GLOBAL HUMANITARIAN RESPONSE PLAN
COVID-19

PROGRESS REPORT

SECOND EDITION
31 AUGUST 2020

Table of contents

Sana'a, Yemen
A volunteer guides and instructs children in the streets of Sana'a on the right way to wash their hands.
Dhia Al-Adimi/UNICEF

[1] While no new countries have been added, the July iteration includes the humanitarian component of existing intersectoral plans for countries where the needs of vulnerable people were not covered under regional refugee and/or migrant plans. These countries are Bangladesh, Djibouti, Ecuador, Jordan, Kenya, Republic of Congo, Tanzania, Uganda and Zambia.

At a glance

The impacts of the COVID-19 pandemic on the lives and livelihoods of the most vulnerable people are enormous, both in terms of the number of people infected and the profound economic crisis that has been unleashed. Individuals and population groups who were already suffering from violence, stigma, discrimination and unequal access to basic services and living conditions are bearing the brunt of this new crisis. The COVID-19 Global Humanitarian Response Plan (GHRP) analyses and responds to the direct public health and indirect humanitarian consequences of the pandemic, particularly on people in countries already facing other crises.

The scope and the scale of the third iteration of the GHRP released on 16 July demonstrate the increasing reach and devastating consequences of the pandemic. The GHRP July update aims to provide aid to 250 million people in 63 countries,[1] over twice the number of people initially targeted for humanitarian aid at the beginning of the year when the Global Humanitarian Overview covering 55 countries was launched in December 2019. Funding requirements to address immediate humanitarian needs caused by or exacerbated by COVID-19 rose from $6.71 billion in May to $10.31 billion in mid-July. The GHRP is currently only 23 per cent funded, with humanitarian partners reporting $2.36 billion of funding. See below for an overview of the cost components, and pages 13–15 for more detail on the funding progress.

COST COMPONENT	REQUIREMENTS (US$)
Country-level Responses	**8.49 B**
Global Response	**1.83 B**
Famine prevention *Measures and put stocks in place to limit the possibility of famine in the most vulnerable communities*	**500.0 M**
NGO envelope *Unallocated supplemental funding for NGOs, in addition to country-level requirements, to bolster NGO rapid response actions and allow NGOs to redirect their response as quickly as the pandemic evolves*	**300.0 M**
Support services *Humanitarian air transport, Medevac, and stranded migrants*	**1.03 B**
TOTAL	**10.31 B**

Looking ahead, in the 2021 Humanitarian Needs Overviews and Humanitarian Response Plans, the effects of COVID-19 will be considered together with other shocks or stresses affecting the population. In consequence, the GHRP will be merged with the Global Humanitarian Overview. In most cases, COVID-19 will be one of numerous causes of humanitarian needs, with the health and socio-economic impacts of the pandemic intersecting with other health, nutrition, food security, livelihoods and protection risks faced by different population groups.

Strengthened humanitarian-development collaboration will therefore be crucial to help reinforce the humanitarian response and foster complementarity across other ongoing or planned responses, avoiding duplication and identifying areas or groups for whom development or socio/economic responses may be more appropriate. This will provide opportunities to share data and analysis, with mutual benefits on the depth of the needs analysis.

This Progress Report summarizes the collective response to the humanitarian impacts of COVID-19 in the 63 countries covered by the GHRP. It presents an update on the operational context; examples of how humanitarian partners continue to adapt their field responses; in-focus sections on Protection and Food Security; a funding overview and analysis; information on how pooled funds are supporting the response; and an update on the strategic response priorities and progress against key indicators. Subsequent versions of this report will be issued in late September and October.

