Africa, South America, and the Caribbean. The explosive epidemic potential of the virus in Europe and the Middle East became clear in the first weeks of March. The disease is rapidly spreading in areas with high population densities, including urban areas, camps and camp-like settings, and often over-burdening weak health systems. It is now clear that the virus does not differentiate between setting or season. Without decisive action, massive outbreaks will happen around the world.

The pandemic has led to a measurable decrease in the treatment of other pathologies and fewer services being offered relating to preventive health care, and prenatal and post-natal care, among others. Many countries have insufficient resources to augment health-care staff, and do not have enough space or the necessary supplies to treat the sick. Critical resources such as trained health workers

Universal health coverage index by country

≥ 79
74−78
65−73
48−64
≤ 47

Data: Coverage index for essential health services, 2017. Based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access. It is presented on a scale of 0 to 100. **Source:** World Health Organization.

and medical supplies are being diverted to respond to the pandemic, thus leaving other essential services heavily under-resourced and dysfunctional, such as for the treatment of malnutrition, assistance to people with disabilities, older people and survivors of gender-based violence, sexual and reproductive health, and mental health and psychosocial support.

The pandemic is adding to the burden of endemic infectious diseases that prevail in many countries with an ongoing humanitarian response, such as cholera, measles, malaria, HIV and tuberculosis. Pre-existing poor hygiene practices, poor coverage in water and sanitation services and overcrowded living conditions also augment the incidence and spread of contamination by the virus.

Public health response

The implications of the evolution of COVID-19 into a pandemic are a clarion call for a step change in attitudes, mindsets, and behaviours in responding to global health emergencies. The necessary local, national and global actions to save lives, societies and economies must be rapidly scaled up. On 3 February 2020, WHO published a Strategic Preparedness and Response Plan (SPRP) outlining the immediate actions to be taken to stop the further transmission of COVID-19 within China and the spread of the virus to other countries, and to mitigate the impact of the outbreak in all countries.

The SPRP's strategic objectives are to:

- Limit human-to-human transmission, including reducing secondary infections among close contacts and health-care workers, preventing transmission amplification events, and preventing further international spread from China.
- Identify, isolate, and care for patients early, including providing optimized care for infected patients.
- Identify and reduce transmission from the animal source.
- Address crucial unknowns regarding clinical severity, extent of transmission and infection, and treatment options, and accelerate the development of diagnostics, therapeutics, and vaccines.
- Communicate critical risk and event information to all communities, and counter misinformation.
- Minimize social and economic impacts through multi-sectoral partnerships.

These objectives are achieved by:

- Rapidly establishing international coordination to deliver strategic, technical, and operational support through existing mechanisms and partnerships.
- Scaling up country preparedness and response operations, including strengthening readiness to rapidly identify, diagnose and treat cases; identification and follow-up of contacts when feasible; infection prevention and control in health-care settings; implementation of health measures for travellers; and awareness-raising in the population though risk communication and community engagement.
- Accelerating priority research and innovation to support a clear and transparent global process to set research and innovation priorities to fast track and scale up research, development, and the equitable availability of candidate therapeutics, vaccines, and diagnostics. This will build a common platform for standardized processes, protocols and tools, and facilitate multidisciplinary and collaborative research integrated within the response.

Indirect socioeconomic impact of the COVID-19 pandemic

Main macroeconomic effects

Many of the countries covered in the Global HRP are already dealing with multiple crises, hosting refugees, migrants, and internally displaced people (IDPs), facing food insecurity, and being exposed to climate, socioeconomic and political shocks. They have the lowest indices of human development and economic growth in the world, and deal with complex supply corridors for humanitarian and commercial goods. Recent crises with complex and multidimensional factors have also heavily impacted middle-income countries owing to the protracted nature of crises and continuing need.

The COVID-19 pandemic is having, and will have for several months or even years, serious effects on economic growth in the most affected countries. Reduction of industrial and tertiary services production is affecting domestic consumption, supply chains, international trade and the balance of payments, public and private debt and fiscal space. Diminishing fiscal revenues – and the repurposing of already limited government budgets for the COVID-19 response – will negatively impact already overstretched social programmes and services (health, education, etc.), leaving the most vulnerable without essential services. Sluggish economic activity will bring about unemployment, declining wages, and, hence, loss of income.

The food and agriculture sector will also be impacted. On the supply side, the sector could get hurt by shortages of labour curbing production and processing of food, especially of labour-intensive crops; transport interruptions and quarantine measures limiting farmers' access to input and output markets; and an increase in food loss and waste resulting from food supply chain disruptions. This will be an issue particularly in the labour-intensive production systems that characterize smallholder farming in all countries with an ongoing humanitarian crisis. In China, the livestock sector suffered from some of these effects. The restriction of cargo and goods movement is also impacting food and fuel availability in importing countries.

On the demand side, diminished export earnings and ensuing currency depreciation translate into more expensive imports, including for basic foodstuffs, with higher food prices. An increase of 10–15 per cent in the price of rice in China, South-East Asia and Europe and in the rice-producing regions of Thailand, Vietnam and Myanmar has been recently observed. Panic buying has also occurred in most countries with mobility restrictions.

Collateral effects on people
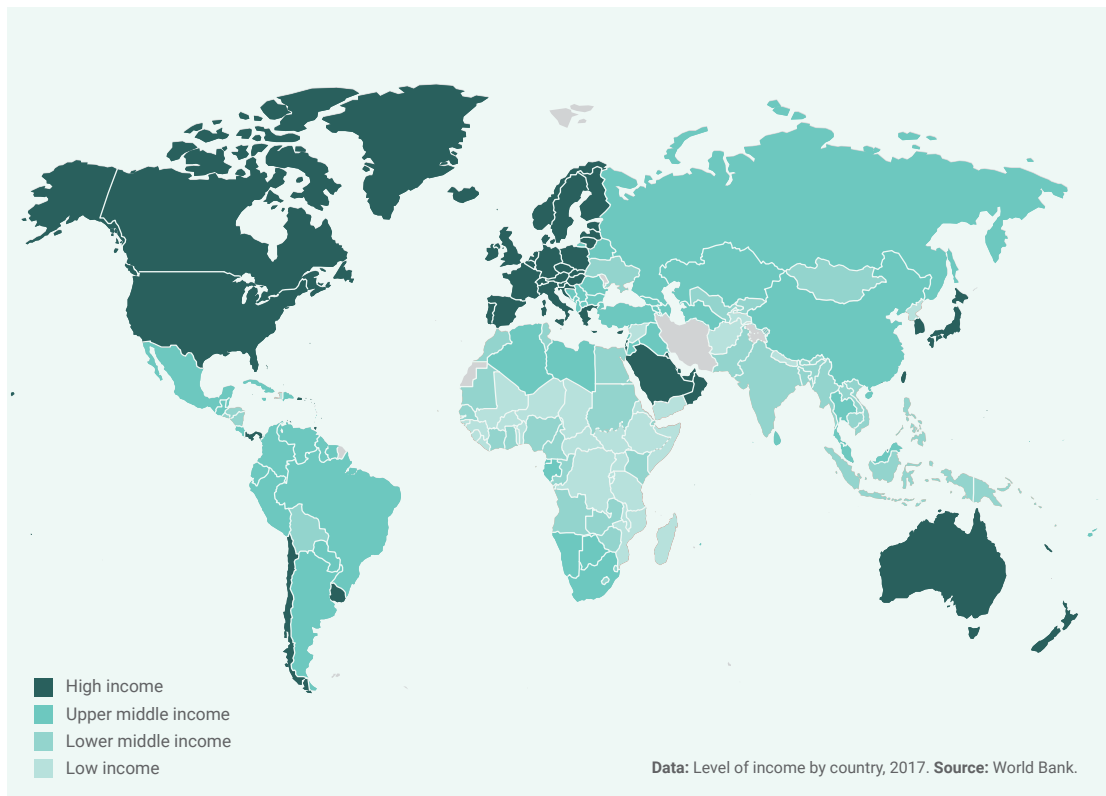
Effects on livelihoods and food security

The COVID-19 pandemic will have devastating consequences on people's livelihoods and employment, especially in post-fragile, crisis and post-crisis environments. Millions will lose incomes, fail to access resources needed for day-to-day well-being, and require new skills/training or new ways of supporting their livelihoods. The outbreak is predicted to have significant effects on many sectors dominated by women. For example, women constitute 70 per cent of the workers in the health and social sector globally and are on the front lines of the response.

The economic impact of COVID-19 will also have significant bearing on vulnerable groups including refugees, migrants, IDPs and host communities due to the loss of income, restricted movement, reduced access to markets, inflation and a spike in prices. It may lead to increases in negative coping strategies such as hazardous forms of child labour and child marriage, for example. As host communities feel the economic impact of COVID-19, they may limit the access of refugees, migrants, and IDPs to land and other natural resources that might have been supporting their basic needs, such as food and energy. These impacts may be alleviated by remittances from abroad, for those receiving them.

Much of the economic impact of the outbreak will stem from Governments imposing bans on certain types of activities, firms and institutions taking proactive measures to avoid infection, business downsizing and closures, and individuals reducing consumption.

People outside of the formal labour market will be the first let go by their employers, while they are more likely to be outside of formal social protection systems. Refugees, migrants, IDPs, the youth and women are often engaged in such informal occupations. They have very limited or no savings or access

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The world by income level

High income
Upper middle income
Lower middle income
Low income

Data: Level of income by country, 2017. **Source:** World Bank.

to credit, and cannot afford to go without employment for any significant period of time. Women are not only more likely than men to work in precarious, informal jobs, but they also shoulder a greater share of unpaid care, adding to their burden.

Effects on protection and rights
The current outbreak of COVID-19 is also fast becoming a mobility crisis. It is changing patterns of and acceptance towards migration, services offered by airlines, attitudes towards foreigners, as well as regimes for border and migration management. An unprecedented number of people are becoming stranded on their journeys. Refugees can face difficulties to leave their country and many migrants face disruption to travel plans, loss of income, or illness as a result of the crisis and may be pushed into vulnerable or exploitative situations. Refugees, IDPs and migrants, particularly those in irregular situations, may be fearful of reporting health conditions and accessing needed treatment.

Measures to restrict the movement of people may increase the risk of denial of access to territory for individuals seeking asylum, and hamper the return of refugees and migrants. In many countries, refugees and migrants do not have access to national health,

education or social security schemes, leaving them unable to rely on the response offered to nationals. Refugees, displaced people and other marginalized groups may also experience xenophobia or a de-prioritization by government security services. Tensions between host communities and refugees/IDPs may arise. Some Governments announced that there should be no movements outside of refugee and IDP camps. Such containment and confinement measures also risk further excluding communities from decision-making processes related to response and mitigation efforts, due to access and existing power dynamics that may be reinforced.

Humanitarian access challenges may also be exacerbated, impairing laboratory testing and awareness-raising. Equally, movement restrictions may make it increasingly difficult for people to leave certain areas to seek health care and other forms of assistance.

School closures may increase protection risks for children, in particular in many of the refugee and IDP-hosting countries or areas. Children outside of family care, such as street children, children on the move, and children in institutions or in detention centres, are particularly vulnerable, including to discrimination within the community. Measures

taken in response to COVID-19 and their impact on family unity and coping mechanisms, may cause children to be at heightened risk of being separated or unsupervised for longer periods, suffer neglect and increase their risk of being abused or exploited, including girls who can fall victim of sexual and gender-based violence.

The social impact of the outbreak could decrease cohesion and further deepen inequalities. Emergency provisions enacted to curtail the spread of COVID-19 may be abused, and when not in line with human rights standards, can equate to misuse of power or targeted action disproportionately affecting key populations, leading to further discrimination and greater potential for conflict. The rise of harmful stereotypes, the resulting stigma and pervasive misinformation related to COVID-19 can potentially contribute to more severe health problems, ongoing transmission, and difficulties controlling the disease outbreak. Stigma and misinformation increase the likelihood of preventing potentially infected people from immediately seeking care or households hiding sick family members to avoid discrimination, especially for minorities and marginalized groups. Targeting and violence against individuals or communities affected by the virus may also increase.

An estimated one in three women worldwide experiences physical or sexual abuse in her lifetime. In times of crisis such as an outbreak, women and girls are at higher risk of intimate partner violence and other forms of domestic violence due to heightened tensions in the household.

Effects on education and society
As schools close, students miss out on opportunities to learn and more vulnerable students may not return to the education system. This translates to reduced learning outcomes and lower long-term earning trajectories for them and their families, and reduced overall human capital for the economies of the countries in which they work and live. By mid-March 2020, an estimated 862 million children were out of school. The suspension of school feeding programmes may also negatively affect children's food consumption and nutritional status.

Confinement measures to increase social distancing separate people from their families, neighbours and other kinship and social networks. The spread of mobile phones and, for those benefiting from reliable access, the Internet may mitigate this for certain population groups but not for others.

Women, older people, people with disabilities and children generally have less access, particularly if they live in rural and remote areas. It is currently unclear whether social distancing will affect participation in community-based initiatives or how isolation and other COVID-19 measures may impact family separation and neglect of children or other people with specific needs, such as people with disabilities or older people. In certain contexts, such as in informal settlements or IDP and refugee camps, or for people with disabilities who require assistance, social distancing may not even be possible.

At the same time, the widespread use of social media, together with less access to some sources of information based on interpersonal communication, may favour the spread of rumours and negative stereotypes, and encourage behaviours contradicting recommended preventive and protective personal actions. The pandemic will result in a more fragile socio-political situation in countries already facing a humanitarian crisis, heightening the risk of civil unrest and violence.

Effects on reduced supply chains and logistics
The impact of the pandemic on supply chains is massive for health and humanitarian partners as well as Governments. More than 107 countries have enacted nationwide travel restrictions and border closures. Border closures, import/export and port restrictions, reduced commercial aviation and shipping operations, and restrictions on movement to/from and within countries have directly impacting availability of food, fuel and other essential needs. Supply chain disruptions put the continuation of humanitarian programmes at stake and significantly complicate any scale-up.

The main short-term implications on both commercial and humanitarian supply chains relate primarily to the disruption of movement of items and people and the interruption of services, including the suspension of flights and maritime traffic: the imposition of quarantine periods and export restrictions; border closures; decreased availability of containers, equipment and space; port closure; and reduced market functioning, among others. Some of these issues are expected to persist for the foreseeable future as the outbreak continues to spread, and it is expected that a number of transport companies and shipping lines and airlines may not survive the downturn in business. Drastic reductions in the availability of international air travel are also impeding refugee resettlement.

Most affected and at-risk population groups

Most affected and at-risk population groups due to COVID-19 and their vulnerabilities and capacities include:

- **People suffering from chronic diseases, undernutrition including due to food insecurity, lower immunity, certain disabilities, and old age.** These conditions increase their susceptibility to the viral infection. Some of these people may also be discriminated against, thus limiting their access to prevention and treatment services.

- **IDPs, refugees, asylum seekers, returnees, migrants, people with disabilities, marginalized groups and people in hard-to-reach areas.** These people lack sufficient economic resources to access health- care, live in remote areas or have difficulties in moving. They may be denied or unwilling or unable to access health care, or there may not be adequate health coverage where they live. Fear of being stigmatized or discriminated against may complicate how, if, or where they are able to access health care. Increased movement restrictions due to COVID-19 may worsen these existing challenges. Some do not receive adapted, actionable or comprehensible information to protect themselves from contamination and lack social support networks to help them face the new threat. They often live in crowded environments that lack adequate health, water and sanitation facilities to prevent contamination and the spread of the virus. The capacity of Governments to provide them with basic services may also be severely undermined, with resources being reallocated to other groups. Some will be stranded due to travel restrictions and may become further vulnerable due to loss or lack of legal status and access to services.

- **Children** losing or being separated from primary caregivers due to quarantine or confinement measures are at increased risk of neglect, abandonment, violence and exploitation. They may also lack access to health treatment, and suffer mental health and psychosocial impacts, and malnutrition. While children are so far not at particular risk of COVID-19 complications, many are affecting by wasting and have a higher risk of morbidity and mortality.

- **Women and girls** who have to abide by socio-cultural norms that require the authorization of a male family member to seek health care and receive appropriate treatments, or who lack power to take decisions are at greater risk of not being tested for the disease and treated. Women caring for others, and the predominant role they play as health and social welfare responders, are particularly exposed to potential contamination. Risks are also heightened for pregnant women who are more susceptible to contracting many transmissible illnesses. Gender-based intimate partner violence is also expected to increase due to the containment measures, compounded by the disruption of support services.

- **People who have frequent social contacts and movements for labour or other livelihood activities.** Household members in charge of fetching water and wood (who are often women and children), of agricultural labour, or who have submitted to repeated forced displacement have greater contacts with potentially infectious people. This also includes front-line health workers in health-care services.

- **People who are losing their income.** Daily workers, small-scale agricultural producers, petty traders and similar groups in the informal sector who cannot access their workplace, land, or markets due to COVID-19 mobility restrictions are unable to secure the income required to meet their basic needs. This increases the risk of negative coping strategies, including lower food consumption, selling off of assets, debt, early/forced marriage and forced prostitution.

The above population groups have intersecting vulnerabilities that compound the health and secondary impacts of the COVID-19 pandemic. Households that have members featuring one or several of these vulnerabilities are particularly at risk of adverse impact from the crisis.

Expected evolution of the situation and needs until December 2020

Projected evolution of the pandemic

Since early March 2020, new major epidemic focuses of COVID-19, some without traceable origin, have been identified and are rapidly expanding in Europe, North America, Asia, and the Middle East, with the first confirmed cases being identified in African and Latin American countries. By mid-March 2020, the number of cases of COVID-19 outside China had increased drastically and 143 affected countries, States, or territories had reported infections to WHO. On the basis of "alarming levels of spread and severity, and the alarming levels of inaction", on 11 March 2020, the Director-General of WHO characterized the COVID-19 situation as a pandemic. It is expected that all regions and countries will be affected.

Projected evolution of humanitarian needs

Scenarios

It is obviously complex to project how the pandemic will affect people's lives, food security and livelihoods in the next few months, due to the rapid increase in the number and spread of cases, and to measures being introduced by Governments. At this point, two scenarios can be envisaged:

1. Quick containment and slow pandemic: The pandemic is slowed down in the coming three to four months and there is a relatively quick recovery, both from a public health and economic impact perspective.

2. Rapidly escalating pandemic in fragile and developing countries: The rate of infection and spread accelerates drastically especially in less developed countries, particularly in Africa, Asia and parts of the Americas. This leads to longer period of closed borders and limited freedom of movement, further contributing to a global slowdown that is already under way. Countries are unable to adequately shore up health systems, the virus continues to spread, and mitigating measures such as lockdowns continue for longer periods. The public health implications and socioeconomic implications of COVID-19 are more severe, experienced worldwide, and last much longer (about 9–12 months).

An extensive spread of the disease in countries with a humanitarian response could take a heavier toll on the economy than it has in those countries which currently see a rapid spread of the virus. Furthermore, the pandemic is spreading at the same time as many countries approach their annual lean season, the hurricane and monsoon seasons loom, and a number of already fragile countries have planned elections. Political stability and security will also be at stake.

Food security and agriculture

Overall, COVID-19 has the potential to significantly disrupt both food supply and demand. Supply will be disrupted due to the disease's impact on people's lives and well-being, but also the containment efforts that restrict mobility and the higher costs of doing business due to restricted supply chains and a tightening of credit. Demand will also fall due to higher uncertainty, increased precautionary behaviour, containment efforts, and rising financial costs that reduce people's ability to spend.

Against that background, countries with high levels of food insecurity are generally more vulnerable to and less prepared for an epidemic. These countries are also more vulnerable to morbidity due to higher rates of malnourishment, and are also likely to see higher mortality rates. The INFORM Epidemic Risk Index, which was developed by the Joint Research Centre of the European Commission and WHO and measures risk based on hazard, exposure, vulnerability and coping capacity, is higher for countries with a higher score for the Proteus index of food insecurity (*see figure next page*).

Agricultural production, food prices and food availability will also be negatively impacted. Blockages to transport routes are particularly obstructive for fresh food supply chains and may result in increased levels of food loss and waste. Transport restrictions and quarantine measures are likely to impede farmers' access to markets, curbing their productive capacities and hindering them from selling their produce. Shortages of labour could disrupt production and processing of food, notably for labour-intensive crops.

During the 2014 West African Ebola outbreak, these factors, in addition to acute agricultural labour shortages, led to more than 40 per cent of agricultural land not being cultivated. The disruption to markets resulted in domestic rice price increases of more than 30 per cent, while cassava prices went up by 150 per cent. During the SARS outbreak in 2003, panic buying and hoarding of food and other essentials were observed in some areas of China.

