GLOBAL HUMANITARIAN RESPONSE PLAN
COVID-19

PROGRESS REPORT

FOURTH EDITION
17 NOVEMBER 2020

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Bangladesh
Around 1200 community workers are working on the ground to promote coronavirus prevention awareness, and distribution of hygiene packages that include soap and hand sanitizer, among poor urban households.
Fahad Kaizer/UNDP

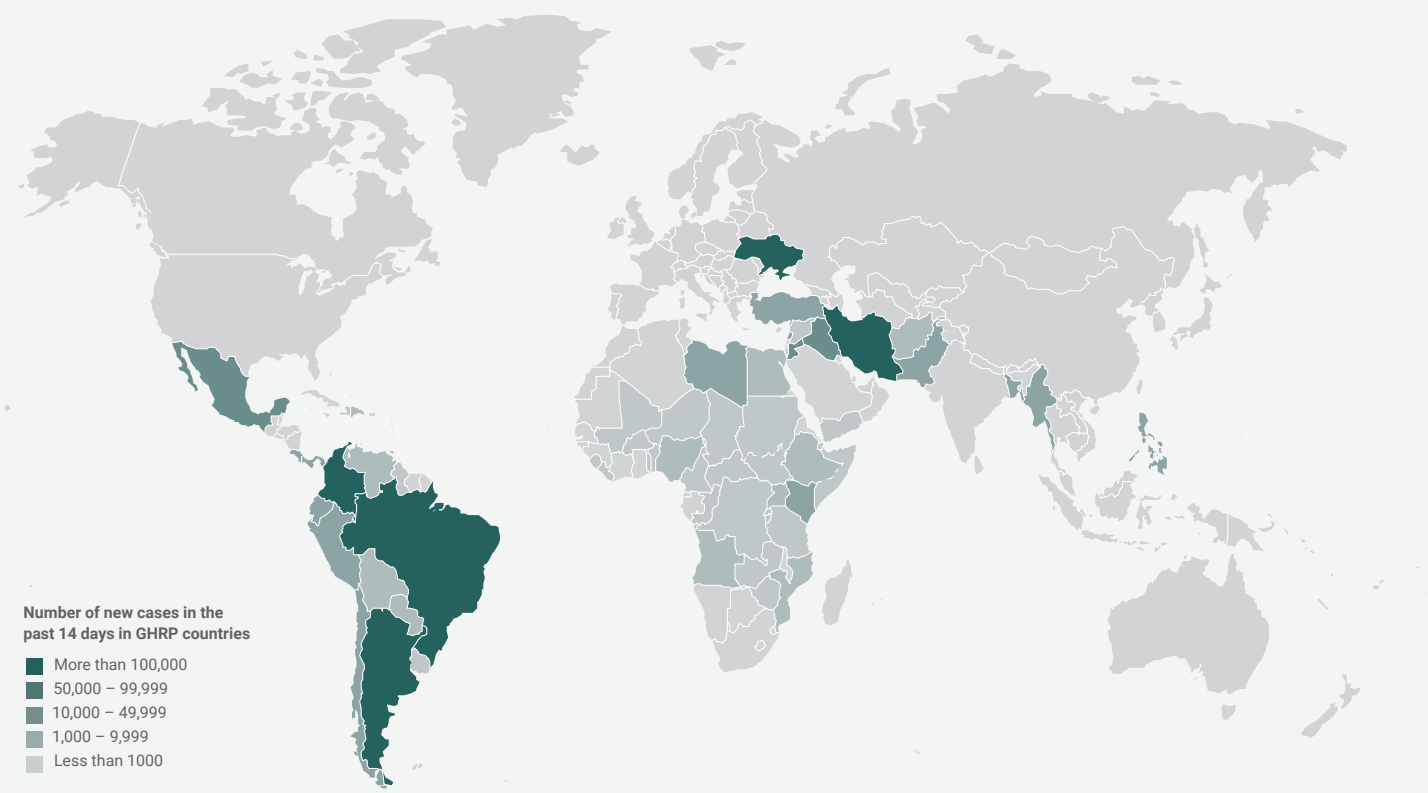
In the eight months since the humanitarian community came together in the COVID-19 Global Humanitarian Response Plan (GHRP), the virus has swept across the globe and impacted entire economies and societies. Millions of people have been pushed to the brink of survival. The extent of the effects is still unfolding. As of 16 November, there were more than 15.7 million confirmed cases of COVID-19 in GHRP countries and 518,000 deaths. This represents more than 31 per cent of global cases and more than 41 per cent of global deaths. The number of reported cases and deaths have thankfully been lower than originally feared in many of the countries with humanitarian needs, but it is the secondary impacts that have been – and will continue to be – devastating for many of the people living in these countries.

At the beginning of the year, humanitarian partners aimed to provide humanitarian assistance to 109 million people. Today, that number has reached record levels at more than 260 million people. This represents the single largest increase recorded in a single year. The pandemic has exacerbated pre-existing and ongoing drivers of humanitarian need, mainly by causing economic activities to decline, reducing household purchasing power and causing a multitude of food-system shocks. The latest evidence shows that between March and September 2020, acute food insecurity has deepened in many countries. The recent FAO-WFP early warning risk analysis has sounded the alarm for 20 countries and situations that are likely to face potential spikes in high acute food insecurity and which require urgent attention. In particular, Yemen, South Sudan, north-eastern Nigeria and Burkina Faso have areas of extreme concern, and further deterioration over the coming months could lead to a risk of famine.[1]

Common factors driving the spike in acute food insecurity include increases in insecurity and violence, including by extremist groups, economic and trade disruptions, displacement, and rises in food prices. For example, the Democratic Republic of the Congo (DRC) faces multiple and large-scale complex crises, including protracted insecurity, mass displacement, and the resurgence of Ebola virus and other diseases. DRC has the highest number of people (21.8 million) with high acute food insecurity ever recorded for a single country. Zimbabwe faces multiple vulnerabilities, including consecutive poor agricultural seasons, ongoing macro-economic challenges, and COVID-19 impacts. In Afghanistan, armed conflict and economic stressors such as widespread unemployment and inflation are likely to continue to cause food insecurity and compound the COVID-19 situation. In the coming months, these factors, combined with humanitarian access constraints, may further aggravate the situation in at-risk areas, causing widespread deaths, acute malnutrition and starvation, and an irreversible loss of livelihoods.

COVID-19 has exacerbated protection challenges, particularly for migrants, refugees, displaced persons, older persons, persons with disabilities, children, and other vulnerable groups. Some 149 countries have fully or partially closed borders. At least 72 countries make no exception for people seeking asylum, seriously limiting the rights of persons in need of international protection. The gendered impact of the pandemic is also clear – women and girls are disproportionately affected and gender-based violence (GBV) has increased. Yet, the requisite funding to help mitigate further suffering for women and girls has not been made available.

[1] For more detailed information about the most at-risk countries and the drivers of the risks of emergency food insecurity and famine, see FAO-WFP's Early Warning Analysis of Acute Food Insecurity Hotspots (November 2020 edition).



APPEALS INCLUDED IN THE GHRP[2]

52

OF WHICH:
HRP 25
RRP 5
RMRP 2
OTHER 21

CONFIRMED CASES

15.7M

CONFIRMED DEATHS

518k

Source: World Health Organization. covid19.who.int

The pandemic has also caused the largest disruption to education in history, with nearly 1.6 billion learners affected in more than 190 countries. According to UNICEF, school closures have impacted 94 per cent of the world's student population, and up to 99 per cent in low and lower-middle income countries. Projections indicate that at least 24 million children, many of them in humanitarian or fragile settings, will drop out of school due to COVID-19, exacerbating pre-existing disparities and reversing decades of progress in education. While more than 90 per cent of countries have implemented some form of remote learning policy, more than 460 million students globally do not have access to the internet, computers, or mobile devices, and are unable to participate in virtual learning while their schools are closed.

The worsening humanitarian situation in many lower and middle-income countries is of utmost concern. An additional 121 million people are projected to be food insecure by the end of 2020. As many as 80 million children under the age of one risk missing vaccinations which will most likely lead to a spike in global child mortality. For the first time in two decades, global poverty is set to rise. In 2020, between 88 million and 115 million people could fall back into extreme poverty as a result of the pandemic, with an additional increase of up to 35 million in 2021, potentially bringing the total number of new people living in extreme poverty to 150 million. These economic trends will hit women and girls hardest, reversing decades of progress. Projections indicate a 9.1 per cent increase in poverty rates for women by 2021 – a sharp contrast with the 2.7 per cent decrease forecasted before COVID-19.

Access challenges remain an important impediment due to ongoing travel restrictions, visa delays, quarantine requirements, and increasing threats against humanitarian workers, particularly health workers, in some countries. Recent increases in violence over the past few months in Syria, South Sudan, Somalia and Cameroon are also concerning.

