GLOBAL HUMANITARIAN RESPONSE PLAN

COVID-19

This publication was produced by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) in collaboration with humanitarian partners across the world. OCHA thanks all organizations, partners and donors that contributed to the Global Humanitarian Response Plan for COVID-19 and that regularly report to the Financial Tracking Service (FTS). Last updated: 28 March 2020

Front cover
A health worker 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. *Yasuyoshi Chiba/AFP/Getty Images*

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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 fght 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 fght 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.

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

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,

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.

U i f!Æobodjoh!sf rvjsf n fou!gps!u i f!Hmpcbm! 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.

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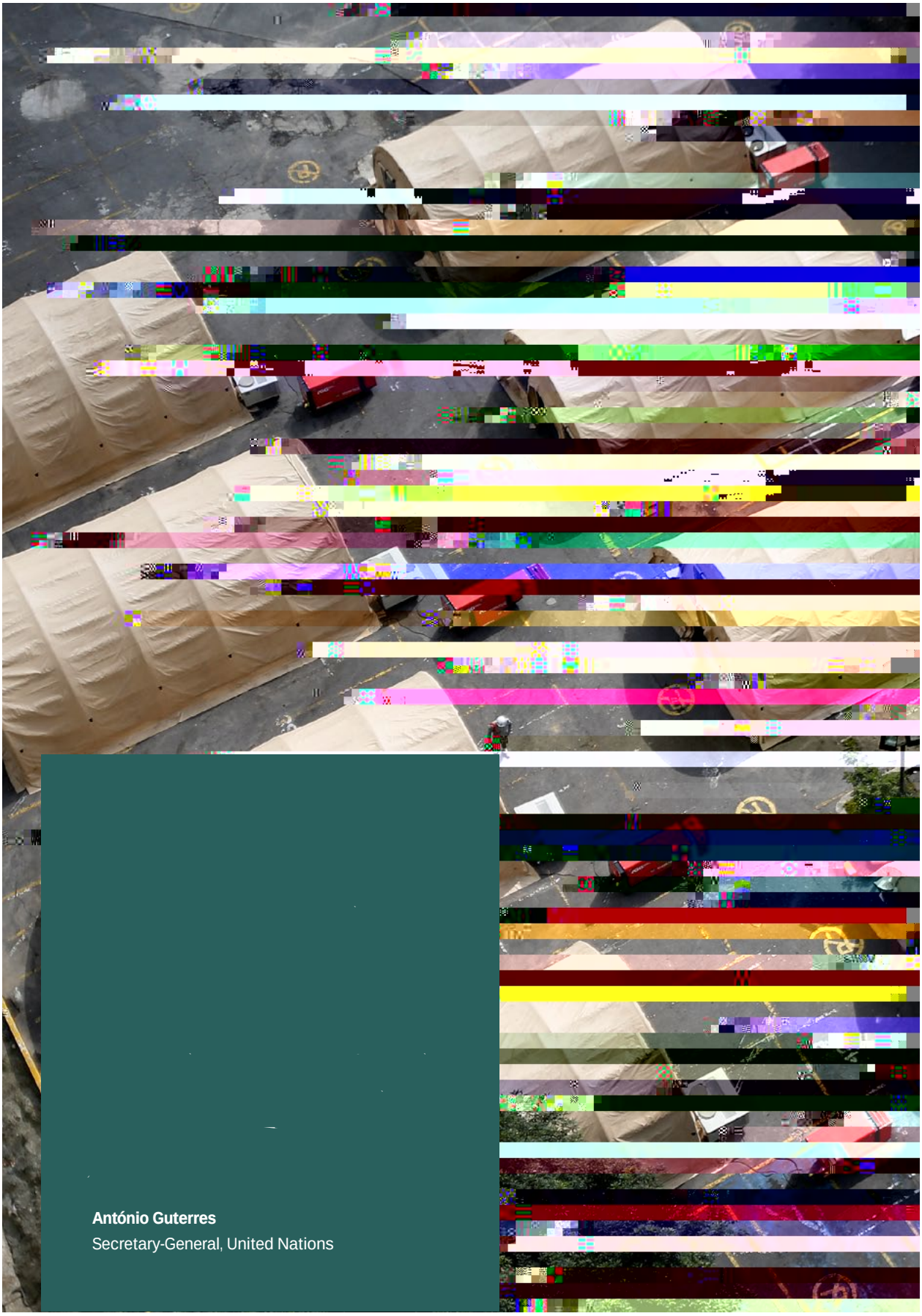
Priority regions and countries



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.
Jennifer Alarcon/ViewPress/Getty Images

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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

Health effects on people

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

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

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. Emer-

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.