For countries already facing a humanitarian crisis, the COVID-19 outbreak will likely be much more difficult to control and potentially further exacerbate tensions. This includes countries currently affected by conflict, the desert locust

Food security and pandemic risk
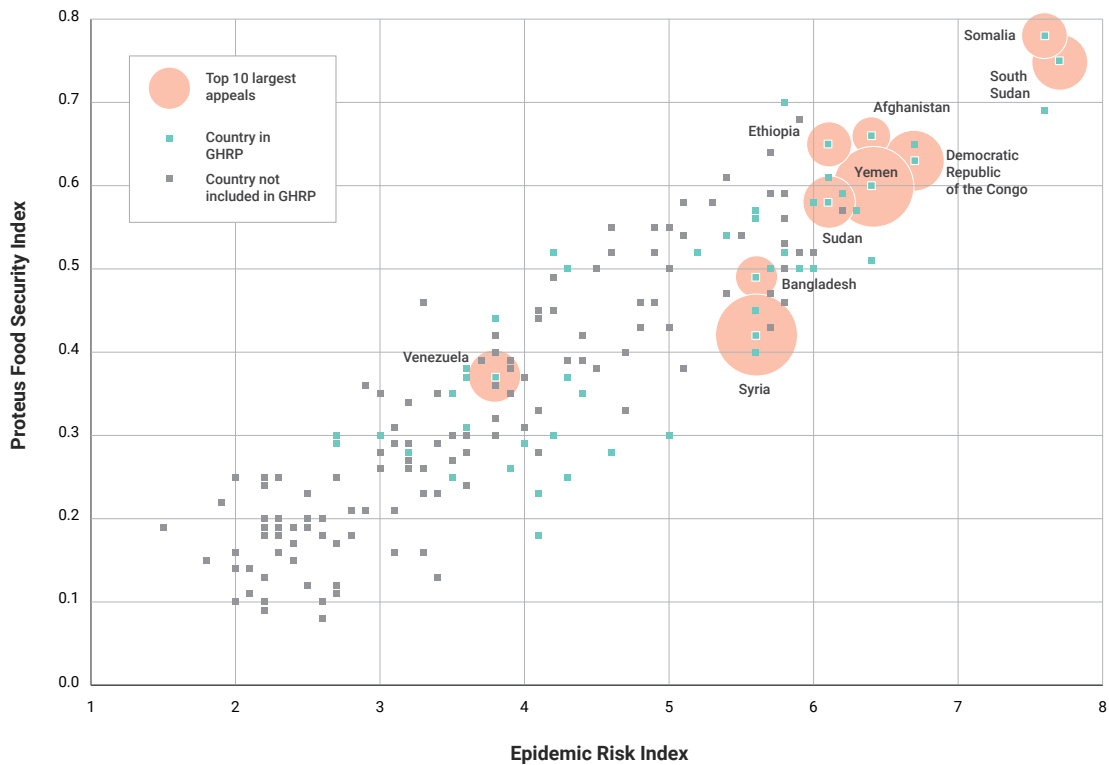
Source: World Food Programme.

outbreak, drought, economic or political crises. An additional layer of COVID-19 impacts will add to the challenges that those areas are already facing and is likely to further increase the number of vulnerable people. Due to access constraints and the limitations of the health sector capacity, it could have the potential to spread more rapidly in hotspots and fragile settings and have more severe impacts that will be difficult to diagnose and contain.

Gender issues

Gender inequalities will be compounded by the pandemic. Risks of gender-based violence will increase, underscoring the urgency to protect and promote the rights and safety of women and girls. Women and girls also typically have reduced access to protective networks and services including sexual and reproductive health care, as a result of public health emergencies, and may be at increased risk of violence in quarantine.

Greater harm can also be expected for lesbian, gay, bisexual, transgender, and intersex (LGBTI) people who typically face prejudice, discrimination and barriers to care, due to their sex, sexual orientation, and/or gender identity.

Priority countries

Due to the characteristics and impact of the COVID-19 pandemic described previously, all countries with an ongoing humanitarian response are prioritized in the Global HRP. This includes countries with an HRP or a Regional Refugee Plan (RRP), the Refugee and Migrant Response Plan for Venezuela (RMRP), and countries covered by the Regional Refugee and Resilience Plan (3RP) for the Syria crisis, and the Joint Response Plan for Rohingya Humanitarian Crisis (JRP). Iran is also included due to the particularly severe impact of the pandemic and call for international assistance.

Systematic monitoring of the situation and needs (*see page 31)* will be done to ensure that countries not prioritised in the first iteration of the Global HRP are included if necessary. Among others, countries such as Greece, Indonesia, Kenya, Madagascar, Mozambique, Nepal, Pakistan, Papua New Guinea, the Philippines, Sierra Leone, Timor-Leste and Zimbabwe, and regional groupings such as Central America and the Pacific warrant close attention.

Criteria for inclusion of additional countries will be agreed-upon at the IASC level.

"We must come together to fight this virus, and as we do so, ensure that life-saving relief operations around the world continue.

It's a moment for solidarity and global action."

—

Mark Lowcock
Emergeny Relief Coordinator, United Nations

GAZA CITY, GAZA
Officials carry out disinfection works as a precaution against
COVID-19 at the Great Omari Mosque of Gaza in Gaza City.
Anadolu Agency/Ali Jadallah

Strategic priorities and response approach

Despite significant challenges, humanitarian and development organizations and Governments are implementing a range of interventions to contain the spread of the virus and alleviate its health and indirect effects

Organizations are taking action to ensure supply chain continuity to deliver urgently needed assistance and mitigate to the extent possible the operational constraints. 100 million people have already received international assistance to mitigate and address the impact of the pandemic.

The Global HRP focuses on the response to the additional, most urgent and direct health, livelihoods, food security and nutrition, and protection needs occasioned by the pandemic. It does not encompass other measures needed to address the macroeconomic, institutional or social impacts of the crisis that require a much greater level of financing and programming on the longer term. The World Bank's Support Plan[2] is an example of such complementary interventions to strengthen health systems and minimise harm to people and to the economy, through grants and low-interest loans to governments and support to the private sector.

The Global HRP prioritises the most vulnerable and at-risk population groups (*see page 16*) in the selected countries (*see page 18*). The situation in second-tier countries at risk of not being able to cope with large humanitarian needs induced by the COVID-19 pandemic will be closely monitored. Preparedness measures in these countries should continue to be encouraged and supported.

Strategic priorities, specific objectives, and enabling factors and conditions are described below. The Plan does not detail the activities that will be implemented. This information is to be found in the respective plans and appeals prepared by individual agencies.

Given the current mobility restrictions, the role of local and community-based actors in the response is essential. The coordination mechanisms (*see page 28*) must foster their participation so that they contribute to the understanding of the situation and needs as they evolve, and influence decisions on priorities and response at field level.

Strategic priorities

The Global HRP builds on three overarching strategic priorities. The strategic priorities are aligned with the goals and objectives of existing plans and appeals issued by humanitarian organizations. They are also coherent with the strategic objectives formulated in most of the current country-level HRPs. Each strategic priority is underpinned by a set of specific objectives, themselves attached to several enabling factors and conditions, detailed below.

Strategic priority 1

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

Specific objectives

1.1

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

1.2

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

1.3

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

1.4

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

1.5

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

1.6

Ensure essential health services and systems: secure the continuity of the essential health services and related supply chain for the direct public health response to the pandemic as well as other essential health services.[3]

Enabling factors and conditions

- National and local emergency coordination mechanisms are effective throughout.
- Health-care facilities with the appropriate level of expertise and capacity to deliver advanced supportive care, and to implement quarantine and patient treatment, are available.
- Logistics, information management, coordination and planning procedures and platforms are in place.
- Large-scale humanitarian air services for humanitarian and health responders, including medical evacuations, are functional and safe to protect passengers and crew from infection risks.
- Humanitarian logistics services including procurement, air bridges and coastal vessels are increased to continue to provide supplies (soap, hand sanitizer, safe water, masks, gown, etc.) for the prevention and treatment of COVID-19.

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

Strategic priority 2

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

Specific objectives

2.1

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

2.2

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

2.3

Secure the continuity of the supply chain for essential commodities and services such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non-food items.[4]

Enabling factors and conditions

- Logistics, information management, coordination and planning procedures and platforms are set up.
- Capacities for real-time monitoring of the situation, needs and response are established.
- The safety, security and access of front-line humanitarian staff are ensured.
- Gender-based violence and sexual exploitation and abuse are prevented.
- Accountability to affected populations and community engagement and outreach are preserved and enhanced.
- Women, adolescents and people with disability are participating meaningfully in needs assessment and response, and their specific risks in the pandemic are addressed.
- Support services, personal assistance and physical and communication accessibility for people with disabilities are preserved, including during quarantine.

- Social safety nets are expanded for the most vulnerable to the pandemic.
- Health-care-seeking behaviour and social impact of the pandemic on the most vulnerable are better understood.
- Humanitarian air services for humanitarian and health responders, including medical evacuations, are functional and safe to protect passengers, crews and relevant populations from infection risks.
- Humanitarian logistics services continue to provide supplies (soap, hand sanitizer, safe water, masks, gowns, etc.) for the prevention and treatment of COVID-19.
- The physical, social and digital infrastructures and services delivery at national and local levels are supported.
- Flexible and reprogrammable funding is provided, in line with existing Grand Bargain commitments.

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

Strategic priority 3

—

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

Specific objectives

—

3.1

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

3.2

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

Enabling factors and conditions

—

- Refugees, migrants, IDPs and people of concern have access to national health systems services.
- Protection monitoring and reporting networks are established in collaboration with Governments and partners to mitigate potential protection risks for people of concern and migrants, including restriction of access to territory and the right of refugees to seek asylum.
- Critical protection functions are maintained or increased, including registration or enrolment, case management, counselling and referrals to ensure access to health and other essential services; and risk communication and community engagement.
- Relevant and accurate communication material in a diversity of accessible and applicable formats and languages is produced and disseminated.

- Social cohesion is preserved by guaranteeing balanced access to migrants and host communities and enhanced information and innovative dialogue approaches.
- Adequate shelter is provided to support density reduction and isolation efforts, especially in high-density living conditions and settlements.
- Shelter, camp coordination and camp management and capacity are strengthened in congested urban, camp or camp-like settings, including transit and detention centres most at risk of COVID-19 outbreak and spread.
- Capacities for real-time monitoring of the situation, needs and response are established.

Response approach

Guiding response principles and key considerations

The Global HRP aims at maximizing coherence and delivering an effective and efficient response by building on the comparative advantages of humanitarian organizations.

Guiding principles

The response approach is guided by the following principles, which will be integrated in all the interventions:

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

Key considerations for the response

In addition to the overarching guiding principles for the response, the particularities of the COVID-19 pandemic call for specific attention to the planning and implementation process. Below are a set of key considerations that apply:

Integration within existing response plans

The response approach in the Global HRP takes into account responses already ongoing to address the effects of the pandemic and as part of humanitarian response plans, including by UN and non-UN agencies. It is clear that the ability to implement many of the current country-level responses will be severely impacted, requiring fundamental changes to many of the operational assumptions underlying existing programming. The Plan also considers the operational constraints due to movement restrictions and supply chains disruption. Decisions will be taken at country level on adjustments required to the programmes, including those predating the COVID-19 pandemic.

In countries with an HRP or other inter-agency plan, changes in humanitarian needs due to the outbreak of COVID-19 will be handled through adjusting the country plan (without requiring a change in the Global HRP for COVID-19) based on available information. Donors are urged to fund the HRPs, 3RP, RRPs, JRP and RMRP in full with flexible funding while limiting bureaucratic requirements to enable humanitarian partners' swift and effective programmatic and financial modifications. Country-based Pooled Funds are a possible channel to enable funding to go as directly as possible to local organizations that are expected to play a key role in the response (*see below*).

Community engagement

Community engagement and ensuring operations are accountable to affected people is a priority and an essential part of humanitarian response. The COVID-19 pandemic has been accompanied by an "infodemic", which has created mistrust and stigmatization, and increased the spread of misinformation. This will undoubtedly have an impact on humanitarian responses for months to come.

Community engagement approaches are critical to understanding the additional impact of COVID-19 on people that are already vulnerable to the impacts of an existing crisis. It is crucial to ensure that communities have access to trusted and accurate information about the measures and behaviours that mitigate the threat of the virus. Current HRPs and humanitarian operations will be able to capitalize on the common risk communication and community engagement strategy developed by WHO, UNICEF and IFRC, and the on-going work on community engagement in the field by UN agencies, international and national NGOs, faith-based groups, the Red Cross and Red Crescent and its National Societies.

Community engagement will be most effective when it is relevant, contextually appropriate and co-owned by crisis-affected populations and when two-way trust between providers and affected populations is established and respected. It is also most effective when carried out by national and local organizations in the humanitarian response, which are present in communities, understand nuanced and complex local dynamics, and can communicate in local languages. It is important that a considered community-centred approach is taken on community engagement and that humanitarian organizations are coordinated across all areas of their interventions. Risk communication and community engagement are important not only to ensure that all people have access to critical, practical and accurate information to make informed decisions to protect themselves and their families, but also that the response is informed by community feedback and optimized to detect and respond to concerns, rumours and misinformation.

Engagement with and role of local and national actors
Local and national organizations are critical to maintain and reinforce humanitarian operations, particularly as international staff face restrictions on travel, will not be deployed to field operations, and may be confined to isolation and working remotely. The same applies to national staff, local authorities and local responders, although international staffing will be more impacted due to greater reliance on international travel. In addition, the scale of the response is such that efforts will also be required to reach and cooperate with non-traditional partners, including technology providers, financial institutions, businesses and others, in a multi-stakeholder collaboration approach.

Putting national and local NGOs at the centre of humanitarian operations has been high on the agenda for a number of years. This will become the reality in COVID-19 operations for the next few months, out of necessity, and has the potential to provide the blueprint for humanitarian operations in the longer-term.

UN agencies and international and national NGOs will need to capitalize on existing local and national capacities in-country, including women and youth-led organizations and organizations of people with disabilities, and engage more robustly with local partners to maintain or scale up their assistance.

Local capacities are substantial in many countries. The Red Cross and Red Crescent network of National Societies has a presence in all humanitarian operations and about 14 million volunteers globally. National Societies volunteers are part of and understand the community and speak the same language. This underpins a high level of trust with crisis-affected people and ensures a deep understanding of the contextual nuances of the operational environment. The same applies to many national and local NGOs, and this capacity and added value is critical to maintain operations in the next months and the longer term.

The Global HRP recognises the added value that national and local partners bring to an operation, and that the international system and national organizations can deliver in an effective partnership based on mutual respect and risk-sharing. This partnership, together with the Government in situations where humanitarian principles are preserved, forms the backbone of continued humanitarian operations at a time when COVID-19 impedes humanitarian response capacity.

UN agencies and international and national NGOs are utilizing the opportunity, even out of necessity, to refocus the relationship and partnerships with local responders to ensure that assistance can be delivered effectively; mobilize the significant national capacity that exists in humanitarian operations to reinforce operations; and establish partnership agreements that are based on a spirit of mutual respect and working together as equals, and not only as implementing partners.

Duty of care

Duty of care is critical in a regular humanitarian setting and is exacerbated in high-risk health situations. Humanitarian organizations will make all efforts to provide their employees with a standard of care that protects them against the health impact of COVID-19 and other risks that humanitarian workers are exposed to. This should include, where feasible, the provision of adequate health insurance and medical air evacuation services if needed, and ensuring as much as possible that all employees are provided with accurate information on the health situation and preventive measures to mitigate the potential for contracting COVID-19, and other health and safety risks in the country of operation.

Humanitarian organizations have an obligation to their employees at all levels and in all locations. While each humanitarian organization maintains its own duty of care policy, international organizations will strive to extend the same duty of care principles and services to contracted parties, including national and local NGOs and their employees.

Local and national partners should also be appropriately resourced and effectively supported while caring for the health and security of their staff.

Response approach to public health impacts - Strategic Priority 1

In the COVID-19 Strategic Preparedness and Response Plan and associated Operational Planning Guidelines, WHO has defined eight pillars that guide preparedness for and response to COVID-19 at the country level: (1) coordination, planning and monitoring; (2) risk communication and community engagement; (3) surveillance, rapid response and case investigation; (4) points of entry; (5) Laboratories; (6) infection prevention and control; (7) case management; and (8) operational support and logistics. These actions are being continually updated as knowledge is gained on how best to prepare for and respond to COVID-19. The guidelines will be used as the basis of planning the public health response for the Global HRP, to be adapted to the specific humanitarian contexts and (Government-led) national actions plans.

Specific guidance has been issued by WHO and by the IASC for managers and public health personnel, as well as Governments and the larger humanitarian community working in humanitarian settings, notably camps and camp-like settings, involved in the decision-making and implementation of COVID-19 outbreak readiness and response operation.

Many countries have also put in place preparedness and response actions around pillars addressing co-ordination, surveillance, laboratory capacity, points of entry, infection prevention and control, case management, logistics, communication and social mobilization, and risk communication. In addition to supporting these efforts, UN Country Teams and WHO are also developing contingency plans and procuring WHO recommended supplies such as hand sanitizers and laboratory equipment, among others.

Response approach to collateral effects on people - Strategic Priorities 2 and 3

Ongoing response

Humanitarian agencies are implementing a range of interventions in various areas to address the indirect effects of the pandemic on people's ability to meet their basic needs. These include, for example (not exhaustive):

- Provision of essential food security, livelihood and nutrition inputs and services, and technical assistance to support vulnerable population groups affected by the pandemic, with direct and indirect benefits including for resilience-building, stability, and the local economy.

- Pre-positioning and stocks of essential food supplies in-country and in strategic regional hubs.

- Technical and capacity strengthening of national and local authorities.

- Social cohesion community-based interventions to prevent the deterioration of livelihoods and strengthen community engagement, particularly in displacement settings.

- Monitoring of food prices, food security and needs, health parameters and the economic impact on fragile economies, for early warning and early action.

- Preparedness planning with line ministries and school authorities to minimize the risk of transmission in schools.
- Mapping of status of points of entry to enable governments and health professionals to better understand human mobility and cargo flows.

Response gaps and challenges

The following responses must be accelerated or scaled up to achieve Strategic Priorities 2 and 3:

- Preparedness to adapt and increase the humanitarian response to the most vulnerable people and continuity of critical assistance in multiple sectors, particularly health, water, sanitation, hygiene, nutrition, shelter, education, non-food items, camp management, food security and livelihoods, and protection, should the pandemic expands further.
- Securing humanitarian corridors and air bridges for the uninterrupted movement of essential cargo and personnel.
- Improved access to information and essential water, sanitation and hygiene (WASH) and health services, and interventions designed to change hygiene practices,
- Life-saving primary health care and sexual and reproductive health services, including the Minimum Initial Service Package.
- Multi-sectoral gender-based violence prevention and response services.
- Referrals of the most vulnerable individuals to appropriate additional protection and social services.
- Food and nutrition assistance as well as rural livelihood support to food-insecure and malnourished people vulnerable to the infection particularly in countries experiencing food crises.
- Continuous functioning of local food markets, value chains and systems, particularly in food-crisis countries, ensuring that people along the food supply chain are not at risk of disease transmission.
- Adapted and accurate risk communication (including through media, social media, radio and mobile information vans and helplines manned by community volunteers), and community engagement for primary prevention and stigma reduction, with special attention to the most vulnerable such as women, people with disabilities and marginalized groups including refugees, IDPs and other people of concern.
- Protection and social, psychosocial, legal and

justice services for all, including asylum seekers, refugees, IDPs, stranded migrants and other particularly vulnerable groups (e.g., survivors of gender-based violence, adolescent girls, unaccompanied/ separated children, etc.) at risk of discrimination and exclusion.

- Shelter, infrastructure improvement and standard operating procedures to decongest over crowded areas and help prevent the transmission of the disease at borders, in displacement sites and in urban sites with vulnerable population groups.
- Systematic advocacy for inclusion of refugees, IDPs, and migrants in ongoing preparedness and response plans.
- Scale-up of social assistance systems, and cash transfer programmes with complementary livelihood assistance (including adaptations for remote digital trade/marketing), particularly for rural crop and livestock workers and producers, small/medium businesses, refugees, IDPs, migrants and host populations, and other food-insecure population groups.
- Support to schools that can safely remain open, and investment in connected education, including offline solutions to enable continuous access to education throughout the crisis.
- Data and analysis to better understand the potential implications of COVID-19 through monitoring of the impact of the pandemic on critical systems (e.g., food systems and agricultural products trade corridors, water, sanitation and other essential non-food items procurement chain) and on population groups most at risk (such as people with health preconditions and IDPs, refugees, migrants and women most exposed and susceptible to the disease and less able to cope), including the use of tools and mechanisms such as the Displacement Tracking Matrix, registration, and platform and infrastructure for real-time remote data collection and early warning.
- Monitoring of eviction cases, particularly among vulnerable groups, and support for protective measures such as moratoriums on evictions and rental support.
- Conflict-sensitive and social cohesion assessments and response to prevent outbreaks of violence and conflict.
- Effective communication to increase the acceptance of humanitarian workers.

The main challenges to implement the response include:

- Border closures, import/export and port restrictions, fuel and commodity price fluctuations, and reduced commercial aviation and shipping operations affect the ability of partners to contract commercial service providers.

- Delivery of COVID-19 essential response supplies is delayed due to ongoing global demand and shortages.