Despite shocks at the onset of the pandemic and ongoing access constraints, humanitarian partners have made necessary adjustments, reprioritized when necessary, and implemented innovative programming to allow the continued and safe delivery of humanitarian assistance. This helped stave off an even worse situation and prevent greater loss of lives. The common services system set up by WFP has been a major enabler for the continuation of humanitarian operations. With the resumption of commercial air services in many areas, the common services system that supported the initial COVID response is beginning to scale back. Several partners have reported that they were able to scale up within the first three months of the response, and some have provided more assistance in 2020 than in previous years. For example, WFP increased its in-kind food programmes (8 per cent increase between January-June 2020

[2] **Countries with HRPs:** Afghanistan, Burkina Faso, Burundi, Cameroon, Central African Republic (CAR), Chad, Colombia, Democratic Republic of the Congo (DRC), Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, occupied Palestinian territory (oPt), Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela, Yemen and Zimbabwe. **Countries with RRPs:** Angola, Burundi, Cameroon, Chad, DRC, Egypt, Iraq, Jordan, Kenya, Niger, Nigeria, Lebanon, Rep. of Congo, Rwanda, South Sudan, Uganda, Tanzania, Turkey and Zambia. **Venezuela RMRP:** Argentina, Aruba, Bolivia, Brazil, Chile, Colombia, Costa Rica, Curaçao, Dominican Republic, Ecuador, Guyana, Mexico, Panama, Paraguay, Peru, Trinidad and Tobago, and Uruguay. **Horn of Africa and Yemen RMRP:** Djibouti. **Other appeals:** Bangladesh. **Countries with COVID plans:** Benin, Colombia, Democratic People's Republic of Korea, Iran, Liberia, Lebanon, Mozambique, Pakistan, Philippines, Sierra Leone, Togo. **Countries with COVID intersectoral plans:** Bangladesh, Djibouti, Ecuador, Jordan, Kenya, Rep. of Congo, Tanzania, Uganda and Zambia

vs. January-June 2019) and cash-based transfers (15 per cent increase between January-June 2020 vs. January-June 2019). UNFPA's GBV and sexual and reproductive health programming expanded significantly in comparison to 2019 (138 per cent increase in the number of people reached with GBV services compared to 2019). Efforts such as these and others set forth in the GHRP must be maintained and expanded even further in many places as the pandemic continues to spread.

There is promising news on safe and effective vaccine developments in the next year, although there are no firm confirmations on timelines for approval of promising candidates. It will be essential to make vaccines available for widespread distribution in the most fragile humanitarian settings. This includes vaccines for the most vulnerable populations, including refugees, internally displaced persons and asylum-seekers, who must be fully incorporated into national planning processes.[3] Support from and collaboration with the private sector on the production and distribution of vaccines to the most vulnerable people will be indispensable.

The humanitarian community will continue to stay and deliver a comprehensive COVID response where the needs are greatest. This will require action on three key asks. First, immediate financial support from Member States is required to mitigate further direct and indirect consequences of the pandemic. This is particularly urgent in the most fragile settings and countries that are at risk of famine. Second, Member States and non-state armed groups must provide safe and unimpeded humanitarian access to serve the people who so desperately need assistance. Third, all parties must respect international humanitarian, human rights and refugee law. The COVID-19 virus has no borders. We must leave no one behind.

Pandemic impacts in humanitarian setting: The case of Iraq

The COVID-19 pandemic in Iraq is growing at an alarming rate. By 10 November, Iraq had confirmed more than half a million cases of COVID-19 and recorded more than 11,670 deaths, making it the 19th most affected country globally and second to Iran in the Middle East and North Africa region. One in every six tests was positive. The situation could deteriorate further with winter conditions which contribute to greater transmission through coughs, sneezing and more time spent indoors.

The pandemic has compounded and aggravated pre-existing challenges and deepened vulnerability, especially among already vulnerable communities with limited coping strategies. Before the pandemic, an estimated 20 per cent of the Iraqi population lived under the national poverty line. Based on an assessment of the impact of COVID-19 on poverty and vulnerability in Iraq, poverty levels are projected to increase.

The economic outlook for Iraq was already poor prior to the COVID-19 shock and Iraq is currently witnessing its worst economic performance since 2003, with the economy projected to contract by 9.3 per cent in 2020. The containment measures to curb the spread of the virus early on had subsequent economic effects, such as disruptions of trade, transport sectors, banks and financial services and loss of employment. These disruptions and any re-imposed lockdown measures could have a long-lasting impact on already fragile communities and lead to an overall increase in socio-economic vulnerabilities.

While food availability has not been disrupted, access to food has been affected by COVID-19 restrictions and loss of livelihoods. In the health sector, the focus on COVID-19 has negatively impacted funds, staff and infrastructure for essential health services. Immunization rates have dropped between 20-30 per cent for vaccines and an estimated 300,000 children risk missing out on vaccinations. As a result, Iraq could see the return of polio, which was eradicated in 2014, and measles outbreaks associated with malnutrition. School closures have affected 10 million children in Iraq, and this has been linked to increased protection risks for children.

The humanitarian response in Iraq has focused on the 1.77 million people who were in acute need of humanitarian assistance at the beginning of the year. Adaptations have been made where necessary to ensure affected people continue to benefit from humanitarian services despite the difficult operating environment characterized by humanitarian access challenges, delayed supply chains, and reduced physical presence of humanitarian staff. The assessments and planning for the 2021 response are fully integrating the pre-existing drivers of humanitarian need in Iraq, as well as the potential impact of the lingering pandemic and widespread secondary socio-economic effects.

SAHELA, IRAQ
A girl receives a vaccination against polio and measles. The Directorate of Health in Dohuk, through UNICEF support, is providing polio and measles vaccinations for all children under 15 years of age at Sahela border point as refugees enter the country.
UNICEF/Rfaat

[3] For more information about the COVAX Facility and the proposed humanitarian buffer, see this WHO explanatory note.

Adapting the response

This section provides examples of how humanitarian partners have continued learning and adapting their programmes and service delivery to an operational context that is still strongly influenced by the pandemic and its secondary impacts to ensure that COVID-related and other assistance reaches those in need.

In **Chad**, additional mitigation and response measures have been put in place to respond to protection concerns regarding forcibly displaced persons and their host communities. Containment measures, including restrictions on movement and assembly, have led to a disruption to livelihoods, closing of schools, and the suspension of core protection activities, such as family reunifications. The pandemic has further stretched the already weak capacity of the national health system to respond to non-COVID medical needs, including the needs of survivors of sexual- and gender-based violence. A total of 1,074 SGBV incidents were reported in the Lac Chad Province alone between January and September 2020. Mitigation measures for protection risks include integrating key messages (in local languages) into COVID-19 sensitisation campaigns; psychosocial support activities for children adapted to the COVID-19 situation with efforts made to address fear and stigma and promote preventive measures; strengthened monitoring along borders to protect persons in confinement at registration/border crossing points; alternative case management measures, i.e. the use of phones instead of in-person counselling and psychosocial support; among others. Protection considerations related to COVID are also being integrated into the overall response plans of the clusters.

In **Ethiopia**, protection partners have been disseminating messages/information to communities at the grassroots level on how COVID-19 does and does not spread as a way to overcome stigmatisation, the climate of fear, and discrimination against displaced groups and their alleged connection to the spread of COVID-19.

In order to comply with social distancing guidance and to limit the exposure of vulnerable people to COVID-19, humanitarian partners have been providing bigger food rations at less frequent intervals since the beginning of the pandemic. In **Sudan** where the re-opening of schools has been further postponed to 22 November, WFP is planning to implement a second round of take-home rations in ten states.

Following the arrival of the pandemic to **Colombia**, the local humanitarian landscape changed rapidly as needs emerged in regions that were previously not covered by humanitarian actors in the country. With the surge in cases in the Amazonas region, UN agencies and their partners acted quickly by carrying out rapid needs assessments. These revealed severe needs, particularly in food security and health, among largely indigenous communities in very remote areas. Humanitarian partners adapted operations, reaching the most remote areas and air lifting essential food and non-food items. This prevented further disease outbreaks, severe malnutrition and subsequently mitigated excess mortality.

Also in **Colombia**, UNFPA established two mobile response teams in collaboration with local hospitals, despite funding limitations, bringing the needed SRH services directly to the people in need, including the migrant population. The teams incorporated new modalities of care for basic examinations of pregnant women, delivery of medicines, contraceptives

HASSAKEH. SYRIA
UNICEF-supported volunteers speak with a family about preventive measures to stem the spread of the novel coronavirus that causes COVID-19. *UNICEF*

and condoms. The programme included subsequent home follow-up and remote consultations in high-risk cases, thus reducing obstetric complications and deaths and regular visits to health services.

Protection partners in **Venezuela** have adapted GBV response mechanisms, including by switching to remote modalities to deliver psychosocial assistance. Partners have set up a dedicated phone line (which has a messaging service via WhatsApp) to provide psychological and legal support for victims of violence. This service benefited more than 14,000 people, most of them women, between March and August. Also in Venezuela, various Health Cluster partners have begun to provide remote services to patients. These include remote consultations, monitoring and management of patients with chronic conditions, health education and prevention, and epidemiological surveillance. This health services delivery modality has helped maintain health services despite COVID-19 restrictions and has benefited over 7,400 people.

The Awaaz **Afghanistan** inter-agency call centre has supported partners with the dissemination of key COVID-19 messages. As of mid-October, Awaaz had reached over 27,955 callers with pre-recorded COVID-19 messages and directly handled 3,582 calls related to COVID-19 from all 34 provinces. Twenty-three per cent of all calls came from women and two per cent from people with a disability.