Operational context

APPEALS INCLUDED IN THE GHRP

52

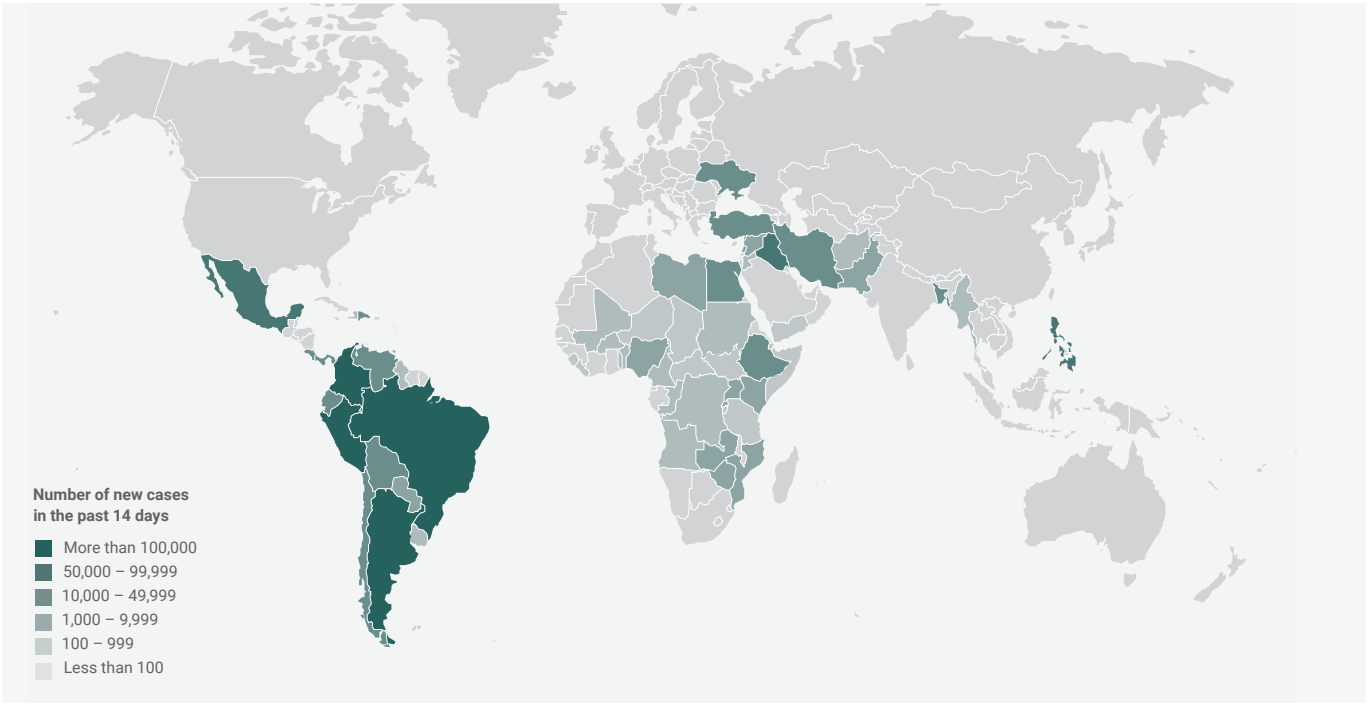
OF WHICH:
HRP 24
RRP 5
RMRP 2
OTHER 21

CONFIRMED CASES

8.86M

CONFIRMED DEATHS

321k



Source: World Health Organization. covid19.who.int

The COVID-19 pandemic has continued to have dramatic effects on the world's most vulnerable people. As of 28 August, the total number of COVID-19 cases in the 63 GHRP countries had reached 8.9 million and at least 321,000 people are reported to have died. GHRP countries in Latin America and the Caribbean continue to represent the majority of cases and deaths. Cases in the Middle East and North Africa have increased over the past month. While reported cases have declined in Africa and Asia Pacific, this is not consistent across all countries in these regions due to a variety of factors, which include domestic testing capacity, socio-economic factors, state of health systems and existing vulnerabilities. As well, there are many examples from across the world where a temporary downturn in cases has been reversed.

The cost of not adequately addressing the pandemic will be devastating to the lives of people and in the economies of these countries. The cost of delays in action will only grow. Analysis carried out by OCHA and its partners indicate that the COVID-19 virus could infect up to 640 million people and kill 1.67 million of the world's most vulnerable populations in 32 low-income countries and push at least 71 to 100 million people into extreme poverty if urgent action is not taken by the international community.[1] Humanitarian agencies are stepping up to respond to COVID-19 and sustain ongoing operations but are facing increasing pressure as the pandemic continues to compound existing fragility and vulnerabilities.

Strong evidence is emerging of the negative effects of the pandemic on food security with an increasing threat of famine in some countries, disruption of immunization campaigns, the impact on children from disruptions to education, and on gender-based violence. The threat of famine and more poverty continue to increase as a result of COVID-19 mitigation measures, including movement restrictions to limit the spread of the virus, and other drivers of acute food insecurity. According to a joint FAO-WFP early warning analysis of food insecure hotspots, 27 countries are in danger of a sharp deterioration in food insecurity. Funding remains poor for food security interventions, despite widespread recognition of a potential massive food crisis in many vulnerable and highly exposed contexts. Urgent and massively scaled-up assistance is needed now to address the magnitude of the potential crisis.

Disruptions to immunization services continue to be widespread and have affected countries in all regions. As of 24 August, vaccine preventable disease campaigns in 45 GHRP countries (over 70 per cent of the GHRP countries) had been fully or partially postponed or canceled due to the pandemic. At the same time, some routine services have resumed and planning is currently underway for vaccine campaigns that had previously been suspended. Examples are measles campaigns in Burundi, Central African Republic, the Democratic Republic of Congo, Ethiopia and Nepal, and a tetanus-diphtheria campaign in Mali. Implementation is still hindered by

[1] See The Price of Inaction during the COVID-19 Crisis, 15 July 2020.

the lack of personal protective equipment (PPE), considerations on safety issues of health workers, the fear of increased COVID-19 transmission, lockdown policy and logistics issues.

Education continues to be one of the most affected sectors, and one where long-term consequences may be most severe. As of August 2020, more than one billion learners have been affected by COVID-19 related school closures. Over half a billion of those learners (more than 250 million women and girls and 300 million boys and men) are in 45 GHRP countries.[2] Only 83 countries reported that distance education was reaching vulnerable or marginalized groups. According to a UNICEF report published on 27 August, an estimated 463 million children worldwide have been unable to access remote learning amid the coronavirus pandemic and widespread school closures. Without urgent attention to this education crisis, millions of children are at risk of not returning to school and are at greater risk of forced marriage, exploitation and abuse as well as increased poverty levels.

Recognizing the increase in gender-based violence (GBV) as one of the consequences of the COVID-19 pandemic due to increased lockdowns and lack of support for vulnerable groups, increased attention to GBV was included in updated country response plans. This year, the Emergency Relief Coordinator has committed $100 million from the Central Emergency Response Fund's (CERF) Underfund Emergencies window to support 10 countries, of which at least $5.5 million are earmarked for GBV. Increased programming is taking place in GHRP countries but continue to be hampered by limited funding.

COVID-19 restrictions on movement continue to constrain humanitarian operations. While, there has been a gradual relaxation and reopening of economies and airspace, local NGOs and national staff continue to face significant challenges, and in some locations the humanitarian presence is less than before the pandemic, despite the rising needs on the ground. Quarantine measures continue to be negotiated to ease the restrictions placed on humanitarians and allow better and more efficient movement within and into countries. However, States must grant humanitarian workers and goods special exemptions so we can continue and increase our footprint to reach the most vulnerable.

Despite all of these challenges, Humanitarian agencies have sustained and expanded life-saving programs, using new approaches wherever necessary. Existing programmes have been reconfigured, and significant progress has been made towards the objectives of the GHRP. But additional strong donor support is required.

[2] UNESCO, Global Monitoring of School Closures caused by COVID-19, dashboard as of 2 August 2020.

Operational context:
Adapting the field response

This section provides examples of how humanitarian partners have adapted their programmes and service delivery to an operational context strongly influenced by the pandemic to ensure that COVID-related and other assistance reaches those in need.

In **Afghanistan**, hotlines receiving calls from women, recent surveys and reports from NGOs show that, across Afghanistan, violence against women and girls has increased during the COVID-19 pandemic. Similarly, services for GBV survivors, including healthcare, police, justice and social services, are particularly impacted by the crisis. A COVID-19 Gender in Humanitarian Action Working Group has been established to lead the analysis and planning of gender-focused response to the pandemic. Protection partners have scaled up protection monitoring and specialized support to mitigate against GBV and child protection risks and address the needs of GBV survivors. Protection partners are providing individual protection assistance, cash grants for vulnerable households with acute protection need, and psychosocial support.

According to local authorities in **Ukraine**, since the start of the restrictive measures in response to COVID-19 there has been a 30 per cent increase nationwide in the number of calls seeking support to address domestic violence. The increase in eastern Ukraine is 40-60 per cent. In response, nearly 200 specialists from local state institutions, NGOs and CSOs have received online training on the principles of psychosocial care by UNFPA. Additionally, UNFPA, together with the National Police and the Ministry of Interior Affairs, has developed information materials for GBV survivors on how to keep safe from abuse or violence during the pandemic.