- Travel restrictions, lack of transport options, and access impediments lead to slow or no response by humanitarian organizations.

- Procedures are lacking in many aid organizations to change their operation and distribution modalities in order to reduce human-to-human transmission and limit public gatherings.

- The full impact of the pandemic on the livelihoods and survival of the most vulnerable populations is not yet known.

Coordination mechanisms

The Global Humanitarian Response Plan is a joint and collective effort among all stakeholders, facilitated at global level by OCHA.

At the field level, the usual coordination mechanisms apply, including liaison with and support to national coordination structures, established coordination under the 3RP, RRPs, JRP and RMRPs, and civil-military coordination procedures.

Global-level coordination

The Inter-Agency Standing Committee (IASC) under the leadership of the Emergency Relief Coordinator, will oversee the global-level coordination and will liaise with other stakeholders, such as the UN Crisis Management Team, as needed. Through the IASC principals, the Emergency Directors Group – which represents UN agencies, NGO consortiums and Red Cross and Red Crescent movements working on humanitarian crises – is leading the overall global-level coordination of the humanitarian response. WHO will continue to operate as a technical lead as outlined in its COVID-19 Strategic Preparedness and Response Plan, and continue to coordinate with partners through the Incident Management Support Team, Global Outbreak Alert and Response Network and Health Cluster partners.

The Emergency Directors Group will continue to provide operational support to countries with an existing HRP and COVID-19 response plan and liaise at field level with the Humanitarian Country Team (HCT), Resident Coordinator/Humanitarian Coordinator (RC/HC) and global coordination mechanisms such as the UN Country Management Team. Similar to other UN agencies, OCHA has established a COVID-19 response unit to support humanitarian country operations effectively.

For the refugee response, UNHCR will use the existing coordination structures in place at global and regional levels.

Regional-level coordination

At the regional level, Cluster Lead Agencies and humanitarian partners with regional presence and capacities will continue to support existing coordination structures at national levels.

Country-level coordination

Countries with a Humanitarian Response Plan
Where the humanitarian programme cycle is implemented, the RC/HC and the HCT lead the response, with WHO providing lead support and expertise on public health issues in consultation with national authorities. In these countries, OCHA-led intercluster coordination groups are also present and lead on operational coordination, supplemented as necessary by refugee coordination mechanisms.

OCHA continues to support RC/HCs and HCTs with overall coordination and intersectoral COVID-19 response, including COVID-19 emergency task forces that have often been set up involving front-line responders to address the impact of COVID-19 on humanitarian needs and response, with a focus on measures to contain the spread of the epidemic and mitigate the direct and indirect effects of the outbreak on vulnerable population groups. Particular clusters such as Health, WASH, Shelter, Food Security, Protection and Logistics will have a more prominent role due to the nature of the outbreak.

The HCT may setup subnational coordination mechanisms if not in place already to boost local coordination and response capacity, and increase the linkages with local coordination mechanisms and the participation of local actors. In some contexts, complementarities with development actors will be key to deliver an effective and sustained response.

In countries covered by a refugee response plan, the existing coordination mechanism will be used under the overall leadership of UNHCR in close coordination with WHO. In countries covered by a refugee and migrant response plan, the existing coordination mechanism will be used, i.e., the inter-agency platform set up by IOM and UNHCR at the request of the UN Secretary-General will coordinate the needs assessment and the response for refugees and migrants.

In countries with "mixed situations", the joint UNHCR-OCHA Note on Mixed Settings lays out the respective roles and responsibilities of the HC and the UNHCR Representative, and the practical interaction of IASC coordination and UNHCR's refugee coordination arrangements, to ensure that coordination is streamlined, complementary and mutually reinforcing.

Countries without a Humanitarian Response Plan
Where the humanitarian programme cycle and refugee plans (3RP, RRP, JRP) and other joint response plans mechanisms (RMRP) are not implemented and a designated HC is not present, the RC and UNCT, with technical leadership from WHO on public health issues, articulate the international component of the response. In some of these countries, emergency task forces which include UN agencies, Red Cross and Red Crescent Movement, NGOs and government agencies have also been set up to address the impact of COVID-19, contain the spread of the epidemic, and support ongoing response efforts at national and local levels.

UNCTs continue to support national authorities in the development and implementation of country preparedness and response plans, which have already been developed in many countries or are in the process of being developed in response to COVID-19. The UNCT may institute subnational coordination mechanisms as appropriate, encouraging links with local coordination mechanisms and participation of local actors.

> "COVID-19 is taking so much from us. But it's also giving us something special – the opportunity to come together as one humanity – to work together, to learn together, to grow together."
>
> —
>
> **Tedros Ghebreyesus**
> Director-General, World Health Organization

ONGATA RONGAI, KENYA
A health workers puts on a protective gear to disinfect the apartment where the first Kenyan patient that tested positive for COVID-19 stayed in Ongata Rongai, a neighboring town of Nairobi in Kenya.
AFP/Yasuyoshi Chiba

Monitoring framework

The COVID-19 pandemic is characterized by the rapidity of its spread and difficulty to project how the epidemic will evolve at country level. As a result, a monitoring mechanism of the situation, needs and response achievements is indispensable to rapidly adjust the interventions.

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In view of the mobility and interpersonal contact restrictions, creative monitoring approaches will have to be applied, including remote monitoring through phonecalls to key informants and households, and third-party monitoring. Monitoring should be attached to real-time learning that enables immediate action and further improvements of the response.

The monitoring framework comprises two components:

- A situation and needs monitoring component to capture the fast-evolving expansion and contraction of the pandemic as well as the immediate and lagged effects on people's lives and livelihoods. The monitoring mechanism should also be able to identify new outbreaks in countries not initially prioritized in the Global HRP.

- A response monitoring component to capture the achievements of the collective response as well as the effectiveness of preparedness actions to respond to new occurrences or rapid deterioration.[5]

Both components must be used together to decide on response adjustments as required, including its geographical scope and types of interventions. **Monitoring results will be used to update the Global Plan on a monthly basis, starting from May 2020.**

The tables below summarize high-level monitoring indicators according to the strategic priorities and specific objectives, rationale, frequency of reporting, and responsible entity(ies). Acknowledging mobility and access constraints, efforts will be made to disaggregate relevant indicators by sex, age, disability and, when appropriate, by other vulnerability and diversity characteristics such as status of displacement.

[5] For the refuge response the existing monitoring mechanisms will be used at country and regional level as applicable.

Situation and needs monitoring

High-level situation and needs monitoring indicators are identified to capture the main changes in the spread and impact of the pandemic. More detailed indicators will also be collected by each agency according to the population, geographic and programmatic focus of their operations.

In the below table, "priority countries'" refer to those included in the first iteration of the Global HRP. Additional countries may be considered in the future based on broader monitoring at the global level.

Situation and needs
Spread and severity of the pandemic

#	INDICATOR	RATIONALE	FREQUENCY	RESPONSIBLE ENTITY
1.1	Number of priority countries with COVID-19 cases	The incidence informs on the trajectory of the epidemic	Daily	WHO
1.2	Number of confirmed cases in priority countries	The incidence informs on the trajectory of the epidemic	Daily	WHO
1.3	Number of priority countries with local transmission	The incidence informs on the trajectory of the epidemic	Daily	WHO
1.4	Number of priority countries with imported cases	The incidence informs on the trajectory of the epidemic	Daily	WHO
1.5	% of deaths among reported cases in priority countries	The incidence informs on the trajectory of the epidemic	Daily	WHO
1.6	% of cases who are health-care workers	The incidence informs on the trajectory of the epidemic	Daily	WHO

Situation and needs
Mobility, travel and import/export restrictions in priority countries

#	INDICATOR	RATIONALE	FREQUENCY	RESPONSIBLE ENTITY
2.1	Number of priority countries with border closures in place	Mobility and travel restrictions are used to reduce the spread of COVID-19. They have a significant impact on the delivery of humanitarian assistance	Weekly	IOM

2.2	**Number of priority countries with international travel restrictions in place**	Mobility and travel restrictions are used to reduce the spread of COVID-19. They have a significant impact on the delivery of humanitarian assistance	Weekly	IOM WFP
2.3	**Number of priority countries with import/export restrictions in place**	Mobility and travel restrictions are used to reduce the spread of COVID-19. They have a significant impact on the delivery of humanitarian assistance	Monthly	WFP

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Situation and needs
Food security

#	INDICATOR	RATIONALE	FREQUENCY	RESPONSIBLE ENTITY
3.1	**Market functionality**	COVID-19 containment measures affect market food availability and access	Monthly	WFP
3.2	**Food consumption score**	COVID-19 containment measures affect household food security	Monthly	WFP
3.3	**Reduced Coping Strategy Index (rCSI)**	COVID-19 containment measures affect household coping capacities	Monthly	WFP
3.4	**Food and crop production estimates**	COVID-19 containment measures affect production of food and cash crops	Seasonal, depending on harvesting periods for key crops	FAO

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Situation and needs
Education

#	INDICATOR	RATIONALE	FREQUENCY	RESPONSIBLE ENTITY
4.1	**Number of children and youth out of school due to mandatory school closures**	COVID-19 containment measures affect children's education	Monthly	UNICEF

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Situation and needs
Sexual and reproductive health

#	INDICATOR	RATIONALE	FREQUENCY	RESPONSIBLE ENTITY
5.1	**Number of Emergency Obstetrics and Neonatal Care services that meet standards of care in areas of high incidence of COVID-19 cases**	COVID-19 containment measures and high COVID-19 incidence rates affect pregnancy and safe delivery	Monthly	UNFPA

Response monitoring

Response monitoring indicators are identified to capture the progress and achievements of high-level responses. The indicators are not exhaustive and do not reflect all the components of the strategic priorities and specific objectives. Additional detailed indicators will be collected by each agency according to the population, geographic and programmatic focus of their operations.

The below table should be refined in future updates of the Global HRP to improve the specificity, measurability, and relevance of the indicators and targets.

Strategic priority 1
Contain the spread of the COVID-19 epidemic and decrease morbidity and mortality

#	SPECIFIC OBJECTIVE	INDICATOR	RATIONALE	TARGET	RESPONSIBLE ENTITY
1.1	Prepare and be ready	**Number and proportion of people most vulnerable to COVID-19 who receive essential water, sanitation and personal hygiene goods and services**	Preparedness is key to decrease risks and prevent the spread of COVID-19	-	WHO UNICEF
1.2	Detect and test all cases	**Number and proportion of targeted countries with functional surveillance and testing systems**	Understanding of epidemiology of COVID-19 and detection is life-saving	-	WHO
1.3	Provide safe and effective clinical care	**Proportion of 60+ patients who recover from COVID-19**	Treatment is a primary method of addressing COVID-19 in positive cases	-	WHO
1.4.1	Prevent, suppress and interrupt transmission	**Preparedness index & Operational readiness index (using 18 different indicators from IHR State Party Self-assessment Annual Reporting Tool)**	Demonstrates the level of preparedness and operational readiness based on the implementation of 2005 International Health Regulations	L1: <=30 L2: <=50% L3: <=70% L4: <=90% L5: > 90%	WHO
1.4.2	Slow, suppress and stop virus transmission to reduce the burden on health-care facilities	**Number of countries that activated their public health Emergency Operations Centre or a coordination mechanism for the 2019-nCoV event**	Indicates national government capacities to coordinate the response	100%	WHO

1.5	Learn, innovate and improve	**Proportion of priority countries eligible to enroll in clinical trials**	Indicates efforts to improve knowledge and response effectiveness	-	WHO
1.6	Ensure essential health service and systems	**Number of functional hubs for prepositioning and storage of essential health and humanitarian supplies**	Continuity of health and humanitarian supply chain is crucial for life-saving response and any interruptions will increase risks	-	WFP

Strategic priority 2

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

#	SPECIFIC OBJECTIVE	INDICATOR	RATIONALE	TARGET	RESPONSIBLE ENTITY
2.1	Preserve the ability of people most vulnerable to the pandemic to meet their food consumption and other basic needs, through their productive activities and access to social safety nets and humanitarian assistance	**Number and proportion of people most vulnerable to COVID-19 who have received livelihood support, e.g. cash transfers, inputs, technical assistance etc. / Number of people most vulnerable to COVID-19 who benefit from increased or expanded social safety net**	Informs on protection of the ability of the most vulnerable people to meet their basic needs	-	FAO IOM UNDP UNICEF UNHCR
2.2	Ensure the continuity and safety from infection of essential services including health, water and sanitation, nutrition, shelter protection and education for the population groups most exposed and vulnerable to the pandemic	**% of safe, functional and non-infected essential services**	Safety and continuity of services is key to serve at-risk populations	-	IOM UNHCR UNICEF WHO
2.3	Secure the continuity of the supply chain for essential commodities and services such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non-food items	**Number of air cargo flights carrying essential commodities**	Helps maintain continuity of life-saving humanitarian response	-	WFP

Strategic priority 3

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

#	SPECIFIC OBJECTIVE	RATIONALE	INDICATOR	TARGET	RESPONSIBLE ENTITY
3.1	Advocate and ensure that refugees, migrants, IDPs, people of concern and host population groups who are particularly vulnerable to the pandemic receive COVID-19 assistance	Refugees, IDPs, migrants and host communities face specific vulnerabilities to the pandemic	**Number of refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic that receive COVID-19 assistance**	-	IFRC IOM UNHCR UNICEF WHO
3.2	Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia towards refugees, migrants, IDPs and people of concern by enhancing awareness and understanding of the COVID-19 pandemic at community level.	Communities must be aware and engaged, and that messages from credible sources reach the most vulnerable	**Number of refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic receive adequate risk information**	-	IFRC IOM UNHCR UNICEF WHo
			Number of communal conflicts in affected communities	-	IOM
			Proportion of affected population expressing satisfaction on access to services, rights and information	-	IOM
			Number of communities with established hotlines functioning and increased access to timely and accurate information on COVID 19 from credible sources	-	UNDP

JUBA, SOUTH SUDAN
Passengers from an international flight are screened for
their temperature at Juba International Airport in Juba,
South Sudan. *AFP/Alex McBride*

Financial requirements

Funding requirements of the Global HRP are estimated at US$2.01 billion. They are above and beyond what has already been prioritized in the existing HRPs, RRPs and similar humanitarian plans, covering the additional humanitarian needs provoked by the pandemic.

Further joint multi-sector needs assessments using approaches adapted to the COVID-19 circumstances will be necessary to obtain more precise information on the number of people requiring assistance as a result of the pandemic, and the corresponding interagency humanitarian response. These figures will be added to those contained in the 2020 Global Humanitarian Overview (GHO).

It is essential that additional funds are mobilized and not diverted from ongoing humanitarian operations. This funding remains critical to address pre-COVID-19 needs caused by conflicts and disasters, while also contributing significantly to affected people and essential services capacity to cope with the pandemic.

COVID-19 response funding takes due consideration of critical programmes that need to be protected and expanded for women and girls, as well as other most vulnerable population groups (*see page 16*). Resources should also be allocated for monitoring and evaluation of the responses, including the need to apply alternative approaches such as remote and third-party monitoring. The Global HRP funding is addressing needs to be identified through clusters and will be further consulted with partners including NGOs. In agreement with Grand Bargain commitments, both existing and new donor funding should maximize flexibility (across the board rather than project by project) to enable rapid adjustments of the response that will be necessary in such a fast-evolving crisis. Most of the funding to UN agencies will be implemented through NGO partnerships. Whenever they are best placed to respond, this funding should be allocated as directly as possible to local and national actors.

Breakdown of financial requirements

REQUIREMENTS (US$)

$ **2.01** billion

FAO	110.0 M	**UNHCR**[7]	255.0 M
IOM	100.0 M	**UNICEF**	405.0 M
UNDP	120.0 M	**WFP**	350.0 M
UNFPA	120.0 M	**WHO**	450.0 M
UN-Habitat	2.0 M		

AGENCIES TOTAL	**1.912 B**
Unearmarked for country-specific NGO response	100.0 M
APPEAL TOTAL	**2.012 B**

Source: Office for the Coordination of Humanitarian Affairs

[6] The WHO SPRP has a broader geographic remit than the countries prioritised in the initial iteration of the Global HRP, given the unique leadership role that WHO is playing in the COVID-19 pandemic response. Consultations are ongoing between WHO and OCHA to enable a proper tracking of donor financial contributions according to the scope of either plan.

[7] For the refugee and IDP response, the budget figure of $255 million is foreseen to cover UNHCR's additional budgetary needs for the next 9 months in responding to the COVID-19 outbreak. UNHCR will reach out to refugee hosting countries as well as partners to update the refugee response plans prior to the next iteration of this appeal. The budget figure may change in line with partner consultation and evolving needs.

In addition, a simplified and harmonized approach to reporting and minimized bureaucratic processes will enable humanitarian partners' timely and appropriate response.

Funding for the Global HRP will be complementary to the financing instrument that is being discussed by the UN Secretary General to support a coordinated UN multi-sectoral response to end COVID19 transmission, and help countries and their economies recover from the pandemic. This fund will complement the Global HRP by focusing on critical actions to tackle the public health emergency, address the socio-economic impact and the economic response and recovery, and help countries recover better. This initiative will promote and leverage the coherence of the UN system in line with the UN Development System Reform Agenda and the 2030 Development Agenda, at the nexus of humanitarian, recovery and development action. It will be inspired from the 2014-17 Multi-Partner Trust Fund for the UN Ebola Response. RC/HCs will play a central role to ensure the complementarity of the different plans and sources of funding.

The financing requirements of the Global HRP cannot be directly allocated to each strategic priority or specific objective as many activities overlap, for example, the procurement of health, water and sanitation items, logistics, risk communication, coordination, etc. Additional details on budgets are available in individual agency appeals and plans. A summary of the main activities planned is provided in the table below.

Country-level requirements
At the time of writing, many priority countries are working on or just issuing their revised plans for the COVID-19 response. Funding requirements have yet to be estimated for several countries. For this reason, individual country requirements will be provided in the next update of the Global HRP.

Response by agency

AGENCY	MAIN RESPONSES
FAO	**Strategic Priority 2 - SO 2.1 - SO 2.2** FAO will (i) stabilize access to food by supporting rural incomes and preserving ongoing critical livelihood assistance to vulnerable households; (ii) ensure continuity of the critical food supply chain; and (iii) ensure people along the food chain are not agents of COVID-19 transmission. This will be done by: • Working with governments to scale up social protection systems; direct cash injections where feasible; and cash+ schemes • Providing time-critical inputs; technical advice; support livelihood diversification and home production; support continued production, transformation, marketing and exchange of food products For IDPs/refugees, support food production in camps, and scale-up cash-based programming • Incentivizing continued production and strengthening agricultural cooperatives to maintain negotiation power for farmers; • Working with WHO to share messages and raise awareness of COVID-19 among food chain actors • Better understanding the potential impacts of COVID-19 on food security and the food supply chains, at country and global level. FAO will continue to play a critical coordination role, through co-leadership of the global and national Food Security Cluster and technical support for food security information and analyses, needs and impact assessments, early warning and monitoring systems, data collection and surveys, etc.

Response by agency

AGENCY	MAIN RESPONSES
IOM	**Strategic Priority 1 – SO 1.1 - SO 1.2 - SO 1.3 - SO 1.4 - SO 1.5 - SO 1.6** IOM will scale up its support to local governments to enhance existing capacities by (i) Providing life-saving primary health care and procurement of critical medical supplies and infrastructure support; (ii); Providing WASH services in health-care facilities and Points of Entry; (iii) Enhancing national capacity for detection through trainings and operations support for laboratory testing, including through cross-border; (iv) Strengthening Community Event-Based Surveillance by linking mobility information to surveillance data, particularly among border communities, strengthen data collection and conduct Participatory Mapping Exercises to identify high-risk transmission mobility corridors/areas. **Strategic Priority 2 – SO 2.1 - SO 2.2 - SO, 2.3** IOM will continue supporting regional, national and local authorities to ensure the continuation of services, including primary health care and WASH facilities, as well as strengthening the access to social networks and livelihoods for migrants, IDPs, and other vulnerable populations. It will also address, prevent, and anticipate community security negative impacts on social cohesion related to lack of awareness and information about COVID-19 pandemic among local communities. IOM will also engage with national authorities and UN partners to support the procurement, storage and distribution of critical supplies. **Strategic Priority 3 – SO 3.1 - SO 3.2** IOM will continue to enhance local-level capacities to ensure the protection and access to services of all migrants, displaced populations and local communities by (i) providing assistance to stranded migrants to access services; (ii) strengthening existing protection mechanisms and social services to identify and support people in need of care or protection and refer them to appropriate services; and (iii) disseminating key messages on service delivery, health and hygiene to migrants, IDPs and other vulnerable populations. Technical guidance and tools will be prepared to ensure risk communication messages are culturally and linguistically tailored. Advocacy efforts will be done for migrant-inclusive approaches that minimize stigma and discrimination. Activities will be implemented to improve living conditions of displaced populations to minimize the risks related to the spread of COVID-19 disease, including improvement of camps and camp-like settings, provision of WASH services, and shelter assistance to support density reduction and isolation. In settings where no humanitarian access is available and IOM has ongoing operations, assistance to new emerging caseloads of vulnerable displaced populations or stranded people will be also provided.
UNDP	**Strategic Priority 1 - SO 1.1 - SO 1.6** UNDP will support the procurement and provision of health products, and support non-medical requirements for the overall response and coordination. Salary/incentives payments will be made to existing and new health workers in resource-constrained settings. **Strategic Priority 2 - SO 2.1 - SO 2.2** UNDP will provide emergency employment, public employment services, as well as basic livelihood and start-up grants including cash aid. It will support the Emergency Operation Centers/ Civil Protection/ National Disaster Management Committees to set up helplines manned by community volunteers to respond to queries of the general public on COVID 19 with special outreach to most vulnerable groups; and community volunteering to help with contact tracing and other information useful for decision making and later recovery planning. UNDP will also conduct rapid needs and impact assessments to identify the most affected population and inform livelihood assistance and recovery.UNDP will also provide immediate support to deliver essential services to enhance protection of fundamental human rights, justice and security needs of vulnerable people and communities. **Strategic Priority 3 - SO 3.2** UNDP will increase its support to local governments to plan and deliver vital basic services rapidly in an inclusive manner to mitigate sources of tensions. It will contribute to mainstream social cohesion and conflict sensitivity across the humanitarian plans in priority countries and nationally-led response plans, help address issues to stigma and discrimination issues, and enable society to maintain cohesive structures and capacities.