WFP is working with food shops in IDP camps in **Iraq** to accept cashless payments by mobile phone. WFP had long planned to trial cashless transactions, using existing platforms developed by mobile money providers, but COVID-19 was the catalyst to fast-track the pilot. WFP's cashless transactions reduce the handling of physical banknotes, avoid unnecessary movements and increase the options of how people can purchase food. This reduces the risk of COVID-19 exposure and increases financial inclusion for IDPs.

The COVID-19 outbreak in **oPt** has been accompanied by an "infodemic" with widespread misinformation online. This is being addressed through effective risk communication to address rumours and misinformation and build trust in credible information sources. UN agencies and NGOs are working with the Ministry of Health on risk communications and community engagement to ensure that all messages are technically and substantively cleared for dissemination to the Palestinian public or specific target audiences, including particularly vulnerable groups. Dissemination channels include the Palestinian private sector and media (television, radio, social media), tech applications, billboards, ATM points, and SMS messaging.

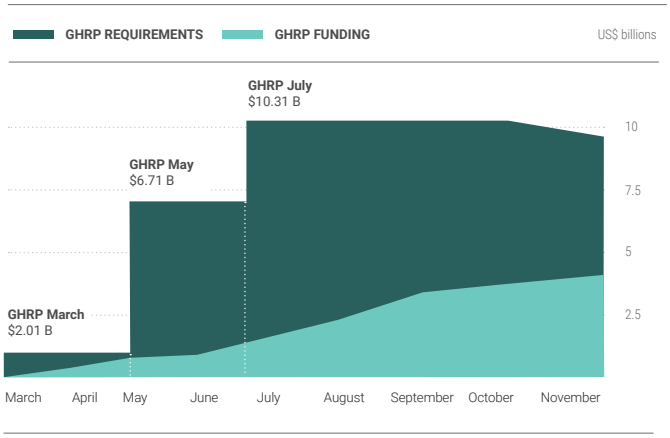
Indonesia has set an example in the Asia-Pacific region on using data for action, specifically regarding risk communications and community engagement. Under the Government's leadership, various actors compiled and analysed community insights from some 28 surveys done by many agencies. The findings have been promoted through Government channels to generate changes in COVID-19 response. The community feedback data is also used by the Humanitarian Country Team to design interventions.

Financial Overview

GHRP REQUIREMENTS (US$)
9.50 B

FUNDING (US$)
3.63 B

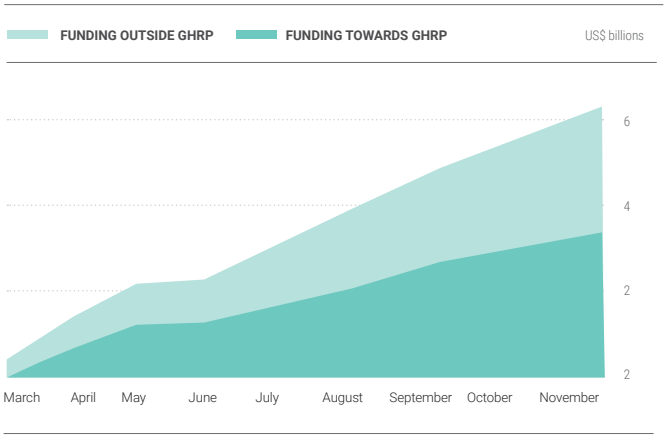
COVERAGE
38%



Source: Financial Tracking Service, OCHA. fts.unocha.org

TOTAL HUMANITARIAN FUNDING TO COVID-19 (US$)
6.27 B

OF WHICH:
Towards GHRP 3.63 B
Outside GHRP 2.65 B



Source: Financial Tracking Service, OCHA. fts.unocha.org

Humanitarian partners continue to face funding shortfalls to meet humanitarian needs that in many cases have increased due to the secondary socio-economic effects of the pandemic.

As of 17 November, funding for the GHRP requirements, including the financial needs for 63 countries, is $3.63 billion, or 38 per cent. Coverage has increased from 28 per cent at the end of September, however, almost $6 billion of requirements remain unmet. In comparison, coverage for the Global Humanitarian Overview (GHO), which includes the GHRP, is 43 per cent. GHRP-specific funding is 21 per cent of all GHO funding recorded to date.

Coverage varies widely by country, with 13 of the 51 plans/situations funded above 50 per cent (compared to only four in September). Thirty of the country / situation response plans are funded less than the 38 per cent GHRP average, leaving significant gaps.

An analysis of COVID-19 and non-COVID requirements in 25 Humanitarian Response Plan (HRP) countries, reveals that some plans are receiving similar levels of support for their COVID and overall (GHO) humanitarian requirements, while significant disparities exist for others. For example, in nine countries, the COVID-19 plans have received funding that is similar (vis-à-vis requirements) to the overall response (within +/- 10 percent): Afghanistan, Burkina Faso, Chad, Colombia, DRC, Haiti, Libya, Myanmar and Syria. In six countries, the COVID response is proportionally much better covered (i.e. more than 20 per cent): Cameroon, Niger, oPt, Ukraine, Venezuela and Yemen. The most noteworthy examples of underfunding of the COVID response in comparison to the HRP are Ethiopia, Iraq, Nigeria, Somalia and South Sudan.

The GHRP financial requirements have decreased to $9.50 billion since the September update, when requirements were listed as $10.19 billion. This is primarily due to a decrease in the COVID-19 Common Services financial requirements following the partial recovery in the commercial sector, as well as updates on COVID-19 response item pipelines. The WFP common services budget was revised downwards from $965 million to $316 million.

In addition to the $3.63 billion reported for the GHRP, a further $2.65 billion of humanitarian funding has been reported for bilateral support directly to Governments, funding to the Red Cross/Red Crescent Movement, funding to UN agencies and NGOs for non-GHRP countries, and funding for WHO's Strategic Preparedness Response Plan, Contingency Fund for Emergencies, and other activities which cover countries beyond those identified in the GHRP. Some of this funding has been provided flexibly to organizations and may eventually be recorded against the GHRP requirements as projects are implemented and more details are received.

As seen below, there is disparity among regions in terms of funding for GHRP requirements. The most serious shortfall is still in Latin America and the Caribbean, with an average of only 20 per cent covered. Coverage in South and East Africa (26 per cent) is also below the global GHRP average of 38 per cent.

REQUIREMENTS AND FUNDING BY REGION (FOR COUNTRIES INCLUDED IN THE GHRP)

REGION	GHRP REQUIREMENTS	FUNDING	COVERAGE
Asia and Pacific	**1.15 B**	458.4 M	**40%**
Eastern Europe	**46.9 M**	42.6 M	**91%**
Latin America and Caribbean	**1.00 B**	200.3 M	**20%**
Middle East and North Africa	**2.25 B**	1.09 B	**48%**
South and East Africa	**2.41 B**	618.9 M	**26%**
West and Central Africa	**1.46 B**	542.7 M	**37%**

Source: Financial Tracking Service, OCHA. fts.unocha.org

Funding per Appeal

INTER-AGENCY APPEAL		GHRP REQUIREMENTS	FUNDING	COVERAGE	GHO REQUIREMENTS	FUNDING	COVERAGE
Afghanistan	HRP	**395.7 M**	175.6 M	44%	**1.13 B**	513.1 M	45%
Burkina Faso	HRP	**105.9 M**	50.3 M	48%	**424.4 M**	233.8 M	55%
Burundi	HRP	**71.4 M**	11.4 M	16%	**197.9 M**	74.6 M	38%
Cameroon	HRP	**81.7 M**	52.6 M	64%	**390.9 M**	167.6 M	43%
CAR	HRP	**152.8 M**	74.6 M	49%	**553.6 M**	351.4 M	64%
Chad	HRP	**124.2 M**	56.9 M	46%	**664.6 M**	286.8 M	43%
DRC	HRP	**274.5 M**	97.7 M	36%	**2.07 B**	694.2 M	34%
Ethiopia	HRP	**332.7 M**	91.9 M	27%	**1.25 B**	689.7 M	55%
Haiti	HRP	**144.4 M**	26.5 M	18%	**472.0 M**	91.9 M	20%
Iraq	HRP	**264.8 M**	95.0 M	36%	**662.2 M**	550.9 M	83%
Libya	HRP	**46.7 M**	39.1 M	84%	**129.8 M**	111.7 M	86%
Mali	HRP	**75.4 M**	44.0 M	58%	**474.3 M**	213.8 M	45%
Myanmar	HRP	**58.8 M**	39.8 M	68%	**275.3 M**	173.2 M	63%
Niger	HRP	**82.3 M**	66.0 M	80%	**516.1 M**	299.2 M	58%
Nigeria	HRP	**242.4 M**	62.9 M	26%	**1.07 B**	535.4 M	50%
oPt	HRP	**72.4 M**	53.5 M	74%	**420.4 M**	227.3 M	54%
Somalia	HRP	**225.6 M**	74.9 M	33%	**1.01 B**	777.1 M	77%
South Sudan	HRP	**383.0 M**	95.4 M	25%	**1.90 B**	959.0 M	51%
Sudan	HRP	**283.5 M**	105.4 M	37%	**1.63 B**	842.2 M	52%
Syria	HRP	**384.2 M**	184.4 M	48%	**3.82 B**	2.08 B	55%
Ukraine	HRP	**46.9 M**	42.5 M	91%	**204.7 M**	120.7 M	59%
Venezuela	HRP	**87.9 M**	39.7 M	45%	**762.5 M**	148.0 M	19%
Yemen	HRP	**385.7 M**	402.2 M	100%	**3.38 B**	1.58 B	47%
Zimbabwe	HRP	**85.0 M**	31.8 M	38%	**800.8 M**	206.2 M	26%
Burundi Regional	RRP	**65.4 M**	7.5 M	12%	**275.4 M**	20.1 M	7%
DRC Regional	RRP	**155.7 M**	11.1 M	7%	**638.7 M**	30.6 M	5%
Nigeria Regional	RRP	**–**	–	–	**–**	–	–
South Sudan Regional	RRP	**128.8 M**	21.5 M	17%	**1.34 B**	72.7 M	5%
Syria Regional	3RP	**758.3 M**	134.9 M	18%	**6.00 B**	2.01 B	34%
Horn of Africa and Yemen	RMRP	**31.5 M**	0.3 M	1%	**76.5 M**	0.3 M	>1%
Venezuela Regional	RMRP	**438.8 M**	85.2 M	19%	**1.41 B**	531.5 M	38%
Rohingya Crisis	Other	**181.4 M**	81.7 M	45%	**1.06 B**	576.0 M	274%