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

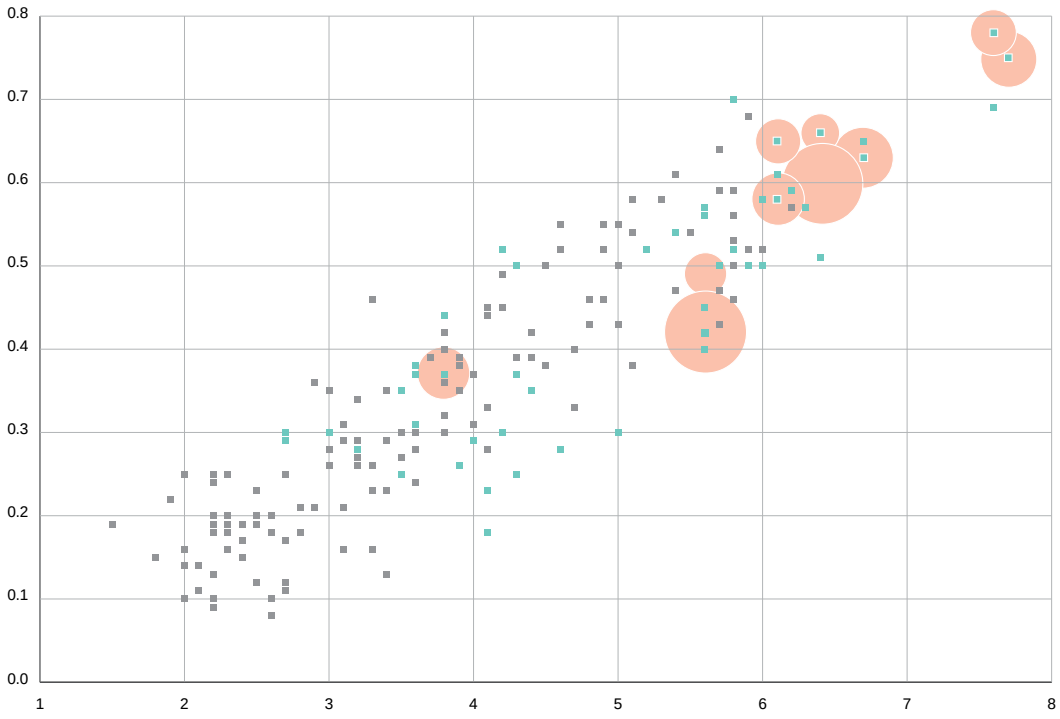
Overall, COVID-19 has the potential to significantly disrupt both food supply and demand. Supply will be disrupted due to the disease's impact on people's lives and well-being, but also the containment efforts that restrict mobility and the higher costs of doing business due to restricted supply chains 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

appeals

GHRP



Mark Lowcock
Emergeny Relief Coordinator, United Nations

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

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.

[2] www.worldbank.org/en/news/press-release/2020/03/03/world-bank-group-announces-up-to-12-billion-immediate-support-for-COVID-19-country-response

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.

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

Decrease the deterioration of human

Strategic priority 3

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

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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.

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

- 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 go of status of pointd

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.

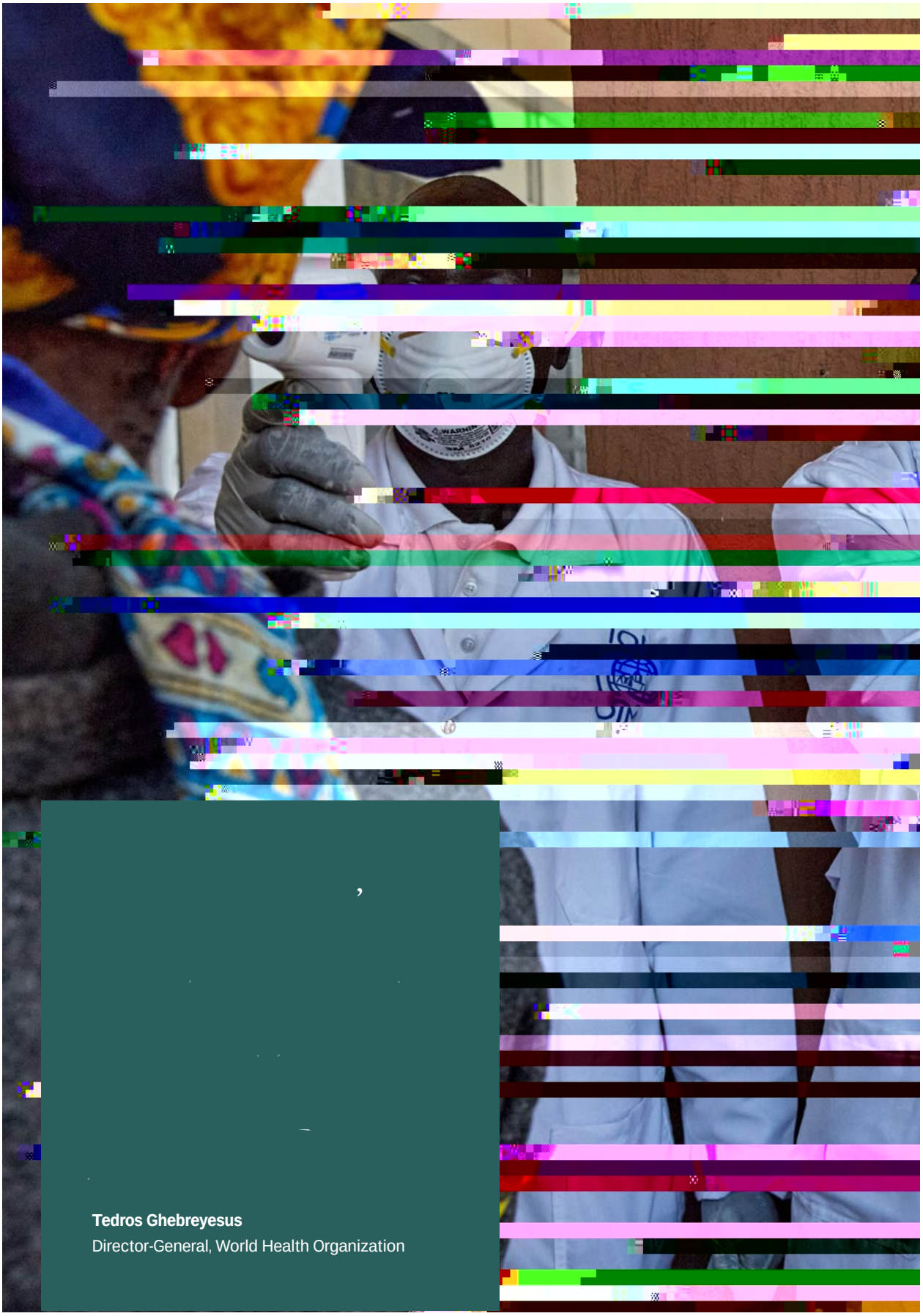
At the field level, the usual coordination mechanisms apply, including liaison with and support to national coordination structures, established coordination under the 3RP, RRPs, JRP and RMRPs, and civil-military coordination procedures.