AGENCY	MAIN RESPONSES

UNFPA

Strategic Priority 2 - SO 2.2 - SO 2.3
UNFPA will ensure the continuity of national and local health system capacity to provide access to integrated quality sexual and reproductive health including: comprehensive emergency emergency obstetric care, routine antenatal, postpartum carel and postnatal care to ensure safe delivery, mental health and psychosocial support, family planning and gender-based violence services, including clinical management of rape, specialised psychological-social support, case management and physical protection / safety and legal services for gender based violence survivors. and gender-based violence services.

It will mitigate the impact on supply chain and logistics management for sexual and reproductive health supplies, ensuring continuity of supplies and care for lifesaving sexual and reproductive health services throughout the COVID-19 pandemic. UNFPA will also provide and protect health workers (in particular midwives, nurses, obstetricians and anesthesiologists) by ensuring that basic personal protection equipment is available.

Strategic Priority 3 - SO 3.2
UNFPA will provide risk communication and community engagement for primary prevention and stigma reduction, strengthening risk reduction messages and addressing needs of women of reproductive age in quarantine. It will distribute dignity / hygiene kits to ensure that women receive essential items while being provided with gender-based violence, sexual and reproductive health and COVID-19 risk mitigation information.

UN-Habitat

Strategic Priority 2 - SO 2.2 / Strategic Priority 3 - SO 3.2
UN-Habitat will support preparedness and response to the COVID-19 pandemic among the most vulnerable populations in urban settlements, especially in informal settlements and slums. Key interventions include:

- Enhanced WASH mobilization and services in informal settlements,
- Modeling of movement in urban areas, both within the cities and flowing out from the cities as populations return to rural areas perceived as more protected from the virus
- Messaging and advisory capacity to local city authorities on preparedness and response, including safe mobility in urban areas, and community mobilization in informal settlements to address preparedness, reduced transmission, community tracing, treatment, and solidarity.

UNHCR

Strategic Priority 3 - SO 3.1
UNHCR will assist governments in meeting humanitarian standards and ensure that the needs of all those seeking protection are taken into account. Critical protection functions include: maintaining or increasing registration or enrollment, case management, counselling and referrals to ensure access to health and other essential services and, risk communication and community engagement Likewise, it will provide cash-based assistance (where possible); reinforce and improve shelters including for isolation purposes; stockpile and provide core relief items, particularly for distribution in congested urban and camp settings; support learning and livelihood opportunities where health conditions allow or otherwise support or invest in connected education and livelihoods.

Strategic Priority 3 - SO 3.2
UNHCR will undertake targeted messaging in camps, settlements and host communities at highest risk on hygiene practices; increase WASH facilities, hygiene supplies and urgent procurement of medicines and medical supplies; and enhance inpatient and outpatient services, intensive care capacity and burial facilities.

UNICEF

Strategic Priority 1 - SO 1.1 - SO 1.2 - SO 1.3 - SO 1.4
UNICEF will strengthen Risk Communication and Community Engagement activities to ensure women, children and their families know how to prevent COVID-19 and are encouraged to seek assistance while also contributing to improvement in Infection, Prevention and Control practices in communities, educational and health facilities is improved through training of health workers, teachers and provision of WASH services. In addition, UNICEF will provide supplies to communities, educational and health facilities to ensure appropriate prevention and treatment of COVID-19, including WASH supplies, Personal Protective Equipment, and case management supplies.

Strategic Priority 2- SO 2.1 - SO 2.2 - SO 2.3
UNICEF will ensure children and women have continued access to essential health care, education, child protection and GBV services. Specifically, it will ensure women and children have access to services such as immunization, prenatal and postnatal care, and HIV care and case management is adapted to children and pregnant women and implementation of breastfeeding recommendations and nutrition support to patients, in an environment safe from infection.

UNICEF will also collect data and analyze the outbreak's impact on children, pregnant women and communities, including local care seeking behaviors and social impact on at-risk/vulnerable populations as appropriate.

AGENCY	MAIN RESPONSES
WFP	**Strategic Priority 2- SO 2.1 - SO 2.2** WFP will focus on tangible assets and supply chain services required for humanitarian and health actors to be able to deliver the response outlined in this Global HRP. Specifically WFP will: • Establish (or reinforce existing) international staging areas and regional hubs for cargo consolidation and forwarding. • Provide logistics services through sea vessels and aircrafts, among others, from international staging areas to regional hubs, and onwards to priority country points of entry if needed. • Provide the humanitarian community with medical evacuation services and the infrastructure for field clinics (not medical equipment) for front line aid workers; • Coordinate storage, sea, and air services for maximum efficiency and effectiveness and ensuring pipeline visibility of cargo to partners. • Expand real-time remote monitoring systems to collect continuous data food security, market and health related indicators to support coordinated analysis and informed decision making for governments and partners.
WHO	**Strategic Priority 1 - SO 1.1 -SO 1.2 - SO 1.3 - SO.1.4 - SO,1.5 - SO 1.6** WHO will continue to respond to the direct impact of the COVID-19 outbreak in order to contain its spread, prevent, suppress and interrupt transmission. It will: • Support interventions to detect and test cases through surveillance and laboratory testing. • Provide safe and effective clinical care to individuals at most risk • Gain and share knowledge about COVID-19 to increase effectiveness of response efforts • Secure the continuity of essential health services and systems and related supply chains.

Annex:
Humanitarian
Response Plans (HRPs)

Afghanistan `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 22 March 2020, there were 34 confirmed COVID-19 cases in Afghanistan. Afghanistan's under-developed health system is thinly spread due to ongoing conflict with mass casualty incidents and recurrent outbreaks of communicable diseases, especially among internally displaced people (IDPs) and infrastructure challenges. Around 30 per cent of the population has limited access to basic health services within a two-hour travel radius. Only 50 per cent of children under age 5 have received the full suite of recommended vaccinations.

Women may be less able or willing to get tested because their access to health care is seriously diminished due to limited availability of female health workers. Care and support to gender-based violence survivors, as well as sexual and reproductive health services may be disrupted when service providers are overburdened by efforts to address COVID-19.

Some 14.3 million people are estimated to be in either crisis or emergency food insecurity (Integrated Food Security Phase Classification 3 and 4), with an estimated 2 million children under age 5 and 485,000 pregnant and lactating women affected by acute malnutrition. This compromises people's overall health and is likely to worsen the symptoms of COVID-19.

Indirect impacts on people and systems

The closure of schools, impacting 8 million children enrolled, may increase the probability of permanent dropouts, especially in a country where some 3.7 million children are already out of school.

The Afghan population has grappled with continued conflict, poverty and repeated natural disasters for decades. A COVID-19 outbreak will further exacerbate these conditions.

Most affected and at-risk population groups

All the groups within Afghanistan's Humanitarian Response Plan – IDPs, returnees, shock-affected people, acutely vulnerable people and refugees are most at risk.

Impact on delivery of humanitarian operations

On 22 March 2020, it was confirmed that key international airlines would stop flying to Kabul from 25 March. There is an urgent need for the UN to establish hubs in the region to support UN air operations for the safety and security of UN and NGO staff, and to facilitate continuing humanitarian operations.

The closure of the Afghanistan-Pakistan border has affected the main road supply routes for relief items – notably food. Several metric tons of food remain stuck across the border in Pakistan, and further delays are expected.

Movement restrictions to areas already impacted by COVID-19 may lead to increased food insecurity. The Food Security Cluster is planning to deliver double rations in case it is unable to return locations.

COVID-19 response priorities

Ongoing response

The Health Cluster is supporting the Government in the establishment of a national isolation centre with capacity for 100 beds and subnational isolation centres with a total capacity of 991 beds. Resources have been allocated to staff and equip four airports and all ground crossings for traveller screenings. Health partners have trained some 360 health-care workers on case management and infection prevention and control; and are re-mobilising the polio surveillance team to engage in nation-wide surveillance and contact tracing.

Other clusters, complementing the health response, have undertaken awareness-raising and risk communication activities, among others.

Response gaps and challenges

Case detection remains low, owing to sub-optimal screening and limited testing kits. The availability of medicines and hospital supplies as well as personal protective equipment is low and insufficient if there is a surge in the spread of the COVID-19 outbreak.

The border with Iran is extremely porous and there has been a surge in returns through official crossings (e.g., up to 8,000 people come through one border crossing in the west each day), undermining screening and registration. While the border with Pakistan has closed, it is likely that there is some informal movement of people.

Burkina Faso `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 19 March, 40 COVID-19 cases had been confirmed and, on 18 March, the first death was recorded. Community transmission within the country is occurring. With a fragile national health-care system, the whole population is at risk as the advent of the epidemic will increase demands on a health system unable to meet needs, particularly in terms of quality and quantity of key services. Financing of the health system is inadequate and constrains the implementation of prevention and response measures.

Health-care is limited with the closure of health facilities in areas affected by insecurity, jeopardizing access for 1.6 million people. Ongoing displacement also challenges epidemic control measures and increases the risk of the disease's spread to new areas.

Indirect impacts on people and systems

The spread of COVID-19 could further slow the country's economic growth, which could have consequences across all humanitarian sectors. All education has been suspended and inflationary pressure, as a result of interrupted food and commodity supply chains, will place the country at added risk of food insecurity at a time of heightened social tension.

Cancellation of passenger flights by all major carriers, as well as the closure of borders in neighbouring countries, has resulted in increasingly limited international movements. As of 20 March, no internal restrictions on movement had been put in place and the country's borders remained open to trade as well as travel.

Most affected and at-risk population groups

Two particular groups are at heightened risk: people experiencing an individual vulnerability linked to age, chronic disease and malnutrition; and IDPs and refugees, as well as people living in areas where health facilities have closed due to insecurity.

Impact on delivery of humanitarian operations

Existing interventions to prevent and mitigate transmission will need adapting while continuing to address urgent needs. Modalities for distributions or activity sites will also need to be reviewed given the Government's directives to limit groupings to under 50 people, although small distributions are strategies for humanitarian delivery already adopted in the insecurity-affected areas.

COVID-19 response priorities

Ongoing response

The Health Ministry has developed a COVID-19 preparedness and response plan and task teams are focusing on coordination, surveillance, Rapid Response Teams, laboratory capacity, infection prevention and control, case management, risk communication and community engagement, and logistics. The country has an active disease surveillance system although capacity at entry points remains a critical gap. Contact tracing for confirmed COVID-19 cases is ongoing. An important aspect of epidemic management, WASH activities are a focus of the ongoing response under the 2020 HRP. The humanitarian community is ensuring that humanitarian response continues and that humanitarian coordination and response infrastructure is brought to bear in a prioritized and complementary manner on the emergency health response.

Response gaps and challenges

The health response under the HRP remains underfunded. COVID-19 confirmed cases are also in areas outside the HRP's priority focus. COVID-19 epidemic management and response will need to be mainstreamed across the humanitarian response, with likely additional requirements to be identified as the situation evolves. Coherence between the emergency health response and the humanitarian response will require prioritization and revision of interventions in the HRP and continued attention to reflecting the evolving humanitarian situation and needs in humanitarian planning.

Epidemic management will pose a significant challenge throughout the country, particularly in areas affected by insecurity and where the health system is already strained by the ongoing humanitarian crisis. Community engagement and communication with affected communities will need strengthening.

Burundi `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 21 March, no cases of COVID-19 had been reported but the virus could impact the entire country straining health-care facilities already overwhelmed by lack of capacity and disease outbreaks. Of about 112,000 internally displaced people, more than 36 per cent do not have access to pharmacies and 93 per cent of the displaced households cannot afford health care.

Over half a million people are in need of health assistance, of whom 260,000 live in health districts considered as "high risk", affected by diseases with high epidemic potential and with presence of displaced people. In an event of COVID-19, the health system would be stretched to treat these people as well as respond to other outbreaks.

Indirect impacts on people and systems

Burundi imports food and the combined impact of COVID-19 with the desert locust outbreak in the region could impact commodity prices. Prices, such as for maize, are already much higher due to recent heavy rainfall. With around 80 per cent of the population reliant on agriculture, a high incidence of COVD-19 would also impact livelihoods.

Among the poorest countries in the world, the per capita economic growth in Burundi remains negative and the Government's capacity to invest in areas such as health services has significantly reduced in part due to some international financial restrictions in place. The heavy reliance on Chinese supply chains could also have an impact on the economy.

Most affected and at-risk population groups

The most vulnerable include IDPs, returnees, host communities and vulnerable populations affected by emergencies and food insecurity. Priority areas include the eastern and northern provinces, due also to the presence of IDPs and returnees, and the western provinces prone to health and natural disaster emergencies.

Impact on delivery of humanitarian operations

The closure of Bujumbura International Airport, Government's mandatory quarantine for people arriving from affected countries, and requirements by neighbouring countries, could become stricter, negatively impacting the delivery of humanitarian programmes. Even without confirmed cases, the humanitarian community could see its capacity reduced due to preventive evacuations of people in high-risk categories.

The pandemic could impact supply systems, especially imports from the Asian market. Food supply is not yet impacted but this could change and be compounded by the ongoing desert locust outbreak expected to negatively impact regional procurement for humanitarian programmes. The level of existing in-country stocks is limited for all sectors, impacting on partners' ability to respond to pre-existing needs.

COVID-19 response priorities

Ongoing response

To increase preparedness, the National Laboratory is equipped with diagnostics machines and the Government has put in place a Contingency Plan. Health authorities have implemented quarantine measures and enhanced screening and surveillance for travellers. Laboratory capacity to diagnose COVID-19 has also been enhanced, although it remains insufficient. While health emergencies are an integral part of the 2020 Burundi HRP's response priorities, the latter will likely need to be revised to accommodate the possible COVID-19 epidemic.

Response gaps and challenges

In line with the Contingency Plan, main challenges include a lack of triage and isolation structures in health-care facilities; lack of logistical and operational support to Rapid Response Teams and other frontline health workers involved in surveillance; and lack of WASH equipment throughout the country. The contingency plan also does not take into account the wider humanitarian impact of a possible outbreak, which would need to be included in a revised HRP. Emphasis should be placed on preventive measures such as community information, hygiene awareness and training of health personnel in the detection, diagnosis and surveillance of respiratory diseases and provision of equipment for infection prevention and control.

Cameroon HRP

Impact of COVID-19

Direct health impact on people and systems

As of 19 March, 20 cases of COVID19 had been confirmed and ongoing transmission is placing a huge strain on a health-care system already overwhelmed by lack of capacity and ongoing disease outbreaks such as malaria and cholera. Insecurity and attacks on health facilities and health personnel, especially in the North-West and South-West regions, will continue to restrict access to quality health- care for millions of people. Immunization coverage of affected populations has reduced, favouring the resurgence of epidemics including measles, cholera and monkeypox. Significant population movements increase the complexity of providing quality health care as well as the risk of transmission.

Indirect impacts on people and systems

The Government has closed land, air and sea borders. The transportation of cargo by air and road is still allowed under supervision, but any further restrictions will impact the supply chains of essential goods, with consequences across different sectors. A drop in oil prices could mean massive losses to the economy and budget cuts could lead to reduced social protection programmes and unemployment. Education is suspended, gatherings of more than 50 people are prohibited, and movement restrictions are imposed on local businesses.

Most affected and at-risk population groups

The most vulnerable groups include IDPs, returnees, refugees, and host communities, as well as the older people and people with disabilities. Sociocultural norms, coupled with limited access to services and information, place women and girls at added risk.

Impact on delivery of humanitarian operations

The restrictions of movement, the deterioration of the economic situation and the limitation of missions inside and outside the country will lead to an increase in needs and is rendering humanitarian assistance more challenging. The HCT is assessing measures to continue the delivery of assistance. Social distancing will also be near impossible to implement particularly for IDPs and refugees. The UNCT is conducting a COVID-19 Contingency Planning exercise focused on preparedness and response and including a UNCT-wide Business Continuity Plan.

COVID-19 response priorities

Ongoing response

The Government has put in place a National Preparedness and Response Plan and with the support of WHO, UNICEF and other partners, is implementing an Incident Management System and training staff at national and regional levels; training all health personnel in epidemiology; deploying Rapid Response and Investigation Teams to the 10regions; developing a medical countermeasures plan as part of the emergency supply chain; conducting surveillance at entry points; and setting up isolation units in each region. In addition to continued operationalization of the pre-existing HRP, in terms of the humanitarian system, response priorities for COVID-19 include infection prevention and control, and implementation of community communication measures to strengthen community awareness and reduce the spread of misinformation.

Response gaps and challenges

Despite measures taken so far, gaps include a limited number of facilities equipped with respiratory platforms, a shortage of testing kits and limited health-care personnel capacity. While responding to health emergencies is an integral part of the 2020 HRP's response priorities, the plan will need to be revised to integrate the significant scale-up of health, WASH, community engagement activities across the country. The provision of adequate WASH is now critical and needs to receive adequate funding.

Central African Republic HRP

Impact of COVID-19

Direct health impact on people and systems

As of 20 March, two cases of COVID-19 had been confirmed. While no local transmission is being reported, it is most likely due to the lack of detection tests. The Central African Republic (CAR) is one of the least prepared countries to face a COVID-19 outbreak, with 2.2 million people already in need of health assistance and about 70 per cent of health services provided by humanitarian organisztions.

Aggravating factors include limited access to water, lack of sanitation facilities and infrastructures, and weak and limited presence of national authorities to enforce prevention and restrictive measures. The medical infrastructures and human resources are extremely limited and will be unable to provide health- care servicesservices and treatment to severely affected people should the epidemic spread in multiple areas. Restrictive measures will pose several challenges including on interministerial coordination, political will, capacity to ensure compliance with restrictive measures and a spiking of anti-foreigners campaigns.

Indirect impacts on people and systems

The suspension of most international airlines will delay the deployment or return of critical staff in the country who will also have to quarantine. MINUSCA's suspension of all non-critical internal movement poses significant challenges to its ability to implement its protection mandate.

The supply of food and non-food items is highly dependent on external provision. A suspension of commercial cargo could have a devastating impact on the overall availability of supplies on the market and generate price speculation. Increased xenophobia against several segments of the population poses a high risk of resurgence of intercommunal violence and conflict. School closures raise child protection concerns.

Most affected and at-risk population groups

Among the most at risk are the 695,000 internally displaced people as well as children, women, people with disabilities and the older people, whose vulnerabilities are expected to exacerbate.

Impact on delivery of humanitarian operations

CAR is one of the most dangerous countries for humanitarian workers and operations are dependent on external procurement. Cameroon's border closure, the spike in threats and violence against foreigners and humanitarian personnel, also spread by the media, pose significant safety and security risks that can result in reduced operations when they are needed the most. The aid pipeline could face ruptures and stock-outs, depriving the most affected people from the only existing safety net.

COVID-19 response priorities

Ongoing response

A WHO-supported National Emergency Cell has been established, with six commissions related to COVID-19. WHO and partners, health district personnel and medical NGOs have started to implement subnational prevention and preparedness measures, including awareness-raising sessions for the humanitarian community and campaigns for the internally displaced and host communities; the creation of isolation spaces; the reinforcement of handwashing points; and strengthening of epidemiological surveillance. The Inter-Cluster Coordination Group andclusters are preparing a light emergency preparedness and response plan of critical actions for each of the four WHO epidemic phases. Sanitation control measures have been reinforced at Bangui airport and communication is being scaled up, including through radio stations and outreach work with communities. A programme to counter misinformation and rumours is being rolled out.