HRP Humanitarian Response Plan FA Flash Appeal RRP Regional Refugee Response Plan RMRP Regional Migrant and Refugee Response Plan Other Other Inter-agency appeals

Please report your contributions to FTS to ensure full visibility of funding:
fts.unocha.org

fts Financial Tracking Service

Funding per Appeal

INTER-AGENCY APPEAL		GHRP/GHO REQUIREMENTS	FUNDING	COVERAGE
Benin	COVID	**17.9 M**	2.8 M	**16%**
Colombia	COVID	**283.9 M**	29.8 M	**11%**
DPR Korea	COVID	**39.7 M**	3.6 M	**9%**
Iran	COVID	**117.3 M**	70.1 M	**60%**
Lebanon	COVID	**136.5 M**	84.2 M	**62%**
Liberia	COVID	**57.0 M**	5.9 M	**10%**
Mozambique	COVID	**68.1 M**	49.8 M	**73%**
Pakistan	COVID	**145.8 M**	81.9 M	**56%**
Philippines	COVID	**121.8 M**	17.5 M	**14%**
Sierra Leone	COVID	**62.9 M**	12.7 M	**20%**
Togo	COVID	**19.8 M**	3.8 M	**19%**
Bangladesh Intersectoral	COVID	**205.9 M**	57.4 M	**28%**
Djibouti Intersectoral	COVID	**30.0 M**	4.5 M	**15%**
Ecuador Intersectoral	COVID	**46.4 M**	19.0 M	**41%**
Jordan Intersectoral	COVID	**52.8 M**	18.3 M	**35%**
Kenya Intersectoral	COVID	**254.9 M**	60.9 M	**24%**
Rep. Of Congo Intersectoral	COVID	**12.0 M**	1.3 M	**11%**
Tanzania Intersectoral	COVID	**158.9 M**	18.2 M	**12%**
Uganda Intersectoral	COVID	**200.2 M**	20.4 M	**10%**
Zambia Intersectoral	COVID	**125.6 M**	23.7 M	**19%**
Famine prevention Global	COVID	**500.0 M**	0.0 M	**0%**
NGO envelope Global	COVID	**300.0 M**	5.9 M	**2%**
Support services Global	COVID	**376.0 M**	291.8 M	**78%**
TOTAL		**9.50 B**	**3.63 B**	**38%**

Note: GHRP funding not yet identified for a specific activity or country response plan: $385.5 M.

Intersectoral plans include the humanitarian component of existing intersectoral COVID-19 response plans in countries already included in the GHRP through a Regional Refugee Response Plan, a Regional Migrant Plan or a Joint Response Plan. This covers stand-alone plans for Bangladesh, Djibouti, Ecuador, Jordan, Kenya, Republic of the Congo, Tanzania, Uganda and Zambia.

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Funding the Response:
Flexible and Unearmarked Funding

Issues related to flexible and timely funding, and cascading to frontline responders, remain at the center of discussions about the financing of the COVID response, and there will certainly be many lessons learned that will impact humanitarian financing for years to come.

The seven UN agencies surveyed report that flexible funding as a percentage of total COVID funding received between 1 March and 31 October varies from 13 per cent to 44 per cent, with an average of 29 per cent.[3] This is less than the 42, 37 and 32 per cent averages reported in June, August, and September, respectively, confirming the trend noted last month that less flexible funding is being given now than at the onset of the pandemic. Six UN agencies also reported that an average of 80 per cent of their flexible funding has been or will be allocated to countries in the GHRP.[4]

As previously described, the benefits of flexible funding and cascading funding to front-line responders have been great, both at the onset of the crisis and as the pandemic has evolved differently in countries across the globe. For example, UNHCR, jointly with the International Council of Voluntary Agencies (ICVA), set up a specific fund for civil society actors to access grants to promote protection from sexual exploitation and abuse (PSEA), and in September, the first round of grants was made to 19 projects representing NGOs working in all regions to reach groups at heightened risk of PSEA, including women and girls with disabilities, sexual orientation and gender identity minorities, and geographically isolated communities. Flexible and unearmarked funding, in particular, allowed the adaptation and scale-up of GBV prevention and response, including the broadening of networks of community outreach volunteers. IOM was able to support local partners in Haiti to deliver assistance in an efficient and timely manner, reaching the people most in need, with particular attention to people with disabilities, a vulnerable group highly affected by the crisis in the country. In Pakistan-administered Kashmir and Balochistan Provinces, UNFPA used flexible co-financing through its Humanitarian Thematic Fund to expand access to integrated SRH and GBV services, including the provision of male and female dignity kits and mental health and pyschosocial support services, as well as risk communication activities. UNFPA also used flexible resources in Burkina Faso, to train social workers, frontline health workers, security agents and justice agents in the Center-North region on gender-based violence, referral mechanisms, the GBV guiding principles, and frontline psychological support and coordination between different actors involved in the management of GBV cases.

Timely funding has been crucial, especially for delivering COVID-related programmes despite considerable funding gaps. For example, where possible UNICEF teams have been purchasing supplies locally to cut down on the costs associated with international procurement and purchasing. UNICEF and its partners are widely using remote and digital means for programme delivery and monitoring of the COVID-19 response, thereby reducing some operational costs in most countries. FAO has been able to tap into multi-year resilience-building programmes to complement GHRP funding and meet the additional needs of the most affected population. UNHCR was able to realign resources internally by using flexible funding received from donors early in the pandemic. WFP was able to maximize funding received for global operational support and promote efficiency by continuously monitoring commercial passenger service worldwide to discontinue routes as soon as private sector capacity became available, and capitalize on pre-existing partnerships with freight forwarders, charter companies and regional air operators.

[3] The actual percentages per agency are 13, 13, 31, 33, 33, 35 and 44 per cent.

[4] The actual percentages per agency are 35, 62, 89, 95, 96 and 100 per cent. This does not include WFP's flexible funding, as the large majority was used for the transport of supplies and was not allocated to specific countries.

GHURIDAHA, BANGLADESH
FAO/Fahad Kaizer

Funding the Response: **Pooled Funds**

TOTAL ALLOCATIONS (US$)
359M

CERF ALLOCATIONS (US$)
136M

CBPF ALLOCATIONS (US$)
223M

COUNTRIES [9]
49

PEOPLE TARGETED: CERF [10]
64.7M

OF WHICH :
Men 18.2 M
Women 18.8 M
Boys 14.0 M
Girls 13.7 M

PEOPLE TARGETED: CBPF [11]
42M

OF WHICH :
Men 11.3 M
Women 12.6 M
Boys 8.9 M
Girls 9.2 M

OCHA's pooled funds have allocated $359 million in 49 country contexts to support humanitarian partners' response to the COVID-19 pandemic, including both new and reprogrammed funding.

CHANNELING RESOURCES TO NGOS FOR FRONT LINE RESPONSE

Country-Based Pooled Funds (CBPF) and the Central Emergency Response Fund (CERF) are playing a critical role in the delivery of urgently needed front-line humanitarian assistance, providing substantial support to NGOs to sustain life-saving activities where people need it the most. Around $168 million[12] has been allocated to international and national NGOs, Red Cross/Red Crescent National Societies and other local partners, directly or as sub-grantees of other fund recipients.

INTERIM ACHIEVEMENTS OF COVID-19 RESPONSE

Together CBPFs and CERF have enabled humanitarian organizations to deliver a fast and localized response in key sectors, including health, WASH, protection (including GBV) and logistics, among others.

CERF and CBPFs have supported the establishment or operation of over 2,000 medical facilities, including isolation centers and intensive care units for COVID-19, benefiting around 2.7 million people. About 32 million people have been reached through health awareness campaigns and hygiene promotion activities, and 21,000 health workers have been trained on early detection and case management. Furthermore, some 7.9 million units of personal protective equipment (PPE), primary health care kits, and medical supplies have been delivered.