In **Sudan**, UNICEF is providing children with psychosocial support to deal with stress caused by COVID-19. UNICEF and partners have provided psychosocial support to nearly 36,000 students in While Nile State, more than 2,700 of them refugees. With the closure of schools and movement restrictions, children are spending most of their time inside their homes and unable to continue their regular activities which leads to stress and tensions. Families have also received tips and guidance on how to support their children through radio broadcasts, WhatsApp messages, and community engagement sessions. In addition, over 200 members of the community-based child protection networks, including social workers and teachers, were trained to provide psychosocial support and counselling to families and children, making it possible to continue the response in the months ahead.

In **Central African Republic**'s capital, Bangui, the incidence of GBV and sexual violence affecting children patients increased from 37 per cent in 2019 to 50 per cent between April and June 2020. Humanitarian partners have been providing targeted programmes to allow children to have access to alert mechanisms in their communities. Advocacy for flexible funding has also been carried out with donors to encourage more funds for the GBV response.

In **Sudan**,the American Refugee Committee (supported by the Sudan Humanitarian Fund) adapted procedures at water points to prevent crowds and encourage safe distancing while queueing. In Bielel, Gereida, Dimsu and other settlements for displaced people in South Darfur, the time at water points was increased to prevent overcrowding and make sure everyone could collect sufficient water for drinking and domestic use. The organisation also included COVID-19 prevention messages as part of hygiene awareness campaigns and are building hand-washing facilities at the water points. Community volunteers are being trained to pass on knowledge about the importance of hand washing other guidance.

In the **Philippines**, Oxfam brought together local humanitarian organisations, local government, and the private sector (Microsoft and PayMaya, a mobile and digital payments company) in a partnership to deliver digital cash transfers to urban poor families who had lost their income and had confirmed COVID-19 cases. The cash support enabled access to food, medicine, water,

GRAND'ANSE DEPARTAMENT, HAITI
Distribution of hygiene kits and cash to beneficiaries of the municipalities of Jérémie, Abricot, Bonbon and Dame-Marie. *John Rutherford/CARE*

and hygiene items. The use of an electronic prepaid card, supplemented by training on digital transactions, helps reduce the risk of virus transmission; is efficient and transparent; and provides families access to financial services beyond the COVID-19 response.

In **Ethiopia**, the Addis Ababa Mayor's Office has formed a public-private coalition with private sector companies (Dalberg Group and Roha Group) and NGOs, including Save the Children, to launch a project called Tenachin Bejachin which means "our health is in our hands". The project is expected to help people living in high-risk communities that struggle with access to water, soap, and other compounding challenges. It will also support businesses that are critical to ensuring the economic health of communities. The project has a total potential value of $6 million to support 1.2 million COVID-19 vulnerable people in the capital city over the next six months.

In **Yemen**, the WASH cluster carried out a rapid assessment (phone/online) in the first half of April on COVID-19 to understand knowledge, risk perception, attitudes and practice in relation to the pandemic. As a result, for example in Aden, humanitarian partners have been scaling up awareness raising by using community radio and social media. Partners are also using megaphones, mosque microphones after each daily call to prayer, and amplifiers installed in IDP centres. The UN and partners have reached 16.5 million people with COVID-related awareness materials through multiple platforms. This includes 13.5 million people reached by text message, 10 million people who have viewed materials on social media platforms, 3.6 million people reached through sermons in local mosques, and 3.2 million people reached through house-to-house visits.

The Cash Consortium for **Iraq** has developed a brief analysing the impact of COVID-19 on prices, markets and household-level consumption. Using data collected across five governorates since March 2020, the brief examines the impact of the recent crisis on the market system and access to goods; identifies potential points of critical hardship; and reviews the geographic distribution of those effects.

In **Afghanistan**, OCHA developed a guidance note on the procedures and coordination of Medevac/Casevac requests from international NGOs and the diplomatic community. The note includes costs and capacity constraints, a list of 14 procedures to be used through the request process, and 10 annexes with the required paperwork. These details were then communicated to the INGOs through the International NGO Safety Organisation, with whom OCHA is coordinating to confirm requests, and UNAMA, the entity responsible for coordinating the evacuations. A UNAMA-contracted Medevac jet is now equipped with an isolation capsule for transporting COVID-19 patients, which puts it within non-stop range of most European airports. The capsule was utilized for an in-country Medevac less than 24 hours after it was delivered to Kabul. Due to the lack of appropriate and secure medical facilities in country, UNOPS is constructing a five-bed intensive care facility in a UNAMA compound in Kabul funded by UK DFID and the Afghanistan Humanitarian Fund. The facility is to be a "turn-key" package for international NGOs, UN, and international community.

In **Yemen**, in-person distributions of food and other items are following social-distancing protocols, including markings on the ground to ensure adequate space between beneficiaries. Some partners have also developed low-tech "foot pedals" for ad-hoc water tanks. These allow individuals no-contact access to water from the tank without having to touch a tap. About 2,700 hand-washing stations have been installed.

Partners supported by the **Sudan** Humanitarian Fund are using megaphones and mobile campaigns in Darfur. Social workers from Nada Elazhar Organization for Disaster Prevention and Sustainable Development in North Darfur had to reduce the number of participants at the sessions they organize on protection, including training, psychosocial support, and campaigns. To make sure they could reach all people in need of support, the frequency of the sessions—that now include COVID-19 awareness messages—has been increased. In South and East Darfur, ALSalam Organization for Rehabilitation and Development also adapted some of it on-going protection work with the displaced community and started campaigns using cars and megaphones to explain to people living in displacement camps how to protect themselves and their families from COVID-19. More than 26,000 people received the messages.

To support the delivery of cash and voucher assistance programming in **Colombia**, the Cash Working Group is producing a CVA risk matrix for COVID-19. The matrix offers an analysis of potential internal and external risks, their associated probability and potential impact, and identifies relevant mitigation measures.

NEWS FROM THE CONNECTING BUSINESS INITIATIVE (CBi)[3]

CBi member networks are local response mechanisms that are particularly important in situations such as COVID-19 when traditional response mechanisms may not be able to deploy or fully meet local needs. The following examples demonstrate their value as first responders and stakeholders in response while working closely with the government and humanitarian community.

During the past three months, the CBi local network in **Haiti**, Alliance pour la Gestion des Risques et la Continuité des Activités (AGERCA), together with its partners, has acted in the fight against the coronavirus both in the field and on digital platforms. AGERCA launched the Response Platform of Civil Society Organizations (PROC19), an initiative that brings together several civil society organizations to carry out responses to this health crisis. The network also conducted an impact survey of the effect of COVID-19 on small- and medium-sized Haitian enterprises, distributed hygiene kits, and provided training on health and safety measures.