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's 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.

level coordination

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 Sec-



Tedros Ghebreyesus
Director-General, World Health Organization

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

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.

In view of the mobility and interpersonal contact restrictions, creative monitoring approaches will have to be applied, including remote monitoring through

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.

#	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 DPWJE.2:!x ip!cfofÆu!gspn! 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	**Proportion of safe, functional and non-infected essential services / Number of Outpatient Patient Department attendance compared to same month previous year**	Informs on protection of the ability of affected people to receive essential services	-	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-				

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 messages from credible sources reach the most vulnerable	**Number of communities with established hotlines functioning and increased access to timely and accurate information on COVID-19 from credible sources**	-	UNDP
			Number of refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic that receive adequate risk information	-	IFRC IOM UNHCR UNICEF WHO
			Number of communal dpoæjdvt!jo!bggfdvfe! communities	-	IOM
			Proportion of affected population expressing satisfaction on access to services, rights and information	-	IOM

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.

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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**
Vo f bs n bs l f e!gps!dpvou sz. tq f djÆd! 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

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 othecoTvulnreabe upoplarions . Itwill calso addr13.6 (oss ,pr)10.(os)65 (v)5 (ent- and ontscipat)ecommunitiyserur

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: •

Annex: ( )

Burkina Faso

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

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.

Chad

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 meas-

Ethiopia

Impact of COVID-19

Direct health impact on people and systems

Haiti

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 repro-
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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

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

Mali

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 than20 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

Myanmar

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 all5 (hig30.001721p ammnot onc Td[ti2 ( )cer)-80allyy1

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

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,

occupied Palestinian territory

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 factor1 (e at3900501.529 Teosn)]As0.5 (emer)2(emer)1 (y 0.9 (.024 -14529 Td[month.9 (ch. Pub5 (educa1,27(eme

Somalia

Impact of COVID-19

Direct health impact on people and systems

South Sudan

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, chiefy 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

Sudan

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

Syria

Impact of COVID-19

Direct health impact on people and systems

Ukraine

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,

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Venezuela

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 chil

Annex:

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[9] Please note that the plans listed under this category are pending partner consultation. Financial requirements will be reflected in the next iteration of this appeal.

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.

South Sudan Regional

Current targeted population

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

Countries covered

Syria Regional

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

Annex:

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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 traffcking and negative coping mechanisms. Moreover, many families and people with specifc 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:

Bangladesh

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

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 hospitaliza-tion 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 result-ed in delays in importation of a near halt of trading and long quarantines for more than 25,000 people and cargo.

Food security remains a , in an agriculture-based economy, the inability to plant, move inj-nally 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 alt-native online options or nutritional support for children.

Most affected and at-risk population groups

Children.58.5 (ar)8.9 (e)0.5 (among)0.5 (the)0.5 (most)0.5 (vulner)19.1 (able)0.5 (t)10.1 (o all)0.5 (aspects of)-10.1 ( )]TJ0.022 -1.529 Td[need. has reached the counjry. Int-national assistance pro-grammes, including critical health inj-ventions, such as surgical and anaesthesia care, e, tuberculosis and other diseases, are facing supply shortages and risk stock-outs.

The effects are being see in the nutrition and WASH sec-

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