Over 475,000 people have received cash assistance to purchase household essentials such as food, water, medicines, utilities, and for rent. Access to clean water supplies, safe drinking water and handwashing facilities has so far benefitted 1.8 million people, and another 6.5 million people have received hygiene and sanitation kits to ensure adequate cleanliness during the pandemic.

CERF and CBPFs have supported essential protection services for 550,000 people, including psychosocial support, legal counselling, and protection awareness campaigns. Of these, around 96,000 people have benefited from GBV prevention and response activities at a critical time when risks and exposure have increased as a result of COVID-19.

CERF and CBPFs have supported livelihoods recovery of 130,000 people with technical skills training, agriculture and livestock inputs, as well as resilience-building activities; and 117,000 people have received shelter and other items (hygiene items, food, tools).

Finally, CERF and CBPFs have supported large-scale logistics efforts, including the establishment or operation of 408 cargo flights and of 81 humanitarian hubs.

[9] Includes reprogrammed funding. / [10] Includes people indirectly targeted, e.g. via information campaigns.
[11] Number of people targeted may include people indirectly targeted (e.g. through awareness and hygiene campaigns), as well as double counting because some people may receive assistance from more than one project. / [12] Please check the next page for a breakdown of allocations.

MAZAR, AFGHANISTAN
Mariam, her brothers and her friend playing in the alley in front of their house. There was nothing when the displaced families arrived in this area. Their re-settlement was supported by the Afghanistan Humanitarian Fund. *OCHA/Charlotte Cans*

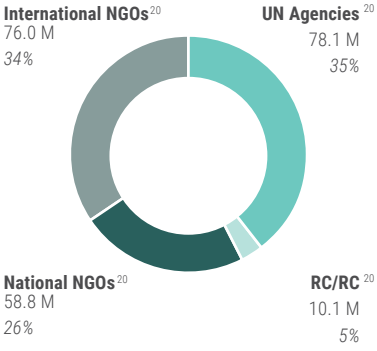
CBPFs ALLOCATIONS PER PARTNER

NO. PARTNERS
254

NO. PROJECTS
656

TOTAL ALLOCATIONS (US$)
223M

OF WHICH: **TO NGOs**
65%



CERF ALLOCATIONS PER UN AGENCY

NO. UN AGENCIES
10

UN AGENCY	ALLOCATIONS TOTAL
WFP	40.0 M
WHO	20.0 M
UNICEF	16.0 M
UNHCR	6.9 M
UNDP	3.2 M
UNFPA	3.2 M
FAO	3.0 M
IOM	2.7 M
UN-Habitat	0.05 M
NGOs *via IOM*	25.0 M
Reprogrammed Funds *from various agencies*	15.6 M

TOTAL CONTRIBUTIONS TO CERF AND CBPFs

TOTAL CONTRIBUTIONS (US$)[21]
1.26B

DONORS
60

TOP 10 DONORS	CONTRIBUTIONS TOTAL	CERF	CBPFs
Germany	**306.0 M**	113.4 M	192.7 M
United Kingdom	**166.4 M**	12.6 M	153.8 M
Sweden	**154.8 M**	84.4 M	70.4 M
Netherlands	**154.5 M**	89.4 M	65.2 M
Norway	**85.0 M**	50.3 M	34.7 M
Belgium	**73.6 M**	24.3 M	49.3 M
Canada	**52.6 M**	22.5 M	30.1 M
Denmark	**50.7 M**	25.2 M	25.5 M
Switzerland	**49.7 M**	24.0 M	25.6 M
Ireland	**43.7 M**	11.4 M	32.3 M

Pooled fund allocations have been made possible thanks to timely investments of donors since the beginning of the year. Their contributions allowed for substantial resources to be deployed immediately in support of humanitarian action in the context of COVID-19 when and where it was needed most. All donors in the table above have also made additional pledges and contributions in the context of COVID-19, frontloaded funding planned for future years, or rapidly disbursed resources planned for later in the year.

[20] Includes funds provided to humanitarian organizations as a primary recipient and as a sub-grantee (some organizations may sub-grant part of their funding budget to another organization).
[21] Donors' contributions as of 3 November 2020.

Thousands of displaced people in northwest Syria are receiving shelters, water and access to basic services

NORTHWEST SYRIA

"We are putting all our efforts for the IDPs to have improved living conditions. I will feel content knowing that IDPs are living more comfortably and that we have contributed to relieving their burdens." Said Ghalia Bubaqy, a civil engineer working on the Bonyan Organization project.

Since the end of 2019 more than one million people have been displaced by violence in northwest Syria, bringing the total number of displaced people in the area to 2.7 million. Thousands have been sleeping in the open air or living for months in inadequate shelters, overcrowded collective centers, or informal settlements. COVID-19 in the area now increases the risks people face in densely populated areas like these.

The International Organization for Migration (IOM) – with support from CERF – is working side by side with the Syrian organizations Saed Charity Association and Bonyan Organization to provide safe refuge and humanitarian assistance to more than 25,000 of these people (5,000 families). Camps in both Aleppo and Idleb are under construction and local front-line organizations will be helping to transport people to the sites once construction concludes.

"We hope that through the establishment of these sites we will in some small part contribute to the restoration of human dignity and the provision of safe refuge for these highly vulnerable displaced families" said Martin Wyndham, IOM Senior Programme Coordinator for Syria Cross-Border.

Upon arrival, the new camp residents will receive non-food items, tents and information on feedback mechanisms. In the months to come, they will continue to receive WASH services, food, and items needed to survive the winter.

Established as "a fund for all, by all", CERF remains one of the fastest enablers of humanitarian action around the world, helping aid agencies save lives and protect people whenever and wherever they needed it most. So far in 2020, CERF allocated a record $678 million to UN and humanitarian organizations working at the front lines to help millions of crisis-affected people across 49 countries.

The UN acknowledges the generous contributions of donors who provide unearmarked or core funding to humanitarian partners, the Central Emergency Response Fund (CERF) and Country-based Pooled Funds (CBPF).

For detailed information on contributions and allocations to the COVID-19 crisis, including reprogrammed funds, please visit pfbi.unocha.org

POOLED FUNDS ALLOCATIONS BY COUNTRY

COUNTRY / POOLED FUND	TOTAL ALLOCATIONS	OF WHICH: CERF	UN AGENCIES	INT'L NGOs	NAT'L NGOs	OF WHICH: CBPFs [22]	UN AGENCIES	INT'L NGOs	NAT'L NGOs	RC/ RC [23]
Global operations	42.2 M	**42.1 M**	42.1 M	–	–	**–**	–	–	–	–
Afghanistan	44.1 M	**2.6 M**	2.6 M	–	–	**41.5 M**	17.4 M	21.5 M	2.6 M	–
Bangladesh	3.2 M	**3.2 M**	0.2 M	1.5 M	1.5 M	**–**	–	–	–	–
Bolivia	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Brazil	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Burkina Faso	4.2 M	**4.2 M**	4.2 M	–	–	**–**	–	–	–	–
Burundi	1.8 M	**1.8 M**	1.8 M	–	–	**–**	–	–	–	–
Cameroon	1.6 M	**1.6 M**	1.6 M	–	–	**–**	–	–	–	–
CAR	14.4 M	**6.8 M**	1.8 M	5.0 M	–	**7.6 M**	1.7 M	5.0 M	0.9 M	–
Chad	2.9 M	**2.9 M**	2.9 M	–	–	**–**	–	–	–	–
Colombia	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Djibouti	1.4 M	**1.4 M**	1.4 M	–	–	**–**	–	–	–	–
DPR Korea	0.9 M	**0.9 M**	0.9 M	–	–	**–**	–	–	–	–
DRC	10.2 M	**–**	–	–	–	**10.2 M**	1.6 M	7.1 M	1.2 M	0.4 M
Ecuador	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Eritrea	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Ethiopia	6.6 M	**1.1 M**	1.1 M	–	–	**5.5 M**	3.9 M	1.4 M	0.1 M	–
Haiti	6.9 M	**6.9 M**	2.9 M	2.9 M	1.2 M	**–**	–	–	–	–
Iran	2.8 M	**2.8 M**	2.8 M	–	–	**–**	–	–	–	–
Iraq	12.3 M	**0.7 M**	0.7 M	–	–	**11.7 M**	0.1 M	6.1 M	5.6 M	–
Jordan	8.6 M	**2.6 M**	2.6 M	–	–	**6.0 M**	0.6 M	3.0 M	2.1 M	0.3 M
Lebanon	18.4 M	**6.6 M**	6.6 M	–	–	**11.9 M**	0.1 M	6.1 M	5.7 M	–
Lesotho [24]	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Libya	5.0 M	**5.0 M**	2.0 M	2.5 M	0.5 M	**–**	–	–	–	–
Mali	2.4 M	**2.4 M**	2.4 M	–	–	**–**	–	–	–	–
Mauritania [24]	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Myanmar	5.4 M	**1.2 M**	1.2 M	–	–	**4.1 M**	1.6 M	1.5 M	1.0 M	–
Namibia [24]	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Niger	1.7 M	**1.7 M**	1.7 M	–	–	**–**	–	–	–	–
Nigeria	6.7M	**1.9 M**	1.9 M	–	–	**4.7 M**	3.4 M	0.8 M	0.5 M	–
oPt	16.8 M	**0.9 M**	0.9 M	–	–	**15.8 M**	5.3 M	6.9 M	3.6 M	–
Pakistan	11.0 M	**1.3 M**	1.3 M	–	–	**9.7 M**	0.9 M	1.7 M	7.1 M	–
Peru	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Philippines	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Rep. of Congo	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Samoa [24]	0.5 M	**0.5 M**	0.5 M	–	–	**–**	–	–	–	–
Somalia	6.5 M	**2.6 M**	2.6 M	–	–	**3.9 M**	3.6 M	–	0.3 M	–
South Sudan	17.3 M	**6.9 M**	2.0 M	3.8 M	1.1 M	**10.4 M**	5.5 M	3.3 M	1.6 M	–
Sudan	22.5 M	**10.9 M**	7.9 M	2.6 M	0.4 M	**11.6 M**	4.6 M	5.8 M	1.2 M	–
Syria	23.6 M	**1.8 M**	1.8 M	–	–	**21.8 M**	14.5 M	4.3 M	2.0 M	1.0 M
Syria Cross Border	26.5 M	**0.4 M**	0.4 M	–	–	**26.1 M**	5.8 M	3.4 M	8.7 M	8.2 M
Tanzania	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Uganda	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Ukraine	4.7 M	**0.9 M**	0.9 M	–	–	**3.8 M**	0.1 M	2.3 M	1.3 M	–
Uzbekistan [24]	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Venezuela	4.4 M	**4.4 M**	4.4 M	–	–	**–**	–	–	–	–
Yemen	17.1 M	**–**	–	–	–	**17.1 M**	16.8 M	0.1 M	0.1 M	–
Zambia	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Zimbabwe	1.3 M	**1.3 M**	1.3 M	–	–	**–**	–	–	–	–
TOTAL	**358.6 M**	**135.6 M**	**112.7 M**	**18.2 M**	**4.7 M**	**223.0 M**	**89.5 M** [25]	**83.5 M** [26]	**40.1 M** [27]	**9.9 M** [28]