In **Madagascar**, the CBi network, Private Sector Humanitarian Platform, distributed 200 solar radios and educational kits in rural areas for families to receive COVID-19 related news and for children to follow classes. The network continued to distribute the illustrated children's book CORONABOKY for awareness raising; maintained food distribution at the prison of Antanimora; took specific health-supporting actions to enhance hospital capacity among other things; and a project was carried out with the Akany Iarivo Mivoy Homeless Shelter to improve their infrastructure and offerings.

[3] CBi is a multi-stakeholder initiative transforming the way business networks engages before, during and after natural and manmade disasters and humanitarian crises to create more resilient communities, increase local capacity and alleviate human suffering. It is jointly supported by OCHA and UNDP. All CBi networks are engaged in the COVID-19 response. More information on CBi activities in the COVID-19 response is available here.

Sectoral focus: Protection

The COVID-19 pandemic is exacerbating protection concerns in humanitarian crises and exposing vulnerable and affected populations, refugees, asylum seekers, internally displaced, migrants, and stateless people to new threats. Despite challenges, protection partners have delivered essential services, including through remote modalities, and seek to ensure that the rights of people of concern are respected.

In countries receiving GHRP funds for COVID-19, some 6.7 million people have accessed protection services. Life-saving protection actions include victim assistance and advocacy for rights, registration and documentation, specialized services to children, the elderly and persons living with disabilities, individual case management for survivors of gender-based violence and referrals to medical care, psychosocial support, security, and legal aid. Coordinated protection action was guided by the COVID-19 operational minimum package of the Global Protection Cluster in IDP settings, and in refugee operations by UNHCR.

THE RIGHT TO PROTECTION FOR ALL

To combat the spread of COVID-19, States have legitimately restricted movement of people. Currently, 154 countries and territories have fully or partially closed borders. At least 79 make no exception for people seeking asylum, limiting the rights of persons in need of international protection. In addition to impacting refugees, many migrants have also found themselves stranded at border points and unable to return home.

Protection partners have worked with state authorities on adaptive measures for the registration of new asylum applications by mail, phone, email, and online to ensure that those fleeing persecution and danger are still able to do so. Similar attention has been applied to the situation of those who found themselves stranded and unable to exercise their right to repatriate and reunite with their families across or within borders.

Over one hundred States (105 at time of reporting) have adapted registration procedures for new applicants. Colombia for example has remotely registered 57,741 individuals (73 per cent women) since the start of the pandemic, ensuring that they are able to access critical services.

While many countries have taken measures to decongest detention facilities, persons deprived of their liberty remain highly vulnerable due to overcrowding, limited access to health care, and unhygienic conditions. Some 109 countries adopted decongestion measures to curb the risk of COVID-19 transmission in prisons following guidance issued by protection partners.

XENOPHOBIA, STIGMATIZATION, AND DISCRIMINATION

Stigmatization, including attacks against displaced and other marginalized people accused of spreading the virus, has increased since the outbreak of the pandemic. Engagement with affected communities has been critical in mitigating the impact of the virus itself, as well new protection risks. Among 57 GHRP countries reporting, 47 per cent have documented COVID-related incidents of xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons. Xenophobic messages on social media or in the news have led to violence and discrimination against non-nationals, including incidents of eviction and denial of service or expulsion from hotels.

States have also implemented COVID-19 policies that, in some instances, have had a discriminatory effect against refugees, asylum-seekers, and other displaced persons. Border authorities in some countries have denied the disembarkation of displaced persons arriving by sea without first determining their need for international protection or access to COVID-related health services.

SAN ANTONIO DEL TACHIRA. VENEZUELA
A protection officer delivers hygiene kits to migrants at a community center. *OCHA/Gema Cortes*

KEEPING COMMUNITIES INFORMED AND ENGAGED

To mitigate the impact of COVID-19 protection actors have increased communication with communities and leveraged existing community-based structures to maintain two-way communication. Community and religious leaders, outreach volunteers, members of women's and youth groups have disseminated information going door-to-door, bicycling to isolated communities, assembling in small groups, or using megaphones and loudspeakers. Thirty-nine countries report that they have undertaken information campaigns reaching remote or otherwise hard-to-reach areas inhabited by refugees, IDPs, migrants and stateless people.

As concrete examples, some 614,000 individuals were reached though WhatsApp groups, outreach volunteers, and mass communication campaigns in Syria. Teachers, community health workers, and hygiene promoters in Eastern Chad reached over 128,000 refugees (96 per cent of the refugees in the province). In Sudan, 54,000 South Sudanese refugees received risk communication on awareness, health promotion, infection prevention, and stigmatization. An assessment conducted at a later stage showed that 96 per cent understood the prevention messages received, including where to go to for assistance if they develop COVID-19 symptoms.

Protection actors also bolstered call centres with integrated voice response in target languages and established 24/7 protection hotlines, followed by interventions aimed at safeguarding access to rights and services. As one example, in Colombia assistance was provided to more than 20,000 Venezuelan refugees and migrants, returnees and internally displaced people via 47 helplines. In the Democratic Republic of Congo humanitarian partners reached 254,000 refugees and IDPs through awareness-raising across the country via group discussions, flyers, and door-to-door messaging.

In addition, millions of displaced and stateless people were reached through bulk SMS texts, audio and text WhatsApp messages. Chatbots were developed to respond to common questions, and communication trees deployed to propagate accurate information across communities. Two-way communication via social media proliferated on Twitter, Instagram, Trello, as well as dedicated Facebook, Kobo and helpline pages in multiple languages, including sign. All 60 countries that report against this GHRP indicator state that functioning feedback and complaints mechanisms have been set up.

Connectivity, however, remains a significant challenge. In conflict-affected areas of Chad, Libya, Niger, and Yemen, connectivity issues hamper the ability to ensure vulnerable communities are kept informed. Connectivity issues are also restricting the capacity to monitor rights violations and manage the COVID-19 response. In central Rakhine, Myanmar, an internet ban has been in place for several months, and the internet was inaccessible in Ethiopia for three weeks in July. To reach those without access to technology, the use of radio and TV to broadcast COVID-19 public service announcements has been used. For example, in Burkina Faso, a daily COVID-19 news programme was broadcast on 37 radio stations in local languages.