Response gaps and challenges

Only 100 COVID-19 tests are available. Stocks of personal protective equipment for health personnel are sufficient for less than a month in Bangui and no stock is available outside Bangui. Only three ventilation kits and one oxygen concentrator are available in CAR. There is only one COVID-19 treatment centre with 14 beds in Bangui and there are no health isolation centres for the treatment of mild and moderate cases or to provide quarantine. Only 4 out of 26 identified priority points of entry have functioning public health controls.

Chad HRP

Impact of COVID-19

Direct health impact on people and systems

On 19 March, Chad reported its first positive case of COVID-19. The country's extreme poverty and limited health facilities puts the population at high risk. Epidemics such as cholera and measles continue to be difficult to eradicate and other public health issues such as malaria and malnutrition are worrisome, resulting in high mortality rates. The weakness of the health system and lack of access to WASH facilities risk jeopardizing prevention and response mechanisms.

Indirect impacts on people and systems

Due to Chad's high dependency on oil exports, any measure paralysing the economy will have a large negative impact, including a rise in unemployment. As the Government has banned gatherings of 50 or more people, schools could be affected as could the distributions of humanitarian assistance. Protection of IDPs and refugees is a concern due to movement restrictions outside of camps and the closure of borders.

Chad has already banned international flights, with the exception of cargo flights, and closed borders. Restricted mobility risks affecting food and essential consumer goods supplies. Pre-existing movement restrictions due to conflict in the western Lac province has already significantly impacted livelihoods and cross-border trade. As many goods arrive in Chad by air, restricted movements could have a critical impact on supplies, including nutritional inputs.

Most affected and at-risk population groups

With a third of the population facing humanitarian needs, vulnerable groups include the older people, women, people with pre-existing health conditions, urban populations, people living with disabilities, as well as displaced in crisis-prone areas. Sociocultural norms put women and girls at added risk.

Impact on delivery of humanitarian operations

Given flight restrictions and imposed self-quarantine on returning international and national staff, as well as potential internal movement restrictions, the HCT is assessing the implications of sustaining operations with reduced staff. Poor connectivity issues make remote coordination and communication challenging, and the HCT is reviewing its business continuity plan.

The impact on key operations is being assessed. Alternative modalities are being sought to manage key distributions, particularly in refugee camps. Disruptions in the supply chain may jeopardize critical humanitarian activities, and the impact on food pipelines is being assessed. Cargo airlift for the large quantities needed is likely to be prohibitively expensive. The potential to use cash may be limited due to poor internal market availability and high prices at the onset of the lean season and when borders are closed. Access is limited in some areas due to on-going military operations.

COVID-19 response priorities

Ongoing response

The Government and health partners have put in place a Contingency Plan in line with the 2020 HRP that takes into account prevention and the response to health emergencies. The response to the COVID-19 epidemic is also aligned with the WASH-Health multi-sectoral strategy and the 2020 HRP health cluster framework. The multisectoral WASH – Health strategy, initially developed for the cholera epidemic, will be extended to integrate management of the COVID-19 epidemic. The HRP health cluster response relates to strengthening coordination of interventions, epidemic surveillance and setting up early warning systems, patient treatment, communication and capacity-building for local and State partners.

Response gaps and challenges

While the HRP 2020 has a strong focus on health emergencies and epidemics, intensified actions to complement these include training of health-care staff; supplies to test cases and drugs for treatment; strengthening displaced populations and communities' awareness and supporting the medical response; addressing needs of people who may be stranded as a result of restrictions on movement; and assessing provincial and local capacities to cope with potential cases.

Colombia `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 20 March, there were 152 confirmed COVID-19 cases in Colombia. Since the origin of all cases could be traced, the country is still in the containment phase. Should the number of cases whose origin cannot be ascertained surpass 10 per cent, the country will move into a mitigation phase.

While Colombia enjoys a strong health infrastructure in many areas, health services may become overwhelmed, particularly in remote areas. Should the virus not be contained, estimates suggest up to 4 million people could be affected, with more than 700,000 requiring hospitalization. Overstretched capacities may affect sexual and reproductive health services and pre/post-natal care as well as continuous care for complex conditions.

Indirect impacts on people and systems

The crisis is likely to have a severe socioeconomic impact. The Government has enacted preventive measures including the closure of borders; nationwide quarantine; and closing schools to contain the spread of the virus. The reduction in tourism, closure of businesses, disruption of the food supply systems, and movement restrictions are expected to significantly impact people's livelihoods. People already facing hardships – including many in the informal sector without access to social protection – will be doubly affected. Women will be particularly affected.

The closure of schools will prevent families from accessing school feeding programmes. Most municipalities will not be able to use online materials prepared by the Ministry of Education due to limited access to computers and the internet.

Most affected and at-risk population groups

In addition to people older than 60 years, people living with pre-existing health conditions, and pregnant and lactating mothers, other high-risk groups include ethnic communities (indigeneous, *Rrom, Afro-Colombian, raizales* and *palenquer-as*), impoverished communities in rural areas with difficult access to health systems, people with irregular status; poor people in urban areas, and homeless people. Health professionals are also considered a group at risk.

As of 16 March 2020, no COVID-19 cases in Venezuelan refugees and migrants or Colombian returnees had been detected, but these populations' vulnerabilities heighten their risk. Of the 1.77 million Venezuelans residing in Colombia,[7] more than half lack a regular legal status, and thus cannot access formal employment or the health-care system except for medical emergencies.

Impact on delivery of humanitarian operations

Restrictions on gatherings of more than 50 people, travel limitations inside the country, minimum health requirements and concerns for staff welfare have led to the reduction or closure of services provided by Mixed Migration Flows Interagency Group (GIFMM) members to refugees, migrants and host communities. Humanitarian partners' access to other vulnerable groups such as ethnic communities, newly displaced people and those under confinement have also been affected. Efforts are under way to identify critical interventions to ensure that assistance reaches those most in need.

COVID-19 response priorities

Ongoing response

National institutions are making significant efforts with the support of PAHO/WHO and th UN system to reduce the spread of the virus and limit its impact. Support to the health sector in risk communication, diagnosis, early detection and reduction of transmission is ongoing.

The Humanitarian Country Team is supporting and complementing Government efforts in monitoring, technical assistance to guarantee food security and nutrition, identification of critical humanitarian activities and developing a response plan to the crisis, among others.

Response gaps and challenges

Should Colombia move towards mitigation, the capacity of health services – particularly in remote areas – will need reinforcement. Minimum actions on sexual and reproductive health, gender-based violence, as well as on critical humanitarian response programmes will need to be ensured. The Ministry of Health has sought the support of international partners for the provision of personal protective equipment and epidemiological surveillance.

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[7] As of December 2019 per official statistics.

Democratic Republic of the Congo `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 21 March, 23 cases of COVID-19 have been reported in the Democratic Republic of Congo(DRC). However, it is estimated that there are a number of unreported cases. The first local transmission was recorded on 17 March, in Kinshasa, and the first death on 20 March. There are not enough tests in-country to keep the data accurate, but initial analysis by WHO indicates that DRC will follow the same evolution as the rest of the world with an approximate doubling of cases every five days. Ongoing transmission will place a huge strain on an already underdeveloped health-care system dealing with a number of outbreaks such as ebola, cholera, measles and malaria. Due to insecurity in some areas, access to health services is limited, which could further aggravate the situation. In addition, significant population movements increase the complexity of providing quality health care and reducing the risk of transmission.

Indirect impacts on people and systems

The Government has blocked passengers of flights from affected and at-risk countries, and movement across borders is monitored. Cargo is allowed under supervision, but movement restrictions will impact on supply chains of essential supplies with consequences across different sectors. Price inflations in the local market are already occurring. Education is suspended and restrictions on movement will jeopardize economic activities with impact on livelihoods, production and income.

Most affected and at-risk population groups

Vulnerable groups include the older people, people living with disabilities, internally displaced, returnees, refugees as well as people with low income and living in overcrowded urban areas. Some of the most vulnerable areas are the eastern provinces (Nord-Kivu, Ituri, Sud-Kivu, Tanganyika) and the Kasaï region.

Impact on delivery of humanitarian operations

Travel and movement restrictions will impact on the humanitarian supply chain and affect access to reach the most vulnerable as well as communications across the vast country. It will also impact on the ability to track and respond to the evolution of the epidemic. Social distancing imposed by the Government (no gathering of more than 20 people) will have a direct impact on the ongoing humanitarian response and it will be near impossible for internally displaced people, returnees and refugees to comply. Protection concerns are high, as these groups already lack access to basic services. The HCT and Inter-Cluster Coordination Group are assessing alternative mechanisms to sustain the delivery of critical humanitarian assistance.

COVID-19 response priorities

Ongoing response

The Government, supported by WHO, has developed a national preparedness and response plan that is currently being updated. It includes epidemiological follow-up; monitoring and surveillance; training of Rapid Response Teams; activation of an emergency response centre; building laboratory capacities; surveillance at points of entry; and elaboration of a communication and sensitization plan. In some provinces, the provincial health directorates are developing provincial contingency plans.

These activities are in synergy with the 2020 HRP health response, which focuses on surveillance, prevention and response to epidemics, and the provision of health services for people in need. Synergies with the Ebola response include epidemiological surveillance, tracking, and a community-based approach.

Response gaps and challenges

Despite initial measures taken so far, gaps include lack of capacity, resources and equipment. While responding to health emergencies is an integral part of the 2020 HRP priorities, the plan may need to be revised as health, WASHand community engagement activities are scaling up across the country.

Ethiopia HRP

Impact of COVID-19

Direct health impact on people and systems

On 13 March 2020, Ethiopia reported the first confirmed case of COVID-19 in Addis Ababa. As of 22 March, there were a total of 11 COVID-19 confirmed cases. There are no COVID-19 related deaths reported yet. In addition, the Ethiopian Public Health Institute (EPHI) reported that so far, 207 contacts have been identified for the six index cases through contact tracing.

Health-care providers are being diverted to help address the pandemic. There are ialready a limited number of health workers, putting extreme strain on capacity to serve patients, especially for non-emergency care. COVID-19 IS likely to overwhelm an already fragile health- care delivery system and reduce the availability of services for endemic health concerns such as malaria and diarrhoeal diseases including cholera. Ethiopia's safe water supply is 30 per cent, serving as the leading cause of communicable diseases in the country.

Indirect impacts on people and systems

At the health system level, there are shortages of medications due to disruptions in supply chains. Remittances and tourism are being affected as the virus spreads worldwide, resulting in a decline in foreign direct investment Fflows, capital flight, domestic financial market tightening, and a slow-down in investments – hence job losses.

The alarm caused by the confirmation of the COVID-19 outbreak in Ethiopia since 13 March has led to an increase in the prices of basic commodities in markets, with prices of some staple foods doubling. Minimal market price increases impact food insecurity among vulnerable people in Ethiopia and contribute to rising acute malnutrition.

Most affected and at-risk population groups

At-risk groups include people living/travelling from the highly infected countries, health-care workers caring for COVID-19 patients and other close contacts, schoolchildren and teachers, hospitality industry workers, nomadic pastoralists, IDPs and refugees, the homeless and residents of informal settlements.

Impact on delivery of humanitarian operations

Humanitarian commodities are transported mainly through the Port of Djibouti. Closure or scale-down of the port will impact humanitarian work in Ethiopia. The other entry point, Bole International Airport, is unreliable given increasing restrictions. Any export/import restrictions of emergency shelter and non-food items supplies from China will adversely impact the response. Local procurement will not be feasible given that most supplies originate from China. Some partners reported that they are exploring cash response modalities where feasible.

COVID-19 response priorities

Ongoing response

COVID-19 readiness activities have been ongoing at the Ethiopian Public Health Institute's Emergency Operation Center, focusing on the following thematic pillars: risk communication and community engagement, points of entry screening, surveillance and laboratory capacity, case management and infection prevention and control, planning and trainings, logistics and supplies, leadership and coordination.

The Government of Ethiopia has decided to close schools and stop all mass gatherings such as sports and meetings to contain the spread of the COVID-19 outbreak in the country.

Response gaps and challenges

Many health facilities, even at the national level, have sub-optimal infection prevention and control measures, due in part to lack of water and sanitation facilities. Classrooms are overcrowded with limited handwashing and sanitation facilities. Further, the social protection sector is not equipped to manage significant shocks to people's livelihoods. Diversion of attention from regular emergency health response to COVID-19 is expected to result in drastic spread of other disease outbreaks.

COVID-19 response will undermine efforts to combat desert locust infestations. While people's lives are threatened by the COVID-19 outbreak, the upcoming two agricultural production seasons are threatened by desert locust infestations.

In Ethiopia, deep-seated cultural norms such as ritualistic greetings and strong social ties challenge key prevention methods such as social distancing.

Haiti `HRP`

Impact of COVID-19

Direct health impact on people and systems

At the time of writing, two cases of COVID-19 had been confirmed, and the number is expected to increase soon. A COVID-19 outbreak would cripple an already weak health system. Haiti's main health problems are related to reproductive health, existing infectious diseases (malaria, diphtheria and measles) and medicine shortages. Access to health services is already low. The 2019 socio-economic crisis has forced many hospitals to reduce activities due to shortages of medical inputs, oxygen and fuel – and they have not regained full functionality. Insecurity has aggravated the situation, making access to health services even more difficult and causing supply problems. A COVID-19 outbreak would increase mortality among the most vulnerable.

Indirect impacts on people and systems

The enacted movement restrictions may lead to another lockdown of the country and a resulting standstill of economic activities. This would have severe humanitarian consequences across all sectors, similar to events of September– October 2019 with disrupted access to food, education, health care and protection services; an increase in violence and destruction of livelihoods.

Most affected and at-risk population groups

At-risk populations include people in remote areas with limited access to health care, urban dwellers with no possibility of isolation, people without access to clean water and basic hygiene and sanitation, people suffering acute food insecurity and people affected by other communicable diseases.

Impact on delivery of humanitarian operations

While the effects of current global travel restrictions on the delivery of aid are not yet clear, they will likely lead to increased costs and limited availability of medical equipment and a need to review the feasibility of cash distributions due to crowds at distribution points, among other issues.

COVID-19 response priorities

Ongoing response

WHO has been assisting the Ministry of Health in the implementation of the National Preparedness and Response Plan (launched on 13 March 2020). WHO has also undertaken preparedness activities across four areas:

- Coordination with authorities and responders.
- Surveillance, training laboratory personnel, provision of supplies, and technical support to assist airport and health personnel detect and notify of suspected cases.
- Infection prevention and case management.
- Risk communication, including preparing key messages on avoiding discrimination against people potentially affected by COVID-19.

The UN has established a Crisis Management Cell to coordinate the UN's internal response. Under the leadership of the Deputy Special Representative of the Secretary-General /RC/HC, three groups have been established to monitor the implementation of the eight pillars recommended by WHO (communication, operational and logistics support, surveillance, entry points, laboratories, prevention and case management). So too, the health sector has re-initiated its meetings.

Response gaps and challenges

Socially, two issues are likely to hamper mitigation of the virus: poor sanitary conditions and the inability of a large swathe of the population to isolate. Poor sanitary conditions and hygiene are expected to constrain current containment measures calling for frequent handwashing and respiratory hygiene, as 60 per cent of households do not have water or soap at home. Further, more than 6 million Haitians live below the poverty line (less than US$ 2.41 per day), and more than 2.5 million are below the extreme poverty line (less than US$ 1.23 per day). For them, the implementation of any sort of quarantine would almost be impossible, since they lack the capacity to accumulate the necessary resources to stay indoors.

Programmatically, WASH activities, logistics, preparedness and response coordination need to be strengthened. Emergency medical units also need to be scaled up, and access to information for particularly vulnerable women's groups must be ensured.

Iraq `HRP`

Impact of COVID-19

Direct health impact on people and systems

The first COVID-19 case was detected on 24 February, and as of 21 March, 203 cases and 17 fatalities had been reported. The Iraqi health system is severely under-resourced and not well suited to addressing a wide scale medical emergency. The Ministry of Health estimates that 20,000 doctors have left since the 1990s, leaving few qualified health workers in the country even in normal times. If all resources are compelled to COVID-19 response, the health system would suffer enormously. WHO has focused on preventive measures due to limited resources, both in terms of supplies and medical personnel.

Indirect impacts on people and systems

To curb transmission, all airports in Iraq closed in mid-March, initially for a week. In Baghdad, Erbil and many other governorates, citywide "curfews" were instituted, including restrictions on movement. These measures have curtailed economic activity. Socially, Iraq is a tribal society where large family gatherings are commonplace and social distancing would weaken social ties. Schools have been closed since mid-February.

About 90 per cent of the Iraqi economy is based on oil production, which has slowed since the outbreak, and many foreign oil workers are in quarantine or banned from entering the country. The collapse of the price of oil will significantly affect the planned 2020 national budget.

Most affected and at-risk population groups

As of 18 March, WHO reported that 52 per cent of positive cases were males and 48 per cent females. Twenty per cent were in the 50–65 age group; and 17 per cent 65 years or older. Most cases have been traced to people who recently travelled to or returned from Iran. Most fatalities have been the older people with underlying health conditions. Iraq is an urbanized society where large extended families live together in one home and interaction would be challenging to suppress. In addition, those with underlying health issues would be more susceptible.

Iraq's unemployment rate in 2019 prior to the outbreak was 17 per cent for men and 27 per cent for women, according to the World Bank. Seven million Iraqis (23 per cent of the population) live in poverty (spending less than $2.2 per person per day). This rate is higher among the 1.4 million displaced people.

Impact on delivery of humanitarian operations

The impact of Iraq's 1.4 million displaced people has not been measured with certainty, but movement restrictions limit humanitarian access to vulnerable people and reduce humanitarian services. Humanitarian access in Iraq is a challenge that would be exacerbated with internal movement restrictions. While transmission rates remain relatively low, due almost entirely to severe movement restrictions (shutting borders with Iran, internal travel bans, closing of airports, and curfews), this may not be feasible in the long term.

COVID-19 response priorities

Ongoing response

WHO has mobilized to support the Government, religious leaders, and health infrastructure to ensure the preservation of low intra-community transmission rates.

Iraq has a strong humanitarian leadership and coordination structure with a Humanitarian Coordinator leading the HCT and the Inter-Cluster Coordination Group. In addition, a Humanitarian Operation Cell has been established to address coordination issues specifically related to COVID-19 preparedness, mitigation and response.

Response gaps and challenges

The humanitarian system is not sufficiently geared to focus response on epidemiology for displaced people or the wider population. The scale-up of health infrastructure in Iraq was not originally an activity sought under the HRP, although this will increasingly impact humanitarian consequences. The humanitarian community will support WASH and hygiene services and will need to boost its programmes (prior to the outbreak, the WASH Cluster had advised its phase-out in Iraq).

Libya `HRP`

Impact of COVID-19

Direct health impact on people and systems

Libya had not reported any COVID-19 cases as of 20 March, but cases may have gone undetected due to the limited capacity to test, hostilities and marginalization of migrants and refugees. Libya is vulnerable to an outbreak due to insecurity, political fragmentation, a weak health system and high numbers of vulnerable people, including migrants, refugees and IDPs. Few hospitals have isolation units, and if they do, they are often inadequate. More than one fifth of public health-care facilities in Libya have already closed due to insecurity. Current laboratory capacity is mostly confined to Tripoli.

Indirect impacts on people and systems

The Prime Minister of the Government of National Accord announced a state of emergency on 14 March due to COVID-19 and two days later all airports and seaports closed, with exemptions for humanitarian assistance and personnel. Schools have also been closed as a preventive measure.

Six hospitals have been identified as isolation wards and intensive care units. However, this move has met resistance by communities and health-care workers. People who may be infected with the virus are at increased risk of discrimination, including eviction from their homes.

Years of conflict and instability have affected Libya's economy. An outbreak of COVID-19 could further slow the country's economic growth. Oil and gas production remain susceptible to disruptions due to conflict. In March, the National Oil Corporation reported losses of more than US$3 billion in oil revenue and warned of a looming fuel shortage.

Most affected and at-risk population groups

- Migrants and refugees, especially those in detention centres experiencing overcrowding and insufficient access to food, clean water and sanitation.
- Older people or people with pre-existing health conditions, as well as people living in areas where health facilities have closed or are inaccessible due to insecurity.
- People in prisons. Although outside of the humanitarian mandate, the UN is advocating to ensure conditions in prisons meet minimum standards.

Impact on delivery of humanitarian operations

The governance systems in Libya responsible for delivering basic services are not at full capacity due to prolonged insecurity and political fragmentation. An outbreak of COVID-19 would easily overwhelm the capacity to respond and impact across all humanitarian sectors.

Response planning focuses on life-saving assistance and minimising transmission risks for staff, implementing partners and people in need. Additional assessments would be launched to evaluate the impact of COVID-19 on the socioeconomic situation at the household level, including community-level feedback.

COVID-19 response priorities

Ongoing response

Health authorities and health partners have prioritized six technical areas: 1) enhancing surveillance; 2) strengthening Rapid Response Teams; 3) supporting health control offices at points of entry; 4) improving laboratory capacity; 5) increasing health communication; and 6) supporting the establishment of isolation wards in selected hospitals and quarantine areas at points of entry.