[22] This table includes funds provided to humanitarian partners as primary recipients only. See previous page for global levels inclusive of sub-grants.
[23] Red Cross / Red Crescent / [24] Non-GHRP countries are included when funds were reprogrammed toward COVID response
[25] Funding received by UN agencies as direct recipients; refer to breakdown by partner on the previous page for funding deducting sub-grants to other organizations.
[26] Funding received by INGOs as direct recipients; refer to breakdown by partner on the previous page for funding including sub-grants provided to and received from other organizations.
[27] Funding received by NNGOs as direct recipients; refer to breakdown by partner on the previous page for funding including sub-grants received from other organizations.
[28] Funding received by RC/RC national societies as direct recipients; refer to breakdown by partner on the previous page for funding including sub-grants received from other organizations

Progress of the Response

Monitoring and reporting are key elements of any robust humanitarian plan, ensuring that the overall strategy and activities remain relevant and appropriate to a given context. The nature of the GHRP as a global inter-agency strategy addressing a global pandemic has brought to light the challenges of reporting comprehensively on the humanitarian response. The following pages present progress on the indicators for the GHRP's three strategic priorities based on information provided by humanitarian partners – noting that there continue to be gaps in the data (refer to the September Progress Report for an overview of the monitoring challenges).

Since the beginning of the GHRP, some aspects of the response have advanced more quickly than others: widespread outreach and risk communications, the provision of personal protection equipment, supporting the movement of personnel and transport, raising awareness of GBV, and enhancing distance-learning opportunities for children and youth. Other areas, however, face challenges stemming primarily from lack of funding and continued movement restrictions: GBV programming has been curtailed, mental health and psychosocial support services – despite being high in demand – do not have sufficient funding, and refugee resettlements have seriously slowed down.

The information and indicators in the sections below present cumulative achievements since the launch of the GHRP on 25 March. As the quantitative and qualitative data show, there has been tremendous progress in addressing the pandemic. Yet, as noted above, this is not consistent across all sectors and considerable gaps remain, putting lives and livelihoods at risk.

MAZAR, AFGHANISTAN
Mariam, her brothers and her friend playing in the alley in front of their house. There was nothing when the displaced families arrived in this area. Their re-settlement was supported by the Afghanistan Humanitarian Fund. *OCHA/Charlotte Cans*

Progress of the response
Strategic Priority 1

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

Humanitarian actors have continued to support **infection prevention and control** measures and the scale of personal protective equipment (PPE) distributions has been one of the strongest achievements of the GHRP. As of October, 90 per cent of the GHRP countries (57 out of 63) had received PPE through the COVID19 Supply Portal set up by WHO earlier in the year. Front-line workers have been equipped with over 250,000 PPEs, health screening materials, and equipment to support contact tracing. However, with continuing community transmission of COVID-19, the demand for PPE will not abate.

The GHRP has also helped maintain focus on **mental health and psychosocial support (MHPSS)**, which has been identified as one of the areas most frequently disrupted by the pandemic, as well as one of the areas where demand for services has increased. WHO assessed the Impact of COVID-19 on Mental, Neurological and Substance Use Services and found that while 46 GHRP countries reported that MHPSS was part of their national COVID-19 response plans, only three had sufficient funding to implement the MHPSS activities. Two-thirds of the responding GHRP countries reported disruptions in psychotherapy and counselling services, and 42 per cent reported disruptions in emergency life-saving mental, neurological and substance -use services.

The international community has also continued to support infection prevention and contact tracing, particularly at points of entry. As of 15 October, IOM had assessed 3,955 points of entries (including 1,033 airports, 2,314 land border crossing points, and 608 water border crossing points) in 174 countries, territories and areas, as well as 1,517 key locations of internal mobility (internal transit points, areas of interest, and sites with populations of interest) across 135 countries, territories, and areas. The agency observed mobility restriction measures which included restrictions on entry and exit, changes in visa and document requirements, medical certificate requirements, and restrictions on nationalities (62 GHRP countries had international travel restrictions in place). To continue supporting **global mobility and operations,** as of end October, WFP had transported almost 25,000 passengers to 68 destinations on behalf of 389 organizations (of which 43 per cent were NGOs through its Global Passenger Service. As of end October, WFP had fulfilled 97 percent of the passenger movement requests received.

Progress of the response
Strategic Priority 2

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

As the secondary effects of the crisis become more widespread, **livelihoods and other socio-economic support** are becoming even more crucial components to promote resilience, prevent negative coping mechanisms, and bring about early recovery: in Nigeria, for example, UNHCR's socio-economic assessment showed that over 66 per cent of refugee and internally displaced households had to reduce their food intake to cope with declining incomes. Agencies have stepped up to the challenge and continue to provide – and follow-up on – support to livelihoods. Between March and end October, FAO delivered livelihoods support (e.g. cash transfers, agricultural inputs and technical assistance) to 2.6 million households or approximately 15 million people, of which 44 per cent were women. Compared to figures reported in August, this represents an increase of approximately 282,000 households or 1.7 million people. In Sudan, UNDP followed up on the 6,600 farming households that were previously supported with seeds and tools, and during the follow-up, farmers where sensitized on COVID-19 prevention measures.

As previously described, the pandemic has caused the **largest disruption to education in history**. In Africa, World Vision International projects that as many as one million girls may drop out of school across Sub-Saharan Africa. UNHCR reported that 136,000 refugee children and youth in 31 countries are out of school due to mandatory school closures in GHRP countries (making a total of almost 1.88 million refugee children and youth out of school due to school closure in GHRP countries). In response to the consequences of disrupted education – not only in terms of academic progress, but also in terms of future earnings and the loss of opportunities to provide protection and nutrition programmes, partners have mobilized to support children and young people to continue their schooling. UNICEF has helped more than 178 million children with distance-based education programmes. Save the Children supported 2.9 million children (52 per cent female) with distance learning due to school closures, and 90,000 children with disabilities (44 per cent female) were given distance learning programmes. World Vision provided educational materials to support remote learning for 5,200 children in Niger.

One of the worst consequences of COVID-19 prevention measures (as necessary as they have been to reduce and prevent further infections) has been the **increase of GBV**. Some UNHCR offices received protection-related calls ten times more than usual. This continues to be a priority across multi-sectoral programming. UNICEF has shifted to safer remote methods of delivering services, including online support for psychosocial activities and phone counselling. In Sudan, UNFPA, jointly with the Unit for Combating Violence Against Women and Children, has launched a national GBV helpline, as well as a state-level helpline in six states. UNFPA has also supported mass media campaigns on GBV prevention and services through the "Happy Family Campaign".

Unfortunately, GBV programming is being affected by mobility restrictions and **lack of funding**. As of 1 October, UNFPA was forced to scale down some of its GBV interventions due to the lack of funding: 12 safe spaces were closed, and other services were reduced by 40 per cent. This has a drastic impact on women and girls, in particular. For example, in Zambia, dignity kits were insufficient for all vulnerable women and girls and more could have been procured and distributed had there been sufficient funding. In addition, some target areas identified in June remain without services. In Colombia, GBV is of utmost concern for indigenous and afro-descendant populations, as well as communities affected by the armed conflict and mixed migration flows.