ENSURING ACCESS TO PROTECTION AND EDUCATION FOR CHILDREN

Child protection risks have escalated across operations – 23 Protection Clusters report increased incidents or heightened risks of violence against children because of COVID-19 measures. To ensure age-appropriate and accurate information, child protection partners use child-friendly communication methods across operations. With full consideration of the factors of age, gender, cultural/religious identity and education level, messages are designed in consultation with parents, caregivers and with the children themselves, and delivered through posters, songs, storytelling and drama. Protection partners support community-based mechanisms to protect children, including child protection committees, parenting groups, adolescent clubs, community volunteers, sports and child friendly spaces, and life-skills education groups.

Response to Gender-Based Violence (GBV)

ELIYA, DR CONGO
Focus group for women organised by the Transcultural Psychosocial Organisation Credit: Alioune Ndiaye/OCHA

Gender-based violence has increased throughout the pandemic. Countries in all seven regions (and 24 of 26 GBV Areas of Responsibility) report increased incidence of GBV, including a surge in family disputes and intimate partner violence. There is also evidence of a rise in harmful practices against girls, such as female genital mutilation and child marriage, which have been reported in 15 out of 26 GBV Areas of Responsibility.

To meet this challenge, GBV actors in 40 of 52 GHRP countries (77 per cent) report that GBV services have been maintained or expanded in response to COVID-19. Service providers have adapted existing referral pathways and bolstered community-based protection. Protection staff in countries such as Kenya, Pakistan, South Sudan, and Zambia have created or expanded 24/7 multi-language hotlines that are key entry points for survivors. For example, throughout Colombia, protection partners established 29 information kiosks and GBV focal points providing orientation, case follow-up, psychosocial, and legal support for GBV survivors by phone and email. Many operations like Lebanon have also broadened their network of community outreach volunteers who serve as a safe and trusted means to refer GBV survivors to services. Operations in Zimbabwe and Mozambique distributed SIM cards and phone credit to community mobilisers to ensure survivors have access and referral to vital protection services. Protection actors in Syria are conducting virtual trainings on GBV for community volunteers and hotline staff.

In Afghanistan home-based and door-to-door psychosocial support kits for children and families were accessed by 100,724 people in the first half of this year. In Chad, protection staff mobilized community child-protection networks, preschool teachers, and mother-teacher-associations to conduct door-to-door sensitization of COVID-19. In Bangladesh, Ecuador, Pakistan and Ukraine, procedures for remote case management include assessments and counselling sessions for children. Protection partners in Ukraine increased emergency assistance to unaccompanied and separated children to cover basic needs and rent. In Ethiopia and Ecuador, monitoring of care arrangements continue to take place through phone calls and the mobilization of community volunteers.

While out of school, children are exposed to further risks of armed recruitment and forced labor (reported by 26 Protection Clusters). Therefore, protection partners have been working to ensure education programmes can reach children living in some of the most vulnerable communities.

Many countries are maintaining national education programmes, including for displaced populations, via radio, online, and television. Currently, 645,000 refugee children and youth are out of school due to mandatory school closures. Many of these children are supported with distance/home-based learning. For example, in Mali distance learning for forcibly displaced children is ensured through broadcasting school lessons on national TV and the distribution of 5,500 solar-powered radios for school children. UNHCR Kenya supported pre-recorded locally developed lessons delivered by teachers on radio for primary and secondary school students, while 2,500 secondary school students accessed learning materials in audio, video and print format through WhatsApp.

THE CHALLENGE LIES AHEAD

The pandemic is disproportionately affecting people who were already vulnerable due to their gender, age, disability, displacement status, or belonging to marginalised or discriminated groups. But the real challenge lies ahead. The humanitarian community will now have to respond to the pandemic while lockdowns ease due to socio-economic pressure felt at both household and national levels, increasing the risk of transmission.

Donors have given generously in the fight against COVID-19; however, severe underfunding for protection activities is limiting the capacity to monitor trends and identify interventions for collective protection outcomes. In many countries, such as Cameroon, DRC, Haiti, Mozambique, Myanmar, Niger, Nigeria, Ukraine and Zimbabwe - the Protection Cluster remains severely underfunded which is ultimately weakening the overall response. The humanitarian community will need to invest and sustain investments in protection programming to respond to the documented increase of protection risks as well as impoverishment, unemployment, civil unrest, and other associated impacts of COVID-19 that are on the horizon.

Sectoral focus: Food security

The COVID-19 pandemic is threatening to push millions of people to the verge of starvation. For millions already struggling to cope with the impacts of conflict, climate change, a desert locust upsurge, and economic turbulence, COVID-19 is yet another shock undermining their livelihoods and pushing them towards acute hunger and malnutrition. There is growing evidence demonstrating that essential COVID-19 mitigation measures are exacerbating and amplifying pre-existing vulnerabilities and drivers of acute hunger, with impacts on food security on both the supply and demand sides. People in 27 countries are at risk of significant deteriorating food security in the next six months according to a recent joint FAO-WFP hunger hotspots analysis, with COVID-19 compounding existing vulnerabilities.[4]

Between April and July 2020, Integrated Food Security Phase Classification (IPC) - or Cadre harmonisé (CH) in French - analyses have been undertaken in 11 countries (Afghanistan, Burkina Faso, Burundi, the Central African Republic, Honduras, Madagascar, Mozambique – urban analysis, Nigeria, Somalia, the Sudan and Yemen – partial analysis). In six (Burkina Faso, Central African Republic, Honduras, Nigeria, Somalia and Sudan), a significant deterioration of the food security situation has been observed compared with the 2019 peak. In Burkina Faso, the number of people experiencing crisis or worse levels of acute food insecurity tripled, while the figure rising by 60 to 70 per cent in Honduras, Nigeria, Somalia and the Sudan, and increasing by almost one-third in the Central African Republic. Burkina Faso has, for the first time ever, reported areas classified in Emergency (CH Phase 4) and populations in Catastrophe (CH Phase 5).

Evidence from the field shows that in rural areas, necessary COVID-19 related restrictions may have reduced agricultural production due to limited access to agricultural inputs and labour (as observed for example in Burundi, Central African Republic, Honduras and Sudan), and disrupted seasonal migratory patterns of pastoralist communities (as observed for instance in Burkina Faso, Central African Republic, Nigeria, Somalia, and Sudan).

However, the magnitude of the pandemic's impacts varies widely by country. For example, in the Horn of Africa, the main driver of acute food insecurity remains the desert locust upsurge, while in Afghanistan, a major emerging issue is livestock disease outbreaks, as veterinary services have been halted or slowed by both continued violence and COVID-related restrictions. As a result, in food crisis contexts, it is necessary to address rising humanitarian needs in a way that takes account of existing and other emerging shocks, with the pandemic as one of the drivers of increasing acute hunger.