The Health Cluster has mapped resources and taken steps to ensure readiness, including training and capacity-building of health-care staff; provision of medical supplies, equipment and personal protective equipment; technical advice and guidance; and support to strengthening surveillance and rapid response management.

The UN has activated the Crisis Management Team, chaired by the DSRSG/RC/HC, to ensure a shared situational awareness, strategic direction and response to the unfolding situation.

Response gaps and challenges

The Health Cluster is targeting more than 1.7 million people with health assistance, just over 200,000 people are included in the 2020 Humanitarian Response Plan. Health partners aim to increase access to life-saving and life-sustaining health assistance, including through early detection of and response to disease outbreaks. Synergies with other cluster responses, particularly WASH, will require strengthened coordination.

Mali `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 20 March, no confirmed COVID-19 cases have been reported in Mali. More than 20 people were tested for the virus, but the results were negative. One of the poorest countries in the world, Mali has insufficient, understaffed and under-equipped medical capacities to face even a moderate number of COVID-19 cases. The inadequate number of medical personnel will quickly be overwhelmed and suffer burnout. Areas particularly vulnerable are those with no facilities due to insecurity. An increase in malnutrition cases may develop considering the lockdown on economic activities, closure of borders and breakdown of the supply chain. This would result in a shortage of medical as well as nutritional supplies. Difficult to contain, the virus may increase if it spreads to IDP sites or host families. As of 20 March, more than 218,000 IDPs have been reported in Mali.

Indirect impacts on people and systems

The spread of COVID-19 could aggravate the security situation, already serious in the centre and the north of the country, with consequences across all humanitarian sectors. Food insecurity could further deteriorate due to supply chain interruptions at a time of heightened social tension. As of 20 March, the Government has suspended all commercial flights coming from affected countries until further notice, and it is not clear if restrictions of movement are applied to neighbouring countries.

Most affected and at-risk population groups

Two particular groups are at heightened risk: people experiencing an individual vulnerability linked to age, chronic disease and malnutrition; and IDPs and refugees, as well as people living in areas where health facilities have closed due to insecurity.

Impact on delivery of humanitarian operations

A decrease of humanitarian response capacity is possible as humanitarian organizations might not be able to return to the country for an unforeseeable period of time due to border closures and travel restrictions, and would then need to self-isolate for 14 days upon return. With restrictions on public gathering, a number of coordination meetings and humanitarian response activities have been postponed and need to be organized virtually. COVID-19 may trigger an increase in community clashes to access services, food or medical supplies. Price speculations could increase food prices and shortages of food, water and other essential items are scenarios to prepare for. As COVID-19 cases will have priority in a full-blown outbreak, other medical needs might be unattended. Under-funding of the current HRP would impact on the ability to implement the humanitarian response in 2020.

COVID-19 response priorities

Ongoing response

Under government leadership, a crisis committee has been put in place to assess the situation on a daily basis through regular consultations and surveillance; strengthen preventive measures and ensure that all suspected cases are quarantined, and positive cases are immediately placed in intensive care; ensure that the outbreak units' care are fully functional; and deliver recommendations and instructions.

Humanitarian partners are supporting the Government COVID-19 response plan at national and regional levels in order to strengthen existing coordination, follow up on and implement collaboration mechanisms; sensitize the population on appropriate hygiene behaviours to avoid catching or spreading the virus through conferences, or door-to-door and community dialogue; ensure strict compliance of self-isolation measures by partner organizations; strengthen the health surveillance system at country entry points and within health facilities; and preposition stock of reagents, medicines and protective equipment.

Response gaps and challenges

Despite no reported cases, the Government has requested support to fill existing gaps in the availability of tests, protective equipment and funds to continue strengthening preparedness, including staff training, and strengthening health care capacities to test and care for affected COVID-19 patients. Funding to the HRP, currently low, is key.

Myanmar `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 21 March 2020, Myanmar had no confirmed cases of COVID-19. There is a limited test kit supply in-country. The Ministry of Health and Sports continues its surveillance at international entry and exit gates and has imposed quarantine measures on international travellers from countries with high numbers of COVID-19 cases. There are also community surveillance systems across the country. Suspected cases are referred to the nearest designated COVID-19 government hospital. There are currently eight hospitals designated to collect samples and only the National Health Laboratory in Yangon can test.

However, in Rakhine, where approximately 79 per cent of the people targeted by the 2020 Myanmar HRP reside, the Government has not designated any hospital for handling suspected or confirmed COVID-19 cases. Restrictions on freedom of movement – most notably for Rohingya IDP communities – already limit access to health care and other basic services. Access constraints and a ban on Internet services in much of conflict-affected Rakhine severely hamper not only the delivery of humanitarian assistance but also the delivery of risk communication messages and referral instructions.

Indirect impacts on people and systems

The global outbreak has had a growing impact on the country's economy, especially on exports, tourism, the garment industry and border trade, among others. The Government has taken some concrete measures, including reducing tax and interest rates to reduce the impact on households and affected industries. There is also a risk that household-level economic shocks may increase the vulnerability of children, especially adolescents, to economic and sexual exploitation.

Government schools have been closed for a summer holiday until the end of May.

There is a high risk of stigmatization and discrimination of people with suspected or confirmed cases of COVID-19, particularly amongst marginalized groups and stateless people.

Most affected and at-risk population groups

The most at-risk population groups include IDPs, stateless people (in Rakhine) and other vulnerable crisis-affected people in Chin, Kachin, Kayin, Rakhine and Shan states. Many of these populations would likely face difficulties accessing health services.

Impact on delivery of humanitarian operations

While the provision of health care continues in all accessible locations, some partners have experienced disruption of cross-border aid delivery to a few IDP camps in non-Government controlled areas of Kachin State. Another concern is potential water scarcity during the dry season (March–May), which could undermine handwashing and personal hygiene.

Educational facilities and child-friendly spaces for displaced communities have suspended activities, reducing the opportunity for awareness-raising among vulnerable populations, and increasing risks for child protection and school dropouts.

COVID-19 response priorities

Ongoing response

In addition to the Government's medical surveillance, detection and case management activities, the UN is developing a Country Preparedness and Response Plan that aims to support the Government in its response.

The Inter-Cluster Coordination Group and subnational coordination bodies are undertaking an impact analysis to prioritize activities, including what to enhance from the ongoing HRP and what additional activities are needed. Partners are scaling up their preparedness measures in all accessible locations, including hygiene promotion and risk communication. Health partners have also begun limited training of front-line responders, notably in Kachin. Humanitarian actors are reviewing their service delivery modalities to ensure they can continue life-saving assistance despite potential movement restrictions.

Response gaps and challenges

The situation in Myanmar is precarious. Going forward, existing access restrictions – notably in non-Government-controlled areas and areas in Rakhine and Chin subject to active fighting – will likely persist. Other challenges include limited medical supplies, insufficient health staff, and crowded IDP camps where the virus could spread rapidly.

Niger `HRP`

Impact of COVID-19

Direct health impact on people and systems

The first case of COVID-19 was reported on 19 March. A potential outbreak would quickly overwhelm the country's weak health system. Affected populations are already vulnerable to malnutrition and epidemics, and access to operational health facilities is limited given remoteness and insecurity in some regions, where health facilities are also prone to attacks. Sociocultural norms also impact on access to health systems. Some capacities for testing and surveillance and detection of COVID-19 exist at land and airport entry points, but are insufficient or ineffective to cover the whole country. In case of an outbreak, these risks will amplify existing vulnerabilities.

Indirect impacts on people and systems

Education is suspended and limitations on gatherings, as well as the closed borders, raise protection concerns for IDPs, migrants and refugees. Social stigma associated with the virus may also prevent people from immediately seeking treatment or adopting needed measures. Lack of access to water, hygiene and sanitation for vulnerable populations worsens their coping mechanisms.

Most affected and at-risk population groups

The most vulnerable groups include IDPs, refugees, returnees, host communities, migrants, high-risk groups susceptible to the COVID-19 virus and the older people. Populations in urban areas or living along the border of affected countries are also at risk, as are women and children.

Impact on delivery of humanitarian operations

The main airports of Niamey and Zinder are closed to travel and although cargo is still allowed in, the additional closure of all land borders will impact supply chains with potential humanitarian consequences across all sectors. Given movement and grouping restrictions, partners are considering alternative mechanisms and sites for humanitarian assistance distribution, including the use of cash.

Continued insecurity in the West (Tahoua and Tillaberi), South and South-East (Diffa) regions, and the extension (on 17 March) of the State of emergency for a period of three months in Diffa, Tillaberi and 2 out of 12 departments of the Tahoua region, all affected by activities by non-State armed groups, will further restrict access to respond to a COVID-19 outbreak in these areas.

COVID-19 response priorities

Ongoing response

The Government has put in place a Contingency Plan and activated a Public Health Emergency Operations Centre supported by WHO for incident management system. The Government is taking measures to contain COVID-19 such as the activation of monitoring entry points; reinforcing prevention and hygiene standard measures; strengthening medical care; and strengthening communication and community engagement and awareness. This aligns with the 2020 HRP health cluster programmatic framework.

Response gaps and challenges

In anticipation of a COVID-19 outbreak, there is a need for additional support in terms of mobilizing additional resources as well increasing surveillance capacity, protection and prevention equipment, and medical equipment for monitoring and treatment of cases (there are currently only 11 hospital beds for COVID-19). Continued insecurity in some regions would also pose a challenge to scaling up a response to meet needs.

Nigeria `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 21 March, 22 COVID-19 cases had been confirmed. Factors that may contribute to a spread are a weakened health system, multiple disease outbreaks, high population concentration in urban centres, lack of access to potable water, insufficient sanitation infrastructure, inadequate awareness of preventive measures, and traditional practices. This is particularly true in conflict-affected states of Borno, Adamawa and Yobe. According to the Borno State COVID-19 Preparedness and Response Plan, experience of managing outbreaks with droplet transmission is not strong in Nigeria and the strain on health-care facilities, overwhelmed by capacity constraints, underlines the need for rapid action.

Indirect impacts on people and systems

As a large oil producer, any loss of export revenue would impact the economy. Reduced social protection programmes will see a rise in vulnerabilities and income inequality will impact livelihoods and extreme poverty. High unemployment and socio-political unrest will likely rise as a result of widespread interruption to trade and services due to the outbreak.

As COVID-19 spreads, resources are being diverted from basic health care and other health emergencies. Preventative health care will be severely impacted. Some schools are closed and social distancing will be impossible for IDPs and refugees. With food insecurity affecting the most vulnerable in the north-east, the outbreak will negatively impact agricultural production systems nationwide.

Most affected and at-risk population groups

Vulnerabilities are linked to personal characteristics (age, gender, disabilities, livelihoods) and geographic location (urban, rural, conflict areas). IDPs, refugees and host communities are at high risk. Priority areas include the conflict-affected states of Borno, Adamawa and Yobe, due to food insecurity and IDP presence.

Impact on delivery of humanitarian operations

The humanitarian situation is expected to worsen due to COVID-19, particularly due to pre-existing stressors on the health system, and will impact on current projections of people in need. A tightening of pre-existing movement restrictions and economic deterioration coupled with strained public services will increase humanitarian needs and compound existing operational challenges.

COVID-19 response priorities

Ongoing response

The Ministry of Health has developed a comprehensive Incident Action Plan, which outlines Preparedness and Response Strategies to guide a whole-of-Government response. Risk communication channels, response task forces and basic health-care infrastructure have been established. This is complemented by state level response plans. Actions include: centralized and state-based follow-up of people of interest; Rapid Response Teams deployment; field investigations and monitoring; basic epidemiology training for health personnel; capacity strengthening of existing treatment and isolation facilities in the Federal Capital Territory and seven other priority states; surveillance at ports of entry and isolation units at designated airports; and testing capabilities in Abuja, Lagos and Edo.

The One UN Response Plan to COVID-19 amplifies the Government's efforts and will support coordination with civil society organizations, the private sector, and international and national stakeholders to increase the availability, affordability, adaptability and acceptability of COVID-19 response services. Within the 2020 HRP, the health sector continues collaboration with WASH, CCCM, shelter and other sectors for a coordinated response. The sector will implement joint programmes with the nutrition sector on treatment of children with acute malnutrition with medical complications.

Response gaps and challenges

Coordination and Rapid Response Teams, capacity-building, the community communication and engagement strategy, and isolation units across the country need to be scaled up, and more test kits need to be procured. Only five labs have the capacity to test for the virus: in Federal Capital Territory, Lagos, Edo and Osun states. There are five hospital beds available for every 10,000 people in Nigeria.

The HRP will likely need to be revised to include additional needs and requirements. Existing contingency plans do not take into account the wider humanitarian impact of a pandemic outbreak and will also need revision.

occupied Palestinian territory `HRP`

Impact of COVID-19

Direct health impact on people and systems

On 5 March, the occupied Palestinian territory (oPt) detected its first cases of COVID-19 and as of 22 Mar, 52 cases were confirmed, with no deaths reported. The Ministry of Health established medical checkpoints at ports of entry, isolation facilities, and designated three health facilities as COVID-19 centres across the West Bank and Gaza. Substantial resources to mobilize medical equipment, bed capacity, intensive care, as well as additional medical workers are required. Containing and limiting human transmission, securing treatment and ensuring protocols are in place are the top priority, specifically in Gaza. About 5 per cent of all cases will require intensive care. Personal protective equipment and essential medical supplies are needed. In Gaza, 48 per cent of all essential drugs are at less than a month's stock.

Indirect impacts on people and systems

A state of emergency was declared on 6 March. Public spaces, education institutions, and factories are closed. As of 21 March, 1,271 people are in quarantine facilities and 2,071 in home quarantine. Movement restrictions imposed by both the Palestinian Authority and Israeli authorities for the oPt decreased the number of workers crossing into Israel from 235,000 under normal circumstances, to 41,000. The economy of the West Bank will be impacted due to reduced domestic consumption. Unemployment is already at 20 per cent and likely to rise. An education plan has been established for the 600,000 students including online learning, hygiene/COVID-19 awareness and psychosocial support. In Gaza, routine life is disrupted, alhtough essential services continue to be provided and businesses are open.

Most affected and at-risk population groups

The most vulnerable groups are the older people, pregnant women, children, and those with hypertension, cardiovascular diseases and diabetes. oPt demography indicates a larger number of such high-risk groups, with high rates of non-communicable diseases and women of reproductive age. In the West Bank, people with disabilities and Palestinian refugees living in unsanitary conditions in camps are considered high-risk. In Gaza, the most affected people are those in quarantine facilities, medical patients, students and commuters working in Israel and residing in Gaza.

Impact on delivery of humanitarian operations

With movement restrictions, the humanitarian community has prioritized its response to urgent critical interventions. Assessments have been halted, field visits and trainings have been cancelled, and meetings are conducted virtually. Partners and humanitarian workers continue to support operations while in quarantine. Of critical concern is the fragility of the health system, which, under normal circumstances is unable to treat several pathologies and referrals are necessary. Currently, Gaza and the Israeli authorities have ensured the entry of necessary equipment to respond to COVID-19.

COVID-19 response priorities

Ongoing response

The UN inter-agency response addresses the immediate needs to support containment and scale-up the health system, complementing the Government on preparedness for a worst-case scenario. A joint Risk Communication and Community Engagement Strategy and Plan was developed, as well as an inter-agency COVID-19 Response Plan seeking $6.3 million to mobilize support for critical activities for the next three months. UNRWA has also launched a regional flash appeal seeking $14 million to ensure that appropriate measures are in place to respond to COVID-19.

Response gaps and challenges

The humanitarian community is deploying efforts to align the response approach planned by the Palestinian Authority and the de facto authorities in Gaza. COVID-19 needs have exacerbated the already chronic shortages of essential life-saving medicines and disposables. Limited medical equipment and consumables remain a challenge. Access constraints and travel restrictions to Gaza and parts of the West Bank for health experts and emergency medical teams hinder the response. Essential trauma and emergency care are acute activities that need to continue. Mental health and psychosocial needs have risen due to the fear of mass outbreak in a fragile health system.

Somalia `HRP`

Impact of COVID-19

Direct health impact on people and systems

Somalia confirmed its first case of COVID-19 in Mogadishu on 16 March, with no related deaths reported as of 18 March. The country's laboratories cannot test for COVID-19, resulting in missed opportunities for early detection of cases. Somalia's capacities to prevent, detect and respond to any global health security threat scored 6 out of 100 as measured by the Health Emergency Preparedness Index in 2016. There are 2 health-care workers per 100,000 people, compared with the global standard of 25 per 100,000. Disease outbreaks such as cholera – with a current outbreak ongoing since December 2017 – are already straining the country's health systems.

Indirect impacts on people and systems

The economic impact on urban areas will be exacerbated by possible lockdowns and resultant lack of income due to business closure. Somalia is currently experiencing a desert locust upsurge that could have significant consequences for food security and livelihoods. The country also experiences seasonal floods, with riverine and flash flooding expected in two months. Flooding in late 2019 affected 547,000 people, 370,000 of whom were displaced. The impact of COVID-19 on the supply chain could be significant, with lockdowns, closure of production plants, exhaustion of stocks, closure of ports, and impacts on access to markets.

Most affected and at-risk population groups

Somalia has 2.6 million IDPs who have limited access to quality essential health care and water and sanitation services and live in crowded urban and semi-urban areas. The older people – approximately 2.7 per cent of the population – and the urban poor are also considered vulnerable groups that could be heavily impacted by COVID-19. Somali social practices of shaking hands, poor handwashing and caring for the sick may also increase the spread of the virus.

The pandemic could also heavily impact vulnerable communities living in areas dealing with food insecurity and desert locusts, nutrition hotspot areas and recent flood-affected areas including Hiraan, Bay and Bakool, among others.

Impact on delivery of humanitarian operations

Supply chains are already disrupted with freight forwarders resisting delivery to Somalia because of the 15-day flight ban effective 18 March. While agricultural inputs are mostly sourced from local markets, market disruption could impact the next *deyr* (short rains), with shortages lasting a few months or more, during which vulnerable groups might require more focused support.

COVID-19 response priorities

Ongoing response

Somalia suspended all international flights into the country, banned large gatherings, and closed schools for 15 days from 18 March for flights and 19 March for gatherings and schools. Accordingly, the UN Humanitarian Air Service and UN Assistance Office in Somalia have also suspended passenger flights into Somalia. A multisectoral committee that includes the UN and an Inter-Ministerial Task Force to coordinate response activities have been established.

Ongoing health activities include training of health workers, development and transmission of key messages in Somali, establishment of isolation centers, procurement and prepositioning of personal protective equipment, expansion of early detection capabilities, and deployment of health workers at key points of entry.

WASH and Health Cluster partners are scaling up hygiene response while ensuring continuity of ongoing humanitarian response. WFP plans to distribute two-month rations in anticipation of a deterioration of the situation.

Response gaps and challenges

Significant gaps in the health sector – including limited health workers, insufficient capacity to prevent, detect and respond, inadequate supplies of personal protection equipment, limited isolation facilities, and absence of laboratories capable of diagnosing COVID-19 will hamper the response. Access constraints could limit the ability to reach people who are living in hard-to-reach areas and areas controlled by non-State actors.

South Sudan `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 20 March 2020, South Sudan has no confirmed cases of COVID-19. Health systems in the country are frail, in part due to underinvestment after years of conflict. Out of approximately 2,300 health facilities that provide health-care services, more than 1,300 facilities are non-functional. The South Sudanese population is highly vulnerable to epidemic diseases, due to low immunization coverage, a weak health system and poor hygiene and sanitation services. South Sudan has one of the highest under-five mortality rates (90.7 deaths per 1,000 live births) and maternal mortality rates (789 deaths per 100,000 live births) worldwide. Around 75 per cent of all child deaths in South Sudan are due to preventable diseases. Health facilities are poorly equipped and staffed, making them unprepared for health risks, such as COVID-19.

Indirect impacts on people and systems

South Sudan is the most oil-dependent country in the world, with oil accounting for almost the totality of exports and around 60 per cent of its gross domestic product. However, despite its dominance in the economy, oil has not generated the jobs needed for social and political stability. As much as 85 per cent of the working population is engaged in non-wage work, chiefly in subsistence agriculture and livestock rearing. A COVID-19 outbreak could limit participation in non-wage work, which would in turn exacerbate the vulnerabilities of the population. Additionally, the high risk of desert locust invasion presents competing challenges in South Sudan's ability to meet basic needs of the people.

Most affected and at-risk population groups

Vulnerable populations, particularly women, children, people with disability, the older people, IDPs and returnees who currently face a compromised immune system are most likely to be adversely impacted by the COVID-19 pandemic. A number of underlying and direct factors contribute to a weakened immune system, including severe food insecurity leading to malnutrition, lack of basic services such as access to WASH services and the inability of vulnerable populations to absorb shocks related to the impacts of climate e.g., floods.

Impact on delivery of humanitarian operations

South Sudan is dependent on medical supplies imported from outside the country in order to facilitate routine care. Given that the public health emergency response is already constrained, supply disruptions would aggravate the situation. Eighty per cent of health services in South Sudan are provided by NGOs, which are increasingly impacted by travel restrictions and could limit their capacity to deliver assistance.