The provision of **sexual and reproductive health (SRH) services** in GHRP countries surveyed by UNFPA has also been severely affected by COVID-19, especially compared to the previous reporting period. The pandemic has strained the health systems, reducing access to routine health services, and essential maternal and newborn care. The number of institutional deliveries, compared to the average in 2019 and used as a proxy for continuity of access to maternal health services, shows a steeper decline than in previous months.

On the positive side, GHRP partners have had success in supporting access to **essential sanitary services and hygiene** and have continued to build on previous work. In Niger, World Vision distributed more than 180,000 hand washing supplies to schools, health centres, households and community leaders. CARE installed 55,618 handwashing stations in GHRP countries and Save the Children supported 762,300 households to access safe water, facilities for handwashing with soap and environmental practices. In Sudan, UNDP and its partners, in collaboration with state ministries of health, reached 11,945 individuals with COVID-19 sensitization messages and partners simultaneously distributed soap to 6,000 individuals during the sensitization campaigns.

The pandemic has also had a positive impact on the use of alternative approaches to aid distribution, such as **cash and voucher assistance**. UNICEF and partners are adopting a multisectoral approach that pairs social protection schemes, including cash transfers and community programmes, with health and nutrition education. Save the Children supported 389,000 households globally with cash or vouchers.

Progress of the response
Strategic Priority 3

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

Forcibly displaced populations have consistently been flagged as being more vulnerable to effects of the pandemic due to crowded living conditions, stigmatization and discrimination, poor access to health and essential services, and tenuous livelihoods. The effects of COVID-19 have **decreased the number of refugee resettlements** with already limited numbers of places available further affected by worries about COVID-19 infections, disruptions to international flights and closed borders. **For the first time in their history, UNHCR and IOM have had to largely pause their global resettlement departures.** As of 7 October, only 11,899 refugees had been resettled by 17 countries, compared to more than 107,000 people accepted for resettlement last year. Protection of refugees continues to be a challenge in COVID-19 times. In addition to the numerous countries that have fully or partially closed borders and that are not making exceptions for people seeking asylum, one or more occurrences of refoulement during the pandemic has been reported in 24 countries. In addition to advocating for refugees and internally displaced persons to be included in national COVID-19 response plans, agencies have also supported practical measures to facilitate returns. For example, many return countries require COVID-19 testing before onward travel to areas of origin. UNHCR is working with governments to adapt testing strategies and seeking additional support to scale up testing.

Overall, GHRP actors have continued their support to refugee populations. IOM continued to ensure health services were accessible at all levels, including by host communities, while expanding its testing and screening capacity. And as part of regional Venezuela migration crisis response, World Vision reached 63,450 Venezuelan migrants and refugee families with food, nutrition, livelihoods assistance, and protection services.

One specific area of action under the GHRP has been **risk communication and community engagement**, which humanitarian partners began working on early in the crisis to help prevent COVID-19 spread and which they have continued to adapt to community contexts, including ensuring gender-sensitive programming. FAO developed specific recommendations and messaging to prevent stigmatization and GBV in the remote and hard to reach areas where it operates. FAO also reached out to specific livelihoods groups, such as nomadic pastoralists, small-scale producers of fresh foods and informal food markets vendors, with awareness raising on how to prevent COVID-19 infection. UNFPA Angola conducted risk communication sessions in four southern districts affected by drought. In Zambia, 19,590 people (57 per cent females) were sensitized to the risks of COVID-19 and GBV prevention through drama, outreach by community volunteers and radio programmes.

Monitoring indicators
Situation and needs

Note: Data provided by UN agencies, NGOs, and Global Clusters, covering the period March – end of October, unless specified otherwise.
Information with a dash (–) indicates information that is not reported or not yet available.

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	OCTOBER REPORT
Spread and severity of the pandemic	Number of confirmed COVID-19 cases in GHRP countries	WHO	14,346,657 (as of 28 October)
	Total number of deaths among confirmed cases in GHRP countries	WHO	484,164 (as of 28 October)
	Number and proportion of new confirmed cases in health care workers	WHO	-
Sexual and reproductive health	Number of institutional births in COVID-19 affected areas globally	UNFPA	Decline in 29 of 46 GHRP countries
		WHO	-
	Proportion of countries where pre-COVID-19 levels of family planning/ contraception services are maintained	UNFPA	-
		WHO	28% no disruption 63% partial disruption 7% complete disruption[1]
	Proportion of countries where pre-COVID-19 levels of institutional births are maintained	UNFPA	Maintained in 16 out of 45 countries; 13 countries showed declines in more than 50% of health facilities, 10 countries showed decline in 25-50% of health facilities and 6 countries in 10-25% of health facilities
		WHO	48% no disruption 48% partial disruption[2]
Mobility, travel and import/export restrictions in priority countries	Number of priority countries with international travel restrictions in place	IOM	62[3]
		WHO	54
		WFP	Overview is available here
	Number of priority countries with partial or full border closures in place	IOM, WHO	56[4]

[1] September values, no update in October.

[2] September values, no update in October.

[3] As of 26 October 2020, 62 priority countries with international travel restrictions in place. Of which, in 17 countries entry to passengers arriving from certain countries, territories or areas are banned and in 21 countries medical measures (mandatory quarantine upon entry) are in place. 44 countries have recorded exceptions to the travel restrictions for entry pertaining to the UN, international and humanitarian organizations, or diplomatic officials, health-care professionals, special approvals from governments, medical cases and others including evacuation and humanitarian emergency flights. (Afghanistan has lifted all international air travel restrictions; oPt is not included when looking at international travel restrictions).

[4] As of 22 October 2020, 56 priority countries have full or partial border closures in place (oPt is not included when looking at the status of border closures).

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	OCTOBER REPORT
Food security	Market functionality index	WFP	Available data cannot be aggregated at global level
	Number and proportion of people with unacceptable food consumption score	WFP	242,449,416 (29.34%)[5]
	Number of people adopting crisis level coping strategies (Reduced Coping Strategy Index)	WFP	194,484,661 (23,54%)[6]
	Number of priority countries with reduced availability of agricultural inputs	FAO	9[7]
	Number of people in IPC Phase 3+ in priority countries (in countries where new analyses are available)	FAO/IPC	60,907,000[8]
Education	Number of children and youth out of school due to mandatory school closures in GHRP countries	UNESCO	225,846,389 affected learners, 12.9% of total enrolled learners[9]
		UNHCR	1.88 million refugee children and youth
Vaccination	Proportion of countries where at least one vaccine-preventable diseases mass immunization campaign was affected (suspended or postponed, fully or partially) due to COVID-19	WHO	57%
Gender-based Violence	Number and proportion of countries where GBV services have been interrupted	UNFPA	8 out of 46
Child protection	Number and per centage of countries integrating a monitoring system able to measure changes and to identify child protection needs	CP-AoR	35 (78%)
Nutrition	Number of countries that have activated the Nutrition Coordination mechanism in response to COVID-19 and/or its impacts	UNICEF (Global Nutrition Cluster)	29
Protection	Number of countries reporting incidents of COVID-19 pandemic-related xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons	UNHCR	29 of 56 countries reporting (52%)

[5,6] Compiled from 22 GHRP countries (Afghanistan, Burkina Faso, Cameroon, CAR, Chad, Colombia, DRC, Ethiopia, Haiti, Iraq, Liberia, Mali, Mozambique, Niger, Nigeria, Somalia, Rep. of Congo, Syria, Tanzania, Yemen, Zambia and Zimbabwe).

[7] Of the 10 countries where data is available at time of reporting nine countries are reporting reductions in availability of/access to agricultural inputs for both crop and livestock production. These countries include Afghanistan, Bangladesh (no data on livestock inputs), Colombia (no data on livestock inputs), Iraq, Libya, Somalia, South Sudan, Sudan, Yemen. Note that this is not nationally representative data (based on the perceptions of key informants, including farmers and agro-dealers).

[8] This figure takes into account all IPC and CH numbers (current and projected) that are valid as of end of October 2020 in the countries referenced. This number represents a marginal decrease compared to the previous reporting period (62.66 million). However, extreme caution should be taken when comparing these figures due to changes in the countries covered (expiration of some IPC numbers reported in the previous period for Tanzania and urban areas in Mozambique and addition of new IPC numbers (Burundi, Central CAR and Uganda). In addition, for a number of countries referenced in both the previous reporting period and this one, the number of people in IPC Phase 3 or above fluctuated due to seasonality and the evolution of other factors contributing to acute food insecurity.

[9] This figure covers the following countries: Afghanistan (10.31 million), Burundi (1.33 million), CAR (1.93 million), DRC (21.83 million), Ethiopia (6.67 million), Haiti (3.99 million), Kenya (0.85 million), Mozambique (0.29 million), Somalia (2.11 million), Sudan (6.39 million), Uganda (2.0 million) and Yemen* (3.21 million). IPC Afghanistan update is expected soon after the publication of the GHRP report with acute food insecurity expected to substantially increase.