Funding remains poor for food security interventions, despite widespread recognition of a potential massive food crisis in many vulnerable and highly exposed contexts Food security sector partners have undertaken an extensive reprogramming of pre-existing interventions in order to counter the impact of the pandemic and support the most vulnerable people in continuing to access and produce nutritious food.. Urgent and massively scaled-up assistance is needed now to address the magnitude of the potential crisis. Critical agricultural seasons, livestock movements in search of pasture and water, food harvesting, processing and storage cannot be put on hold. A massive scale up of food and livelihoods assistance – similar to the one made in 2017 to avert famine in northeast Nigeria, Somalia, South Sudan and Yemen – is needed to avert a worst-case scenario and bring millions back from the brink.

[4] An updated analysis and map of hunger hotspots will be published in September in the joint FAO-WFP Early Warning Early Action report.

TRIPOLI, LEBANON
Humanitarian workers fill vans with food parcels and hygiene items. *Paul Assaker/CARE*

PRESERVING AND SCALING UP CRITICAL HUMANITARIAN FOOD, NUTRITION AND LIVELIHOOD ASSISTANCE

An immediate priority has been to ensure that ongoing humanitarian livelihoods assistance and food production among the most vulnerable groups was not affected by the pandemic. Partners have adapted and scaled-up distributions of agricultural inputs and livestock assistance to ensure continuous food production and income generation in the most vulnerable areas.

Between March and July 2020, FAO provided emergency livelihoods assistance to two million households in 34 countries. These were already vulnerable prior to the pandemic. FAO has supported over one million farming households (approximately 6.1 million individuals)[5] with crop and vegetable production inputs to sustain planting seasons and counter pandemic-related challenges linked to labour shortages and limited access to inputs. Livestock assistance (animal health services, fodder, feed) to 800,650 households (approximately 4.6 million people) has been provided, including facilitated access to water, protection of transhumance corridors, and access to markets and information on COVID-19 containment measures among nomadic populations.[6]

WFP is mobilising to meet the needs of up to 138 million people in 2020. Given that cities are bearing the brunt of the COVID-19 crisis (accounting for 90 per cent of cases), more than half of WFP's operations are now scaling up direct assistance in urban areas, some for the first time.

UNDP, in partnership with other agencies, has supported over 2.4 million people through the provision of agricultural seeds/inputs, start-up packages for micro and small businesses recovery, cash for work, training and employment creation in Bangladesh, Colombia, Djibouti, Ecuador, Philippines, Sierra Leone, Sudan, Togo, and Uganda.

ADAPTING ASSISTANCE AND MESSAGING

Assistance programmes have been adapted to safeguard the health and safety of beneficiaries as well as humanitarian staff. This includes using more physical distancing, for example adopting digital alternatives for cash and input provision, as well as alternative food distributions, such as cooked meals, take-home rations and fortified foods.

Alongside these, food security actors are providing COVID-19 sensitization and prevention messaging. In Somalia, existing mobile money platforms have transitioned fully to mobile transfers and expanded to include cash+ livelihoods assistance programmes. Tailoring accurate information and guidance to contain risk transmission for the context of rural farming, fishing and pastoral communities is key. This includes key messaging on COVID-19 prevention for people along the food supply chain including WHO advice on COVID-19 prevention for the public. Ongoing COVID-19 messaging campaigns reached an estimated 3.5 million people between March and July 2020.

MINIMIZING INTERRUPTIONS TO CRITICAL FOOD SUPPLY CHAINS AND ENSURING THE FUNCTIONING AND RESILIENCE OF AGRI-FOOD SYSTEMS

The proper functioning of market chains and the flow of agricultural products are key factors influencing food security and nutrition. Primary and secondary data being collected indicates that food processing, storage, marketing and transport are being particularly affected by COVID-19 risk containment measures. Post-harvest losses especially among small-scale producers are increasing due to reduced capacities of storage and processing facilities, limitations with transport and access to national and international markets. Fruits, vegetables, milk and meat products are particularly affected. In Afghanistan, local traditions are being combined with modern tech-

[5] An estimated 2.4 million women benefit from FAO's crop and vegetable production support.

[6] An estimated 1.96 million women are among those benefitting from FAO's livestock support. Among these households, 45,463 (representing approximately 225,582 people) also received cash as part of FAO's Cash+ approach.

Story from the field

AFGHANISTAN

FAO'S poultry training projects specifically targeted women.

As essential COVID-19 containment measures were rolled out in Afghanistan, businesses struggled to continue and many workers found themselves without a source of income. With no social safety net, many families faced serious constraints in accessing enough food and meeting basic needs.

Hafizullah, a carpenter in Ghor province with seven children, found himself wondering how to cope. FAO and a local partner run a project that focuses on enabling vulnerable women-headed families to bolster their incomes through poultry and vegetable production. This created an opportunity to support local artisans and Hafizullah was contracted to produce doors and windows for the chicken coops that would be distributed to the women, enabling him to cope with the lockdown and building closer links between the women-headed households and their community. "I was very concerned about how I can continue to feed my family during the lockdown, but with the help of this project, I was able to survive the most difficult times. FAO helped me to sustain my business during the COVID-19 crisis", he said.

niques to build local capacity for food processing, while constructing cold storage, zero energy storage units and warehouses to safely store local produce. In Sierra Leone, women farmers and youth are being trained on processing and preservation of vegetable and fruits and marketing; and negotiating market corridors for women during COVID-19 lockdowns.

SUPPORTING GOVERNMENTS TO REINFORCE AND SCALE UP SOCIAL PROTECTION SYSTEMS AND STRENGTHENING BASIC SERVICE DELIVERY

To effectively mitigate the socio-economic impacts of COVID-19, action to realize the Grand Bargain commitments to improve the effectiveness of humanitarian response and 'leave no one behind' is vital. Partners have been advocating and acting on the scale up of the use of cash where appropriate, in both the humanitarian and social protection response, to meet the needs of people affected by COVID-19 and in particular in the rural areas. Since March, FAO has supported over 1.1 million people (47 per cent of whom are women) with cash-based assistance. FAO used the Cash + approach to support 50 per cent of these. WFP's support to governments to provide cash-based transfers include a program in Ethiopia to reach 17,500 people; activities in Nairobi, Kenya to aid 279,000 people living in informal settlements; and assistance for 180,000 food-insecure and vulnerable people living in disadvantaged, high-density, and low-income urban and peri-urban areas across Zambia.