Any disruption to supply chains through Ethiopia, Kenya, and Sudan could affect food deliveries to 3 million people.

COVID-19 response priorities

Ongoing response

While no COVID-19 cases have been reported, preparedness activities are under way. A COVID-19 Country Preparedness and Response Plan has been developed, covering a six-month period to September 2020.

Activities include risk communication and community engagement, screening at points of entry, and the establishment of an incident management structure. South Sudan has established a High-Level Task Force Committee to take extra precautionary measures in combating the spread of COVID-19.

Response gaps and challenges

As no cases have been identified in South Sudan, there are no response gaps. Nonetheless, the risk remains high due to the country's weak health system, the challenge of maintaining humanitarian supply chains through neighbouring countries and through Nimule, which is a strategic point of entry into South Sudan and a major trade and humanitarian supply route from Uganda. Another concern is the lack of funding to implement the COVID-19 Preparedness and Response Plan.

Sudan `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 20 March, Sudan had two confirmed COVID-19 cases, and 67 suspected cases were in isolation centres.

Sudan also remains prone to other disease outbreaks, including cholera, chikungunya, dengue, malaria, measles and Rift Valley fever in 2019 alone. Sudan lacks sufficient medical staff to support increases in outbreaks. COVID-19 cases may force health facilities to close to other patients. Regular treatments for malnutrition or maternal care may also have to be suspended.

Indirect impacts on people and systems

While there is not yet evidence of immediate economic impacts from COVID-19, Sudan is already facing severe economic challenges. The Prime Minister has indicated that the country needs up to $8 billion in support over the next two years to cover imports and rebuild the economy.

The closure of border crossings as well as reduced remittances (estimated at about $3 billion per year) due to global economic slowdown are likely to impact people's access to funds. In 2019, Sudan imported 2.6 million metric tons of wheat and flour. A prolonged closure of the country's borders could limit the availability of these items.

Most Sudanese academic institutions and students do not have Internet capacity to establish online learning platforms. Extended school closures would create significant disruptions to education.

Most affected and at-risk population groups

Some 2.1 million people are displaced within Sudan. Many are living in crowded conditions in IDP camps; 80,000 are over 60 years old; and 5,000 are chronically ill. In addition, 1.1 million refugees live in Sudan, many in congested areas which increases the risk of the spread of the virus. 600,000 older people with chronic medical conditions lack access to basic medicines. An estimated 2.7 million children under age 5 suffer from acute malnutrition, including an estimated 522,000 who are severely malnourished.

Impact on delivery of humanitarian operations

Non-essential staff from the Sudanese Humanitarian Aid Commission were granted leave until 29 March. This is likely to slow administrative procedures and access to vulnerable populations. Border closures and flight cancellations are creating further obstacles, including preventing the entry of humanitarian personnel. Limited Internet bandwidth across Sudan will have an impact on remote work modalities for humanitarian staff.

COVID-19 response priorities

Ongoing response

The Federal Ministry of Health and WHO have developed a countrywide preparedness and response plan including management of arrivals at points of entry, isolation, patient care, infection prevention and control, supplies, risks communication, surveillance and capacity-building. The HCT has developed a Country Preparedness and Response Plan to support the Government's efforts.

Since February, the UN has supported the Federal Ministry of Health with setting up an ICU unit in Khartoum; provided medicines and medical supplies; procured and disseminated infection prevention and control materials and education and communication material; trained staff deployed at points of entry and rapid response teams in Khartoum; and distributed 156 test kits.

Two isolation centres have been created to treat COVID-19 patients. Sudan closed airspace to all international flights on 16 March, with a temporary reopening from 19 to 21 March, though flights with humanitarian supplies are exempted. Schools and universities are closed for one month and public gatherings such as weddings, social events and sports are banned. Mosques were directed to reduce the time between the call to prayer and prayer itself to under 15 minutes.

Response gaps and challenges

The health system in Sudan is already crippled by years of under-investment and economic crisis. Only one third of health facilities offer a complete basic package of care. Health facilities are understaffed and underequipped to cope with large-scale outbreaks, and there are significant shortages of essential medicines. Vaccine coverage is low, and disease surveillance capacity is extremely weak.

Syria `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 22 March, Syria had one confirmed case of COVID-19. Syria is at high risk due to continued displacements, overcrowded camps and sites, and high vulnerability in large parts of the country. After nine years of crisis, the already fragile health system in Syria is heavily disrupted and unable to adequately respond to the widespread COVID-19 outbreak.

Ongoing surveillance, preparedness and health response to cases exists with the Early Warning, Alert and Response Network's sentinel sites and Rapid Response Teams (RRT), including in north-east Syria, for alert verification, investigation and sample collection, and respiratory disease surveillance systems. North-west Syria is covered by the Early Warning, Alert and Response Network. The central laboratory in Damascus has been capacitated for testing, and Rapid Response Teams from all governorates have been trained. COVID-19 task forces have been formed and Preparedness and Response Plans developed.

Indirect impacts on people and systems

An estimated 90 per cent of the population live under the poverty line. The effects of a COVID-19 outbreak will likely aggravate further economic decline, leading to households' reduced purchasing power and limited access to commodities and services, including health care.

Most affected and at-risk population groups

Locations without adequate health services, particularly in north-east, insufficient WASH and shelter are at elevated risk, specifically, last resort sites (more than 1.4 million IDPs in 1,367 sites) and communities hosting IDPs and returnees (up to 8.8 million people), with ratios particularly high in north-west Syria. Dense urban areas and overburdened host communities particularly in Damascus and Rural Damascus, are at risk for spread of disease and caseloads may quickly overwhelm health facilities.

Impact on delivery of humanitarian operations

The speed of the outbreak and measures to slow transmission will determine whether the system becomes overwhelmed. Global shortages, travel restrictions and closures of international conveyance pose a challenge on humanitarian partners to mobilize supplies and personnel. Additionally, unilateral coercive measures restrict importation of necessary materials and reagents for testing. Insufficient and interrupted WASH services and electricity in health facilities limit safe operations, diagnostic capacity, and cold chain in many parts of the country.

Fragmented governance and dynamic population movements negatively impact key prevention measures. Specifically, containment and mitigation measures are difficult to implement in the north-west of the country, with 4 million people living in a small area. Few options for self-isolation are available. Sample collection is difficult, and samples will be sent to Turkey as there is currently no capacity in north-west Syria to confirm COVID-19. Cross-border humanitarian assistance from Turkey is vital to obtain commercial goods and humanitarian trans-shipments in north-west Syria, and UN Security Council resolution 2504 (2020) must be extended beyond July 2020. Prepositioning supplies can mitigate some risk; however, there is no adequate alternative for the loss of cross-border health and WASH assistance.

COVID-19 response priorities

Ongoing response

Response, organized around eight pillars, is focused on prevention and preparedness as no cases of COVID-19 have been identified. Detailed operational plans are updated with sectors reviewing/developing guidance.

The RC/HC, with WHO, is the overall technical lead. In government-controlled areas, UN coordination is in Damascus with five hubs. For non-government-controlled areas, inter-cluster/sector coordination is carried out through Turkey cross-border and North-East Syria Forum architecture. Task forces are established under the Health Cluster. National and international NGOs have hubs and regional bodies to enable operations and advocacy.

Response gaps and challenges

Response to COVID-19 and coordination will be a challenge, due to political fragmentation, ongoing hostilities and dynamic population movements. The health system suffers from damaged infrastructure, shortage of personnel, supplies, and intensive care unit capacity. Inadequate WASH services, nutrition status and food insecurity in vulnerable locations, lack of awareness, and failure to implement protective behaviours are critical gaps.

Ukraine `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 22 March, the number of confirmed cases was 47, including 3 deaths, with 790 cases processed. A COVID-19 outbreak in eastern Ukraine could be of considerable scale; the risk is high due to (i) a large older people population; (ii) large and regular population movements across the "contact line"; [8] and (iii) the deterioration of the health-care system.

At the national level, health facilities are expected to shift available resources and personnel to areas most affected by COVID-19, which could limit other services, including access to HIV/TB treatment, maternal and newborn care, and access to dialysis and other chronic diseases treatment. Vulnerability in Donetsk and Luhansk oblasts in eastern Ukraine – ravaged by six years of armed conflict – is compounded by the inadequate health-care system, lack of maintenance, shortages of medicines and supplies, understaffing and curtailed access to referral hospitals.

Both the Government of Ukraine and de facto entities in the non-government-controlled areas (NGCA) have placed restrictions on population movements across the "contact line" to/from government-controlled areas (GCA), based on their own criteria.

Indirect impacts on people and systems

The Government has introduced temporary measures: closing educational facilities, limiting passenger transportation and mass gatherings, and suspending the operation of catering, cultural, shopping and entertainment establishments. In NGCA, de facto entities have established measures to limit mass gatherings to some extent, requiring people to self-identify and register if they visited affected countries undergo regular temperature checks and reporting any respiratory issues.

The global economic impact, coupled with falling public confidence in the State administration, could add pressure on the country's economy. There is likely to be significant business losses, a decrease in incoming remittances and an internal trade contraction. In eastern Ukraine, where unemployment and poverty were already high due to the conflict, economic uncertainty is likely to further damage the region. NGCA would be harder hit due to their socioeconomic exclusion and the existing international sanctions regime.

COVID-19 may become an additional burden on the mental and psycho-social well-being of a population already traumatized by armed conflict.

Most affected and at-risk population groups

The high proportion of older people (36 per cent of the population) in the conflict-affected region increases their vulnerability. Almost all older people there (97 per cent) have at least one chronic illness, making them highly susceptible to complications if infected with COVID-19. In isolated settlements, the proportion of older people is even higher (41 per cent).

Impact on delivery of humanitarian operations

Limited humanitarian access to NGCA will make it difficult to assess the extent of the outbreak and take appropriate mitigation action, including the exclusion of humanitarian convoys through the territory of Ukraine by de facto entities. Government-imposed travel restrictions mean that only citizens, permanent residents and accredited members of the diplomatic and international community, will be permitted entry.

COVID-19 response priorities

Ongoing response

The Government has developed a National Preparedness and Response Plan to ensure the readiness of the health sector and improve risk communication, emergency coordination, infection prevention, and control and supply management for emergencies.

The humanitarian response plan will focus on mitigating and minimizing the humanitarian consequences of COVID-19. Activities include risk communication and community engagement, supporting allocation of supplies, strengthening public health care, strengthening community-based mental health and undertaking food distribution, among other actions. Geographically, the humanitarian response plan will adapt to the different operational contexts in GCA and NGCA.

The HCT will have overall responsibility for overseeing the response in eastern Ukraine.

Response gaps and challenges

For eastern Ukraine, two factors will be challenging: the limited outreach capacity and availability of services in NGCA and temporary restrictions on crossing the "contact line" may aggravate the limited, existing humanitarian capacity.

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[8] On average, there were 1.2 million crossings per month in 2019.

Venezuela `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 21 March, Venezuela had confirmed 70 cases of COVID-19. Laboratory kits have arrived in the country and the technical capacity to test exists. The Ministry of Health has designated 47 hospitals for response and treatment, and has developed a national prevention and response plan. The Government declared a state of emergency on 13 March and subsequently implemented a national social quarantine, limiting people's movements and social interactions. On 17 March, the Government formally requested support from the UN for the COVID-19 response and to address its socioeconomic consequences.

The overall public health-care system has limited capacity. This is due to a combination of factors, including shortages of medicines and supplies, the lack of regular water and electricity and the migration of health-care professionals. Lack of regular and sufficient access to WASH services in many communities will be a challenge for prevention and control.

Indirect impacts on people and systems

The COVID-19 pandemic will likely have a further negative impact on the economy, which has already experienced five consecutive years of contraction. The national social quarantine, including the closure of fuel stations in some areas, has already increased the price of basic commodities. Supply distribution systems of food and other basic goods are under strain and depend on the Government's ability to import basic goods amid internal and external economic limitations.

The quarantine may increase the risk of gender-based violence from people living in close quarters and limit access to information and protection services for people who most need it. Families, especially women, who are often caregivers, will have to cope with anxiety and stress, increasing the need for mental health and psychosocial services.

The closure of educational facilities has interrupted children's teaching schedules and their access to school feeding and child protection programmes, and could increase the number of dropouts.

The closure of the borders with Brazil and Colombia are already having health, economic and social repercussions: people relying on cross-border trade for their livelihoods have had to stop their activities; people who require medicine and treatment from Colombia, such as those with HIV/AIDS, are facing difficulties accessing them; and the use of irregular border crossings has increased, affecting COVID-19 monitoring. The regional measures taken to control COVID-19 could impact the flow of remittances – an important source of income for many Venezuelans.

Most affected and at-risk population groups

The most vulnerable groups include people in need older than 60 years; people with pre-existing health conditions; people with limited access to WASH services; food-insecure people; the indigenous population; health-care workers, and people on the move living in crowded accommodation or collective centres.

Impact on delivery of humanitarian operations

Many of the 81 humanitarian partners in-country have limited or temporarily suspended their activities due to quarantine measures. Fuel restrictions have led to shortages in certain areas, resulting in higher fuel prices and restrictions on mass-gatherings. Humanitarians will need to adopt new distribution methods.

Only critical humanitarian staff are working on-site. The UN has facilitated an agreement with the authorities to issue special access passes for critical staff and vehicles.

COVID-19 response priorities

Ongoing response

To complement national efforts, the UN and partners are implementing a COVID-19 inter-sectoral prevention and response plan, focused on health, WASH, mass communication and re-prioritizing of other critical cluster activities.

Response gaps and challenges

Lack of funding for the overall humanitarian response is a key challenge. Limited capacity due to lack of registration of international NGOs and the ability of WFP to enter the country and to operate under humanitarian principles are additional challenges. Movement restrictions due to the quarantine may limit operations. The humanitarian pipeline for supplies could be affected and become more expensive due to global demand.

Yemen `HRP`

Impact of COVID-19

Direct health impact on people and systems

As of 22 March, there were no confirmed COVID-19 cases in Yemen. WHO is testing every case that meets the case definition; to date all results have been negative.

Only about half of health facilities in Yemen are fully operational, and there are gaps in basic equipment, medicines and funding for public institutions providing health care. If COVID-19 does reach Yemen, the health system is likely to be quickly overwhelmed. The global shortage of ventilators and personal protection equipment is of high concern.

As a precaution, schools have been closed nationwide, and passenger flights have been suspended. Land entry points for travellers have been closed, and strict measures at informal crossings are being applied. Cargo imports are continuing with health checks. Domestic movements of goods and people are experiencing some delays as authorities finalize regulations to minimize risks.

Indirect impacts on people and systems

School closures may have an impact on school feedings, depending on the duration of the measure.

Depending on how cargo regulations are applied, commercial imports could be affected, which are vital to the population. Humanitarian cargo could also be affected. Impact to date is limited, and authorities are engaging to ensure regulations are appropriately applied.

Most affected and at-risk population groups

With 80 per cent of the population already in need of humanitarian assistance and only about 50 per cent of health facilities fully operational, disease vulnerability is extremely widespread in Yemen.

Displaced people living in crowded informal sites or dense peri-urban neighbourhoods are particularly at risk. Currently, about 3.6 million people remain displaced across Yemen, including more than 700,000 people who live in more than 1,700 informal sites scattered across the country with little or no services.

People with underlying health conditions are also at grave risk, particularly as treatment for chronic conditions has deteriorated significantly over the course of the conflict.

Impact on delivery of humanitarian operations

Flight suspensions will interrupt the regular movement of humanitarian staff, particularly if these are extended beyond the initial two-week period without exceptions. This will be impacted both by regulations in Yemen and in UN Humanitarian Air Service-Yemen departure countries (Jordan, Djibouti). Depending on how regulations for cargo are applied, these measures could delay aid operations.

COVID-19 response priorities

Ongoing response

The RC/HC has established a Crisis Management Team chaired by the COVID-19 Outbreak Coordinator. The Team is responsible for effective coordination of COVID-19 preparedness and response, including liaison with authorities. A UNCT Preparedness and Response Plan outlines standard operating procedures to ensure preparedness, response protocols and business continuity. As no COVID-19 cases have been identified, current work focuses on preparedness and community outreach.

Partners are actively preparing for cases and implementing prevention measures, including setting up isolation units at Sana'a and Aden airports, preparing mass communication campaigns, and identifying quarantine facilities. These activities are in addition to other health priorities for the HCT including the reduction of outbreaks of cholera and other infectious diseases.

WHO has purchased 76 ventilators, which are currently being dispatched to health clinics in Yemen. Efforts are under way to source additional ventilators. As part of duty of care for staff, a plan is also being finalized to procure soft-skin ambulances that can transport infectious diseases cases; these would be dispatched to field hubs. Reliable protocols for evacuation of staff members, including staff members with infectious diseases, are urgently needed.

Response gaps and challenges

Should COVID-19 reach Yemen, an outbreak could quickly stretch the already worn-out health system. Funding gaps are also likely to pose a significant challenge, as more than 30 UN programmes – including some health activities – are set to start reducing or closing down by the end of April due to lack of funds.

Annex:
Regional Refugee Response Plans (RRPs)[9]

Burundi Regional `RRP`

Current targeted population
325,000 Burundian refugees and 2.5 million host community population

Countries covered
Democratic Republic of the Congo, Rwanda, Uganda and Tanzania

Needs and gaps analysis

Burundian refugees are at significant risk during the COVID-19 crisis due to their residing in densely population camps, in some cases with severe restrictions on freedom of movement and entirely depending on humanitarian assistance which does not meet minimum standards in a number of sectors including water and sanitation, due to that the Burundi refugee situation being one of the most underfunded globally.

With the exception to a certain extent of Rwanda, overcrowded and weak health services with poor human resource capacity and a lack of infrastructure and supplies are a feature of most of the health facilities available to Burundians living in remote areas of countries of asylum. Critical gaps include the establishment of additional spaces for proper isolation, capacity building in case management, provision of essential medicines and material including for infection prevention and control, and personal protective equipment and oxygen concentrators.

The interest of Burundian refugees to avail themselves of the ongoing assisted voluntary repatriation from Tanzania and elsewhere may be influenced by the unpredictable evolution of the COVID-19 pandemic in the region, as well the national elections in Burundi planned for May 2020. Additional health screening and the ability to implement quarantine measures for any suspected or confirmed cases will be required in order to continue the programme.

Response approach

Coordination structures are in place in all asylum countries, with dedicated Crisis Management Teams and task forces by sector to map and tackle the most urgent gaps. UNHCR is working in collaboration and under the leadership of the national authorities with technical support from WHO so ensure the response to refugees is integrated into national efforts.

Prevention activities are being carried out in all countries, addressing the most urgent needs including procurement and distribution of soap, awareness raising campaigns, training of health providers, establishment of detection and quarantine areas, and assessment and mapping of the capacities of health and WASH facilities.

With additional funding response partners will work to scale up health staffing; establish additional water storage capacities and improve WASH facilities at schools, health centers, other public facilities and at household level; expand and sustain information and awareness campaigns; strengthen care referral mechanisms; procure critical drugs and medical supplies; and establish additional quarantine and treatment areas including for intensive care.

DRC Regional `RRP`

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

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

Needs and gaps analysis

Recently displaced Congolese continue to arrive into neighbouring countries, requiring assistance and protection. They join those refugees who have been in a protracted situation of forced displacement – many for over a decade. Given the constantly growing needs and increasing strain on resources in the host countries, effective coordination continues to be an essential tool to rally support and provide immediate humanitarian assistance. Access to health care in the region differs per country; however, there are many countries with very poor health-care systems. While most host countries are supportive of the inclusion of refugees into national systems that are being established, there are serious concerns that there are insufficient preparedness and specialized medical services needed to respond.

Considering that the supply of medication and equipment has been compromised, there is an urgent need to review procurement processes (including importation and customs) for medical and other essential supplies, and consider local sourcing to ensure sustainability so that refugees and host communities have access to medication needed to support health care needs. There is a need to establish measures put in place to ensure continuity of essential health care and WASH services for refugees and returning refugees as part of the Business Continuity Plan and ensure that refugees have access to secondary health care. In addition, food distribution should be maintained, providing food rations in all camps, settlements, and transit reception centres and use different modalities to safeguard refugees and distributors from possible transmission. During the emergency, RRP partners need to consider the impact of reduced food rations, access to livelihood activities and how to support refugees, returnees and host communities from negative coping mechanisms and exploitation. There will also be a need for sanitization and personal protection equipment for response partners, as well as an increased need for hygiene kits, and food assistance through cash-based interventions.

Response approach

A comprehensive context-specific outbreak preparedness and response plan for refugee sites is currently being developed in coordination with all partners and in line with the national/district-level plans, but with specific considerations that each site needs to make to be prepared for or respond to an outbreak in a refugee site. Primary focus during this period is on preparedness and response readiness measures, together with awareness and sensitization (contingency plan, coordination strategy, logistics and supplies, sensitization, and strengthening infection prevention and control measures particularly in health facilities etc.).