Monitoring indicators
Strategic Priority 1

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	OCTOBER REPORT
Ensure essential health service and systems	Number of passenger movement requests fulfilled	WFP	90%	97%
	Number of cargo movement requests fulfilled	WFP	90%	95%
	Number of hubs established for consolidation and onward dispatch of essential health and humanitarian supplies	WFP	8	8
	Number of GHRP countries with multisectoral mental health and psychosocial support technical working groups	WHO	100%	79%
	Number of caregivers of children less than 2 years old reached with messages on breastfeeding, young child feeding or healthy diets in the context of COVID-19 through national communication campaigns	UNICEF	14,393,176	13,047,789
	Number of 3 plies/medical masks distributed against need (or request)	UNFPA	25,000,000	5,642,058
		UNHCR	20.5 million	11.5 million (56%)
		WHO	-	104,064,465
	Number and per centage of children and adults that have access to a safe and accessible channel to report sexual exploitation and abuse	UNICEF	10,127,158	14,344,293
	Number of existing or newly established service points continuing to offer specialised services to victims of sexual exploitation and abuse during the COVID-19 crisis	UNFPA	-	1025 services points of a total of 1254 in 46 countries
	Number of health workers provided with PPE	UNICEF	10,127,158	14,344,293
		UNRWA	1,405,349	1,067,269
		WVI	3 months supply of PPE for more than 3,000 UNRWA front line health workers.	100%
Learn, innovate and improve	Percentage of countries implementing sero-epidemiological investigations or studies	WHO	20%	33%

Note: Indicators which list multiple agencies cannot be aggregated, as the numbers are specific to each agency, units for counting in some indicators differ from one agency to another and there may be slight overlap in numbers.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	OCTOBER REPORT
Prepare and be ready	Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	UNICEF	60	60
	Proportion of GHRP countries that have a national Infection Prevention and Control programme including water, sanitation and hygiene (WASH) standards and WASH basic services operational within all health-care facilities	WHO	100%	29%
Prevent, suppress and interrupt transmission	Proportion of GHRP countries with a functional, multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	WHO	100%	98%
	Number and proportion of countries with COVID-19 Risk Communication and Community Engagement Programming	UNICEF	60	59
	Proportion of GHRP countries with COVID-19 national preparedness and response plan	WHO	100%	98%

Monitoring indicators
Strategic Priority 2

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	OCTOBER REPORT
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 protection and humanitarian assistance	Number of people/households most vulnerable to/affected by COVID-19 who have received livelihood support, e.g. cash transfers, inputs and technical assistance	FAO	-	2,670,624 households / 15,044,444 people
		UNHCR	1 million people	726,900[8]
		UNICEF	1.3 million households	162,635
		UNDP	20 million people	23,734,845
		IOM	1,505,269	717,928
		DRC	-	805,786
		CARE	-	638,385 (food) and 559,726 (cash and voucher assistance) in 34 GHRP countries[9]
		WVI	-	146,971

[8] This does not include cash assistance, which is reported under Strategic Priority 3, overall assistance. Most of the cash (95 per cent) is disbursed without restrictions, giving the choice to refugees and others of concern on how best to meet their own needs, therefore covering a wide range of purposes, including protection and basic needs, further to livelihoods.

[9] Afghanistan, Bangladesh, Burkina Faso, Burundi, Cameroon, Chad, Colombia, DRC, Ecuador, Ethiopia, Haiti, Iraq, Jordan, Kenya, Lebanon, Liberia, Mali, Mozambique, Myanmar, Niger, Nigeria, oPt, Pakistan, Philippines, Sierra Leone, Somalia, South Sudan, Sudan, Syria, Tanzania, Uganda, Yemen, Zambia, Zimbabwe.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	OCTOBER REPORT
	Number of people/households most vulnerable to/affected by COVID-19 who benefit from increased or expanded social protection	FAO	–	511,756 households [10]
		UNICEF	15.4 million households	8,811,461 households
		UNDP	4 million people	2,480,000 people
		UNRWA	850,000 Palestine refugees	In September, UNRWA provided cash and food assistance to some 302,000 Palestine refugees
		UNHCR	640,000 people	332,745 people
Ensure the continuity of 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	Number of people (girls, boys, women, men) who are receiving essential health-care services	IOM	5,821,662	2,526,042
		UNHCR	6 million	5.9 million
		UNICEF	43,450,524	43,888,596
		UNRWA	–	427,350 in September
	Number of people reached with critical WASH supplies (including hygiene items) and services	UNICEF	61,816,915	427,350 in September
		IOM	28,073,839	21,892,725
		DRC	-	337,110
		CARE	-	3 million people received increased access to safe water, 1.9 million with hygiene kits, 55,618 handwashing stations with soap and water were installed
		SCF	-	762,300 households supported to access safe water, facilities for hand-washing with soap and environmental practices.
		WVI	-	14,082,968
	Number of children and youth supported with distance/home-based learning	UNICEF	178,336,631	107,787,056
		UNHCR	1.2 million	836,350 refugee children and youth
		SCF	-	2.9 million children, including 90,000 children with disabilities
	Number of children and youth in human-itarian and situations of protracted displacement enrolled in pre-primary, primary and secondary education levels	UNHCR	1.7 million	816,740 refugee children and youth
		UNRWA	533,000	541,049[11]

[10] This includes FAO's support to governments for both the vertical and/or horizontal expansion of social protection systems.

[11] This latest enrolment estimate for 2020-2021 is still tentative, as student enrolment is ongoing, verification of enrolment requires observation of physical presence in schools, and students are not currently attending school in some fields due to COVID-19.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	OCTOBER REPORT
	Number of people (including children, parents and primary caregivers) provided with mental health and psycho-social support services	UNICEF	17,658,974	18,445,203
		UNHCR	390,000	321,576
		IOM	2,156,785	1,878,821
		SCF	-	190,000 children (55% female, 45% male) and 287,000 adults (53% female, 47% male) received MHPSS support.
	Number and proportion of countries in which minimum child protection services are operational during the COVID-19 crisis	UNICEF	60	58
	Number of children 6-59 months admitted for treatment of severe acute malnutrition (SAM)	UNICEF	3,616,340	1,972,801
		UNHCR	55,000	37,803
	Number of children 6-59 months admitted for treatment of moderate acute malnutrition (MAM)	UNHCR	140,000	91,424
		SCF	-	257,500
	Number of women and girls who have accessed sexual and reproductive service	UNFPA		10,066.682 women in 46 countries 5,199.714 youth in 42 countries
		UNHCR	710,000	815,477
		CARE	–	1.5 million [12]
	Number and proportion of countries where messages on gender-based violence risk and available gender-based violence services were disseminated in all targeted areas	UNFPA	100%	100%
		UNICEF	30	30
		CARE	–	26
	Number and proportion of countries where GBV services are maintained or expanded in response to COVID-19	UNFPA	61 GHRP countries	82% (38 out of 46 countries)[13]
		UNHCR	All GHRP countries	(80%) (44 out of 55 countries)[14]
		CARE	–	33 GHRP countries

[12] 1.5 million women and girls received continued SRH services in CARE Supported health facilities during the COVID19 crisis. 3,493 health facilities/service delivery points (e.g. mobile clinics) supported by CARE to provide health / SRH COVID-19 related services

[13] Gaps in services remain in some target areas in 25 countries

[14] Data focuses on UNHCR's persons of concern's access to expanded/maintained GBV services.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	OCTOBER REPORT
	Number of people who have accessed protection services	UNHCR	10.7 million	10.8 million
		IOM	1,426,738	734,597
		DRC	-	995,458
		CARE	-	1.3 million people[15]
		SCF	-	72,000 children
		WVI	-	1,365,243
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 and per centage of countries that have had requested consignments of reproductive health kits and other pharmaceuticals, medical devices and supplies to implement life-saving sexual reproduction and health services shipped since 1 March 2020	UNFPA	100%	100%: 47 of 47 GHRP requesting countries had their requests shipped; 43 of those (91%) have arrived at country 42 of those (98%) have been distributed to implementing partners.

[15] This figure reflects people who have received updated GBV service referral information (e.g. relevant domestic violence hotlines or other GBV prevention/response services

Monitoring indicators
Strategic Priority 3

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
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	Number of refugees, IDPs and migrants particularly vulnerable to the pandemic that receive COVID-19 assistance	IOM	32,598,938	26,585,310
		UNHCR	67 million people	33.1 million people[16]
		SCF	-	389,000 households received cash and/or voucher transfers
		DRC	–	2,751,551
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	Number and proportion of countries where areas inhabited by refugees, IDPs, migrants and host communities are reached by information campaigns about COVID-19 pandemic risks	IOM	60	51 countries
		UNFPA	100%	94% (32 countries out of 34)
		UNHCR	100%	68%
		UNICEF	-	6 countries[17]
		DRC	-	25 countries have reached 1,6 million people by the end of August
	Proportion of countries inhabited by IDPs, refugees and migrants with feedback and complaints mechanisms functioning	UNHCR	All GHRP countries	100%
		UNRWA	Palestine refugees in all 5 fields of operation	Hotlines operational in all 5 fields of operation

[16] Approximately 33.1 million refugees and IDPs have received COVID-19 assistance, including access to protection services, shelter, health, nutrition, education, cash, in-kind and livelihoods support etc. This figure includes over 4.7 million individuals who received cash assistance.

[17] Counting only those countries that report on disaggregated data by refugee/IDPs, while most don't do this disaggregation.

“We are not powerless. If we follow the science, and demonstrate unity and solidarity, we can overcome the pandemic.”

António Guterres
United Nations Secretary-General
Video message for the World Health Summit, October 2020