REACHING EXCLUDED GROUPS AND TAKING INTO ACCOUNT THE SPECIFIC IMPACT OF COVID-19 ON WOMEN AND GIRLS

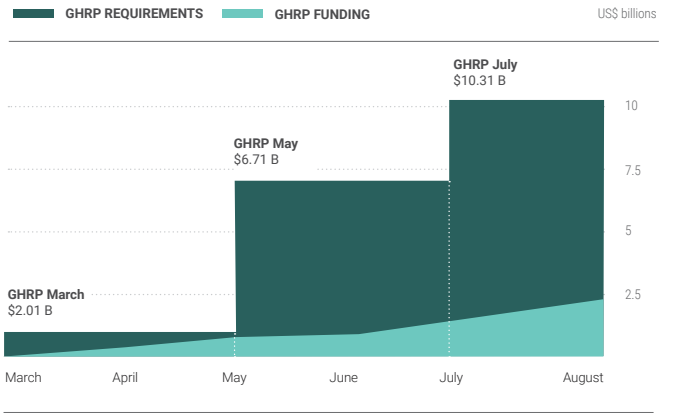
The Colombian department of La Guajira has one of the highest incidences of poverty in the country and local populations have been hosting a growing number of returnees and migrants from Venezuela. With Wayúu families reliant on the sale of artisan products in local markets for their incomes, the existing support to the community was adapted to move the Wayúu market online, enabling more than 79 artisan workshops to continue generating an income and meeting their families' needs despite containment measures. In West Africa, FAO has launched a "household basket" initiative with UN Women and UNFPA, which aims to bring together producers (especially women's cooperatives) who cannot sell their food products because of restrictions related to COVID-19 and households that are facing food and nutritional insecurity, especially those headed by women. In Nepal, WFP is supporting UN Women to provide cash transfers to 600 female-headed households from vulnerable and marginalized groups in response to COVID-19.

Financial overview

GHRP REQUIREMENTS (US$)
10.31 B

FUNDING (US$)
2.36 B

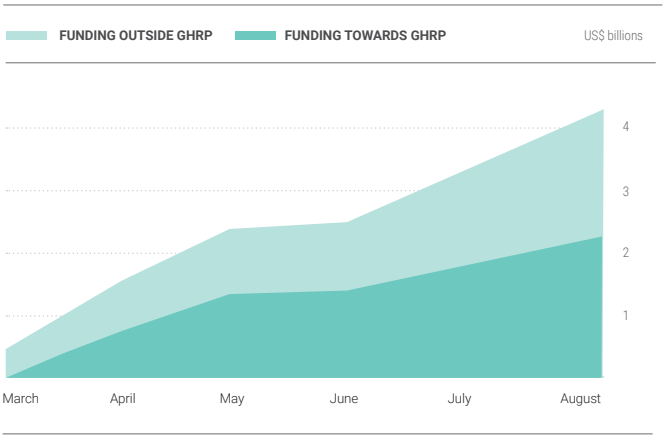
COVERAGE
23%



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

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

OF WHICH:
Towards GHRP 2.36 B
Outside GHRP 1.98 B



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

Funding towards the GHRP and COVID-19 response has been generous, yet insufficient to meet the needs of the most vulnerable people in countries in crisis. Swift donor action at the onset of the pandemic resulted in large amounts of announced funding in March and April. Reports on new funding have slowed significantly, despite the increased requirements and alarming evolution of the pandemic, especially in the world's poorest and most fragile countries. Access constraints, market closures, lockdowns and movement restrictions challenged national and international humanitarian partners, however, the funding provided made it possible to continue COVID-19 and non-COVID-19 humanitarian responses in most areas.

As of 31 August, funding for the GHRP requirements, including the financial needs for 63 countries, is $2.36 billion, or 23 per cent, leaving $7.96 billion of requirements unmet. This is $940 million more than reported in the first GHRP Progress Report at the end of June. Coverage varies widely by country, with over half of the country response plans funded less than the 23 per cent global average, leaving significant gaps. The global operational support requirements of $1.03 billion are only 22 per cent funded. Funding for the GHRP makes up more than 20 per cent of all humanitarian funding reported to date in 2020.

An additional $1.98 billion of humanitarian funding has been reported for bilateral support directly to Governments, funding to the Red Cross / Red Crescent Movement, and funding to UN agencies and NGOs not towards GHRP countries, including more than $500 million to WHO's Strategic Preparedness Response Plan and Contingency Fund for Emergencies which covers countries beyond those identified in the GHRP. Some of this funding has been provided flexibly to organisations and may eventually be recorded against the GHRP requirements as projects are implemented and more details are received.

As seen above, there is disparity among regions in terms of funding for GHRP requirements, with the most serious shortfall in Latin America and the Caribbean, with an average of only 11 per cent covered, despite the tremendous increase in cases in this region. GHRP coverage in South and East Africa (16 per cent) is also significantly below the global average of 23 per cent.

The cost of not taking extraordinary measures to fully fund the planned response is high. Without sustained financial and political commitment to fund the GHRP and coordinated humanitarian action, vulnerable groups will continue to be hit hardest, including older persons, IDPs and refugees, women and girls and persons with disabilities.

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

REGION	GHRP REQUIREMENTS	FUNDING	COVERAGE	COVID-19 TOTAL FUNDING	% OF TOTAL FUNDING TOWARDS GHRP
Asia and Pacific	**1.15 B**	313.6 M	27%	**436.8 M**	72%
Eastern Europe	**46.9 M**	22.3 M	48%	**29.1 M**	77%
Latin America and Caribbean	**1.05 B**	114.2 M	11%	**119.3 M**	96%
Middle East and North Africa	**2.22 B**	527.8 M	24%	**590.2 M**	89%
South and East Africa	**2.99 B**	470.2 M	16%	**546.9 M**	86%
West and Central Africa	**1.03 B**	254.2 M	25%	**300.1 M**	85%

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

Funding per appeal (1/2)