RRP partners will initially map available resources and supply systems in health and other sectors. In this connection, partners will conduct inventory reviews of supplies, including human resources, and prepare advocacy tools to seek funding support to fill the gaps. Areas of work include identifying critical staff among the UN agencies and partners; anticipating critical roles and working with the Ministry of Health on guidance and support; anticipating reduced staffing if some staff become infected or movement is restricted; supporting appropriate stock use and replenishment; establishing quarantine procedures; providing psychosocial support; and supporting the key role of community health workers.

Nigeria Regional `RRP`

Current targeted population
Some 285,000 Nigerian refugees and 400,000 host community population

Countries covered
Cameroon, Chad and Niger

Needs and gaps analysis

Refugees live in overcrowded communities, in poor sheltering conditions in camps and settlements of remote areas, characterized by weak health, water and sanitation systems, often already overstretched and poorly resourced. Originating from poor and violent areas, Nigerian refugees in exile face the triple burden of non-communicable diseases, infectious diseases, and mental health issues, which have been identified as vulnerability factors for COVID-19. In the event of a coronavirus outbreak, the already existing gaps will be widened. These include the limited number of trained health personnel in emergency response, as well as in the case detection management, and the inadequate treatments units, particularly in remote areas hosting refugees. The supply and logistics systems are inadequate, and there is a lack of treatment and isolation units.

The health and nutrition situation in the refugee-hosting zones of Chad, Cameroon and Niger is characterized by the persistence of diseases such as malaria, respiratory infections, measles and diarrhoea, exacerbated by a precarious overall nutritional situation. Health-care facilities are overstretched and under-resourced, and heavily dependent on support from humanitarian organizations. The construction, rehabilitation and maintenance of infrastructure in all refugee camps, as well as in urbanization sites, is essential to ensure adequate service provision. Water supply remains substandard in most refugee hosting areas, while critical needs also persist with regard to sanitation, given that almost half of the refugee population shares communal latrines due to the insufficient quantity of individual ones. With the disruption of many livelihood opportunities due to displacement and security restraints in countries of asylum, most Nigerian refugees rely heavily on assistance. Thus, continued food assistance (in-kind or through cash-based interventions) will remain essential. There is also a need to ensure continuous access to relevant and curated information on the disease, in applicable languages, as well as to ensure that refugees are involved in the overall preparedness and response processes.

Response approach

The response will focus on strengthening the health systems, particularly in infection prevention control in health-care facilities, on reinforcing the capacity of health-care professionals through training on case detection and case management, as well as by providing medicine, consumables and personal protective equipment. In addition, isolation units will be expanded or constructed. Furthermore, the response plan will strengthen waste management systems to reduce the risk of contamination in and around health centres, as well as in schools and other communal structures, such as in churches, mosques and markets.

Within the camps and refugee sites, UNHCR and partners will also strengthen referral systems, including through the provision of ambulances. Response partners will also ensure that nutrition interventions are sustained to anticipate the potential negative impact of COVID-19 on refugees' nutritional status. In terms of WASH, the response aims to increase the number of handwashing stations in camps and settlements, including at entrance points. The number of latrines will also be augmented, with attention to access for people with specific needs, among which figure the older people, who are highly vulnerable to the virus. Inter-agency efforts will seek to expand sensitization and behaviour change communication activities supported by the provision of culturally adapted information, education communication materials and hygiene kits. To encourage refugees to take ownership of the behavioural change interventions, refugees will be trained as trainers on COVID-19 risk communication.

Adequate shelter is critical to preventing the occurrence of respiratory diseases prevalent among refugees, particularly infants, young children and the older people. As such, efforts will continue to improve shelter conditions for refugee families in need.

South Sudan Regional RRP

Current targeted population
More than 2.2 million South Sudanese refugees and
2.7 million host community population

Countries covered
Democratic Republic of the Congo, Ethiopia, Kenya,
Sudan and Uganda

Needs and gaps analysis

The main risks to South Sudanese refugee populations
regarding the COVID 19 crisis are related to population
density in camps or urban settings, lack of awareness, poor
health and nutrition status, and inadequate sanitary provi-
sions and humanitarian assistance. The South Sudanese
refugee population in the region remains the largest and
one of the most vulnerable groups. The health and nutrition
status of many South Sudanese refugees is still poor, and
sustainable health screening services at border points and
reception centres remains a challenge. While in almost
all countries hosting South Sudanese refugees, basic
standards are not met, the supply of water and soap is not
adequate for the additional handwashing required and the
need to upgrade and increase access to WASH facilities
remains a critical gap.

Due to limited agriculture and livelihood opportunities, the
vast majority of South Sudanese refugees rely on food
distributions that due to funding shortfalls, do not always
meet the standard of 2,100 kcal per day, per person. Food
rations for the South Sudanese in Ethiopia have been
reduced by 15 per cent, while 30 per cent ration cuts are
already in place in Kenya and they are foreseen in Uganda
and elsewhere starting in April. In many of the asylum
countries, global acute malnutrition rates and severe acute
malnutrition are high among South Sudanese refugees, as
the rates of anemia among children.

Several health zones hosting refugees face deteriorating
infrastructure, lack of qualified staff, and inconsistent sup-
plies of vaccines and drugs – a situation that limits access
to health care for refugees and host communities alike.
Under these conditions, local service-based responses
can only ensure quality services where there are sufficient
funds and partners to reach remote communities. While
health centres in refugee camps and settlements may be
able to manage patients with mild symptoms of COVID-19,
there is little capacity for isolation or for management of
severe and critical conditions that require hospitalization
and intensive care, including oxygen. In addition, there is a
lack of protective equipment for health personnel, increas-
ing risks during the pandemic.

Response approach

Coordination structures are in place in all asylum countries,
with dedicated Crisis Management Teams and task forces
by sector to map and tackle the most urgent gaps. UNHCR
is working in collaboration and under the leadership of the
national authorities, with technical support from WHO, to
ensure the response to refugees is integrated into national
efforts.

Response partners will seek to provide increased medical
equipment and supplies, including with prepositioning
of drugs and equipment for health facilities. Teams of
community outreach workers will be expanded to conduct
awareness-raising, and sensitization campaigns, and gen-
eral hygiene promotion activities will be increased.

Response activities will aim to considerably increase
WASH support and step up humanitarian assistance (food,
shelter, non-food items, hygiene items, etc.) of populations
at high risk. Increased water trucking to ensure adequate
supply may be required in some locations. The supply of
alternatives to firewood may be required in the event of
restrictions on movement for camp-based populations.

Response partners will develop case referral mechanisms
in refugee settings and capacity-building will be provid-
ed to community-based committees. In this connection,
partners will step up information technology equipment to
enhance connectivity and facilitate remote monitoring and
coordination.

Syria Regional `3RP`

Current targeted population
More than 5.5 million Syrian refugees and and 4.5 million host community population

Countries covered
Egypt, Iraq, Jordan, Lebanon and Turkey

Needs and gaps analysis

National health systems across the region continue to be the primary responders to the needs of Syrian refugees. In Turkey, Lebanon, Jordan, Iraq and Egypt, Syrian refugees are either eligible to receive health- care on the same basis as nationals or have access to a range of subsidized primary health-care services. While refugees can access national systems in many parts of the region, Syrian refugees' access to timely and quality health services can be challenging, due to health system capacities, the financial capacity of refugees themselves, and other compounding factors. National water and sanitation systems have also come under increasing strain, resulting in higher health risks in urban areas, including densely populated or crowded settlements.

The ability of refugees and other vulnerable groups to access health services as well as access to income and livelihood opportunities could be challenged further in the context of COVID-19 as general restrictions are put in place to curb the spread of the virus. Health crises can also exacerbate existing protection risks and add to the pressures and inequities facing those with specific needs (older people, people with disabilities), as well as sexual gender-based violence and sexual exploitation and abuse survivors, and others who are already more vulnerable to economic and health challenges. In some countries, there is also an increased risk of tensions between host and refugee communities.

Response approach

3RP partners across the region will continue to prioritize supporting the capacity of national health systems to increase access to essential health care for refugees and other vulnerable groups. In countries with refugee camps, health-care services will continue to be provided in those camps in cooperation between Government authorities and 3RP partners. This support will come in various forms, including direct support through the provision of equipment and supplies, capacity-building, and system strengthening, supporting the health workforce and systems, including assisting with national COVID-19 surveillance, preparedness and response planning and activities.

Health partners will also continue to provide direct subsidies to help individual refugees access health services, including for referral to essential secondary and tertiary health care. Targeted interventions will continue to meet the needs of specific groups, including women, girls, children, adolescents and youth, the disabled, and older people. Key protection activities will include protection monitoring and reporting networks; support prevention and response through access to information, mental health and psycho-social support (MHPSS); updated and ongoing protection services, including case processing community based of protection and advocacy on documentation, counselling, communication with communities. The aim is to ensure access to timely information to reduce and mitigate additional protection risks.

In terms of WASH, activities will ensure adequate access to clean water; hygiene supplies such as soap, narrow-necked water containers, and covered buckets for households; and waste disposal in refugee and host communities, as well as will encourage good practices related to sanitation and hygiene. The response will ensure that refugees, their host communities and people of concern have access to timely, relevant and accurate information in applicable language/s, and counter the spread of misinformation and stigmatization. To prevent increased negative coping mechanisms due to the loss of income and livelihoods opportunities induced by COVID-19, 3RP partners will seek to continue and increase social assistance to refugees and the most vulnerable populations in host communities.

Annex:
Venezuela Regional Refugee and Migrant Response Plan (RMRP)

Venezuela Regional RMRP `RMRP`

Current targeted population
Some 4.1 million refugees and migrants and 1.4 million host community population

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

Needs and gaps analysis

Of the approximately 4.9 million refugees and migrants from Venezuela displaced globally, some 4.1 million are hosted in Latin America and the Caribbean, with no prospects for return in the short to medium term. Colombia alone hosts 1.8 million refugees and migrants, including more than 1 million with an irregular status, who are without proper documentation to facilitate access to basic rights and services, including existential health care, WASH, nutrition and other live-saving facilities.

With new or revised entry requirements imposed in the context of the COVID-19 pandemic, the ability of refugees and migrants to regularly enter and stay in some countries has decreased, resulting in risks of increased irregular border crossings and heightened pressure in areas of concentration and available services there.

Refugees and migrants, including in particular those in irregular situations, are at high risk of being left out of health responses and continue to be particularly vulnerable to exploitation and abuse, including violence and discrimination, smuggling and trafficking and negative coping mechanisms. Moreover, many families and people with specific needs among the refugee and migrant populations have been exposed to discrimination, violence, exploitation and abuse throughout their displacement.

With the current COVID-19 pandemic, refugees and migrants have become even more vulnerable. Largely, they are unable to cover basic needs such as shelter, food or health care. For those on the move and in densely populated areas and/or in shelters, social distancing and/or limiting outdoor activities are virtually impossible to implement. At the same time, refugees and migrants face additional stigma by host communities, including negative perceptions associated with a fear of the spread of the virus.

Response approach

Working closely with 17 individual government-led responses, it is crucial to ensure proper integration into the national health responses and to extend additional support to the particularly vulnerable group of refugees and migrants from Venezuela. As part of the emergency response to the COVID-19 pandemic, and to be responsive to the new and acute needs of refugees and migrants from Venezuela, the Regional Inter-Agency Coordination Platform (R4V) will engage in a review of the Regional Refugee and Migrant Response Plan (RMRP). A particular focus of this review and reprioritization will be on the areas of health, protection, shelter, WASH, food and nutrition, provision of non-food items, and increased livelihood and integration opportunities that will complement national authorities' response capacities. It is crucial to ensure proper integration into the national health responses and to extend additional support to refugees and migrants from Venezuela. It is also necessary to retain a strong focus on targeted assistance, counselling and protection activities, building on and expanding the scope of the existing RMRP.

The coordination of the response for refugees and migrants from Venezuelans and for affected host communities, which brings together more than 200 response partners at regional and national levels, will continue to be conducted through the Regional Inter-Agency Coordination Platform, complemented by eight national and subregional platforms. The platforms are co-led by UNHCR and IOM, with a range of different agencies and organizations co-leading the various thematic sectors that are in place both at regional and national levels. In the context of the COVID-19 response, and in line with its global leadership, WHO/PAHO leads the health-related aspects of the response plan.

Annex:
Others

Bangladesh `OTHER`

Needs and gaps analysis

Current targeted population

More than 850,000 Rohingya refugees and 400,000 host community population

Given the highly congested conditions in all of the refugee camps in Bangladesh, and the high levels of vulnerabilities among the population, the severity of the possible impact of the virus on refugess is of major concern. Actions must be taken to support key outbreak response pillars as per the national plan. These priorities are health, WASH and Communicating with Communities. Containment and social distancing are key elements of prevention and response, including the rapid construction of additional isolation facilities.

There exists a lack of testing capacity at the district level, while staffing is expected to be a major bottleneck, given increasing restrictions on travel and movement, and limited availability of skilled staff. Partners must take into consideration the limited capacities in the refugee settings and local health centres, and the current lack of isolation and treatment capacities, including intensive care. In addition, the cyclone season is nearing, and cyclone preparedness is coinciding with the COVID-19 response, increasing risks.

Response approach

Immediate measures will include reducing the footprint of the operation by reducing activities to essential services and assistance only, and immediately scaling up risk communications and hygiene promotion. At the same time, health partners will prepare to respond to an outbreak in the camps and the wider districts, including by establishing additional isolation facilities. Partners will ensure all health facilities in and around the camps have triage and isolation in order to receive suspected cases.

Through community engagement, hygiene promotion will seek to ramp up hygiene promotion and community engagement, focusing on: changing sneezing, spitting and coughing behaviours, enhancing systematic handwashing practices with soap, and changing social attitudes like hand shaking. The network of community health worker volunteers will be critical to these efforts, and training and support to those people will be increased. Distribution of hygiene kits and of hygiene top-up items (soap) and aquatabs is planned as well. Messaging will also be tailored to reduce stigma and encourage people to seek medical attention. In this connection, there is a need for recruitment of additional international and human resources to support the response (WASH and/or public health profiles).

Partners will scale up water and sanitation by increasing the availability of handwashing facilities (including at the household level) and water quantity. Scale-up will also be done through prepositioning of emergency water treatment supplies, water trucking and additional storage capacities. Provision of extra disinfection devices to piped networks if and where needed or other on-site chlorination will also occue, as will scale-up of water-quality monitoring capacities.

Protection services and gender-based violence risk mitigation will continue to be integrated across the response, with particular focus on adapting to service delivery modalities that minimise health risks to the affected population.

Democratic People's Republic of Korea OTHER

Impact of COVID-19

Direct health impact on people and systems

As of 13 March, the Government reported to WHO that there were no detected cases of COVID-19. The health system in the Democratic People's Republic of Korea already lacks supplies and many health-care facilities also lack electricity, water and sanitation. This is most prevalent in rural and hard-to-reach communities. About nine million people are estimated to have limited access to essential health services. While the scope of and testing capacity is unclear, the increased COVID-19 screening and hospitalization may strain the already overburdened system and come at the expense of other vulnerable groups – including pregnant and lactating mothers, children, older people and those suffering from pre-existing conditions.

Indirect impacts on people and systems

Since 31 January, the Government has enacted preventive measures, including closing borders, wide quarantines and travel restrictions between cities and regions. This has resulted in delays in importation of materials, a near halt of trading and long quarantines for more than 25,000 people and cargo.

Food security remains a major concern and now, in an agriculture-based economy, the inability to plant, move internally and import super-seeds or food has heightened the situation. The food distribution system, already limited in scope and resources, is under pressure. The Government has communicated its awareness of the economic toll but will continue to prioritize prevention.

Education has been suspended, with no alternative online options or nutritional support for children.

Most affected and at-risk population groups

Children are among the most vulnerable to all aspects of need. Nearly 1 in 10 children under age 5 is underweight and nearly 1 in 5 children is stunted. Maternal health is also a priority for intervention. The older people and those in rural and hard-to-reach communities may also be more affected.

Impact on delivery of humanitarian operations

Since the end of January, no supplies or programmatic aid has reached the country. International assistance programmes, including critical health interventions, such as surgical and anaesthesia care, maternal care, tuberculosis and other diseases, are facing supply shortages and risk stock-outs.

The effects are being see in the nutrition and WASH sectors. For example, some 440,000 children and pregnant and lactating women will not receive micronutrients, around 95,000 acutely malnourished children will not receive treatment and 101,000 kindergarten-age children will not receive fortified foods. Some 89,500 people will not have their damaged water supply systems restored.

COVID-19 response priorities

Ongoing response

Activities will combine a response to public health needs with the Ministry of Public Health and a prioritized response to needs stemming from the outbreak. National authorities are concentrating on preventive measures, examination and monitoring of potentially ill people and increasing health and hygiene advocacy.

The Health Sector Working Group is developing a strategic operational plan to support preparedness and response. The plan aims to limit human-to-human transmission; identify and reduce transmission from animal sources; communicate risk; and minimize socio-economic impacts.

In-country supplies have been redirected towards an initial response. These include personal protective gear, diagnostic capabilities for other diseases, basic medications and WASH supplies.

Response gaps and challenges

Funding will be crucial. The current low funding level and extremely poor availability of cash (in lieu of banking) will impact response. Quarantine measures, the inability to import medical supplies, the rotation of international staff and inability to effectively engage with government officials has hampered the response. International staff are still unable to enter the country, resulting in under 25 per cent of staff capacity in-country. Most in-country supplies (including vaccines) will be depleted through the second quarter of 2020.

Iran[10] `OTHER`

Impact of COVID-19

Direct health impact on people and systems

Iran is the sixth most COVID-19 affected country globally. As of 22 March, there were 20,610 cases and 1,556 deaths, with 7,635 recoveries reported. All 31 provinces in the country are affected. Screening facilities are installed at airports, railways, bus terminals and city entry points, resulting in more than 14 million people screened.

Iran has a strong health-care system and there is a National Mobilization Plan for COVID-19; however, the epidemic has overstretched its capacities. Sanctions have impacted the health system and there are shortages of medical supplies. The system has lost 40 health workers and doctors to the virus.

The health response includes:

- 5,000 tests daily, with an aim to increase to 10,000 tests.
- Temporary recovery settings and quarantine units for released patients unable to return home
- Triage, early detection and contact tracing
- Armed forces in the COVID-19 response
- Self-assessment app linked to health information systems for users to self-screen symptoms and receive steps for follow-up

Indirect impacts on people and systems

Most international flights to and from Iran are suspended, with limited flights permitted to take foreigners out and for Iranian citizens to return home. Schools and universities are closed; religious gatherings, cultural activities, and public events are cancelled.

The Iranian economy is significantly based on oil production, which has slowed considerably due to sanctions. The national budget provides a 40 per cent allocation to social support and 25 per cent allocation to investment. A relief package worth US$35 billion targets businesses and households for three months and includes a moratorium on utility bills. An estimated 5–10 percent decline in gross domestic product is expected during the course of the year, which pushes another 500,000 people into unemployment.

Most affected and at-risk population groups

The most vulnerable groups are older people; refugees, especially those living in crowded settings and individuals with precarious and unstable sources of income, specific needs and/or poor health status; people living with HIV; pregnant women; children with disabilities; children without caregivers; people in prisons; and the unemployed. Economically, groups affected comprise 4.5 million households, of which 1.5 million are identified as unemployed and poor, and 3 million are identified as self-employed, semi-skilled, unskilled and temporary workers. There are some 1 million Afghan refugees and an estimated 1.5 million to 2 million undocumented Afghans.

Impact on delivery of humanitarian operations

Iran is a middle-income country prone to natural disasters such as floods, earthquakes, droughts and locust invasions. In Iran, the COVID-19, response is led by Ministry of Health in coordination with the security forces.

Humanitarian operations will focus on the most vulnerable population groups and individuals in several provinces affected by ongoing natural disasters impacting the livelihoods of tens of thousands of farmers in five provinces.

COVID-19 response priorities

Ongoing response

The RC leads the Crisis Management Team and the Country, Preparedness and Response Plan as the main coordination mechanism for the COVID-19 response, with critical support from security, operations and communications teams. The UN's health response is focused on the eight pillars of the WHO global plan and aligns with the national plan.

The Afghan refugee response is coordinated through the Solutions Strategy for Afghan Refugees, led by UNHCR. The UN has provided critical equipment and supplies for personal protection equipment through support from UNICEF, WHO, WFP, UNHCR and UNFPA. WHO also provides technical assistance to the Ministry of Health.

Response gaps and challenges

Critical gaps include: risk communication and community engagement, scaling up early detection, testing capacity and contact tracing, and personal protection equipment for health workers.

Residual challenges, travel restrictions and socio-economic considerations aggravate the ability to implement a multisectoral, evidence-based response.

[10] Please note that this is a UN Country Team Plan.

"We are facing a global health crisis unlike any in the 75-year history of the United Nations — one that is spreading human suffering, infecting the global economy and upending people's lives."

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United Nations Secretary-General,
António Guterres, remarks on COVID-19:
A Call for Solidarity