INTER-AGENCY APPEAL		GHRP REQUIREMENTS	FUNDING	COVERAGE	GHO REQUIREMENTS	FUNDING	COVERAGE
Afghanistan	HRP	**395.7 M**	109.1 M	28%	**1.13 B**	330.9 M	29%
Burkina Faso	HRP	**105.9 M**	38.6 M	37%	**424.4 M**	146.0 M	34%
Burundi	HRP	**38.0 M**	9.6 M	25%	**197.9 M**	59.2 M	30%
Cameroon	HRP	**81.7 M**	23.0 M	28%	**390.9 M**	100.7 M	26%
CAR	HRP	**152.8 M**	39.5 M	26%	**553.6 M**	209.7 M	38%
Chad	HRP	**124.2 M**	22.5 M	18%	**664.6 M**	195.0 M	30%
DRC	HRP	**274.5 M**	93.0 M	34%	**2.07 B**	472.0 M	23%
Ethiopia	HRP	**506.0 M**	72.2 M	14%	**1.65 B**	452.6 M	27%
Haiti	HRP	**144.4 M**	23.6 M	16%	**472.0 M**	74.0 M	16%
Iraq	HRP	**264.8 M**	77.3 M	29%	**662.2 M**	250.7 M	38%
Libya	HRP	**46.7 M**	26.8 M	57%	**129.8 M**	110.9 M	85%
Mali	HRP	**75.4 M**	32.0 M	43%	**474.3 M**	166.2 M	35%
Myanmar	HRP	**58.8 M**	31.0 M	53%	**275.3 M**	112.3 M	41%
Niger	HRP	**82.3 M**	19.2 M	23%	**516.1 M**	195.6 M	38%
Nigeria	HRP	**242.4 M**	56.7 M	23%	**1.08 B**	353.6 M	33%
oPt	HRP	**42.4 M**	33.9 M	80%	**390.4 M**	184.5 M	47%
Somalia	HRP	**225.6 M**	55.3 M	25%	**1.01 B**	565.5 M	56%
South Sudan	HRP	**387.3 M**	67.3 M	17%	**1.90 B**	616.0 M	32%
Sudan	HRP	**283.5 M**	87.8 M	31%	**1.63 B**	714.9 M	44%
Syria	HRP	**384.2 M**	107.4 M	28%	**3.82 B**	1.47 B	38%
Ukraine	HRP	**46.9 M**	24.2 M	52%	**204.7 M**	60.2 M	29%
Venezuela	HRP	**87.9 M**	19.5 M	22%	**762.5 M**	61.9 M	8%
Yemen	HRP	**385.7 M**	77.7 M	20%	**3.38 B**	811.0 M	24%
Zimbabwe	HRP	**85.0 M**	19.0 M	22%	**800.8 M**	151.2 M	19%
Burundi Regional	RRP	**65.4 M**	9.6 M	15%	**275.4 M**	22.9 M	8%
DRC Regional	RRP	**155.7 M**	10.3 M	7%	**638.7 M**	29.9 M	5%
Nigeria Regional	RRP	**-**	-	-	**-**	-	-
South Sudan Regional	RRP	**128.8 M**	12.7 M	10%	**1.34 B**	64.0 M	5%
Syria Regional	3RP	**758.3 M**	113.2 M	15%	**6.00 B**	1.32 B	22%
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**	38.7 M	9%	**1.41 B**	297.2 M	21%
Rohingya Crisis	Other	**181.4 M**	50.0 M	28%	**1.06 B**	477.5 M	45%

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 (2/2)

INTER-AGENCY APPEAL		GHRP/GHO REQUIREMENTS	FUNDING	COVERAGE
Benin	COVID	**17.9 M**	0.1 M	**1%**
Colombia	COVID	**329.4 M**	23.9 M	**7%**
DPR Korea	COVID	**39.7 M**	1.8 M	**5%**
Iran	COVID	**117.3 M**	56.8 M	**48%**
Lebanon	COVID	**136.5 M**	40.6 M	**30%**
Liberia	COVID	**57.0 M**	2.6 M	**5%**
Mozambique	COVID	**68.1 M**	12.9 M	**19%**
Pakistan	COVID	**145.8 M**	63.8 M	**44%**
Philippines	COVID	**121.8 M**	11.4 M	**9%**
Sierra Leone	COVID	**62.9 M**	8.9 M	**14%**
Togo	COVID	**19.8 M**	2.7 M	**14%**
Bangladesh Intersectoral	COVID	**205.9 M**	47.1 M	**23%**
Djibouti Intersectoral	COVID	**30.0 M**	2.9 M	**10%**
Ecuador Intersectoral	COVID	**46.4 M**	8.5 M	**18%**
Jordan Intersectoral	COVID	**52.8 M**	–	**–**
Kenya Intersectoral	COVID	**254.9 M**	17.8 M	**7%**
Rep. Of Congo Intersectoral	COVID	**12.0 M**	8.3 M	**69%**
Tanzania Intersectoral	COVID	**158.9 M**	2.9 M	**2%**
Uganda Intersectoral	COVID	**200.2 M**	7.2 M	**4%**
Zambia Intersectoral	COVID	**125.6 M**	13.3 M	**11%**
Famine prevention Global	COVID	**500.0 M**	–	**–**
NGO envelope Global	COVID	**300.0 M**	3.9 M	**1%**
Support services Global	COVID	**1.03 B**	228.5 M	**22%**
TOTAL		**10.31 B**	**2.36 B**	**23%**

GHRP funding not yet identified for a specific activity or country response plan: $389.8 M

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

fts Financial Tracking Service

Funding the response: Flexible and unearmarked funding

Early in the pandemic, it was recognized that flexibility, timeliness, and ensuring that frontline responders had the funding and materials they needed were essential for the COVID-19 response. This was important for preparedness, anticipatory actions and actual response on a global scale in a rapidly shifting operational context. UN agencies and NGOs have worked closely to develop the IASC Proposal for a Harmonized Approach to Funding Flexibility in the Context of COVID-19 (30 June) and the IASC Proposals to Address the Inconsistency in Unlocking and Disbursing Funds to NGOs in COVID-19 Response (20 July). These documents outline the compelling reasons why flexible funding and timely pass-through from UN agencies to NGOs is crucial, not only for the immediate response, but also in line with the long-term commitments outlined in the Grand Bargain to improve efficiency and effectiveness of humanitarian aid, to deliver flexible and unearmarked funding, and to increase funding to frontline actors.

According to a survey of seven UN agencies, the amount of flexible (unearmarked and softly earmarked) support from donors for the COVID-response has varied widely. Flexible funding as a per centage of total COVID-19 funding received between 1 March and 31 July varies from 12 per cent to 65 per cent, with an average of 37 per cent.[7] This is less than the 42 per cent average previously reported for the 1 March to 31 May period.

Flexibility regarding where and how to use resources has been advantageous in many ways. **UNFPA** used flexible funding to prioritize PPE needs and logistics management as the crisis evolved. This allowed the agency to allocate resources globally based on needs, rather than relying solely on contributions earmarked at the country level. Flexible funding was also used to transport PPE and other life-saving supplies with minimal delays, overcoming logistics bottlenecks caused by the pandemic at the international and national levels.

In the Democratic Republic of Congo, when COVID-19 first hit the country, **UNICEF** recognized the likely devastating impact of the virus on the country's public health services, and the potentially lethal repercussions for children. Flexible resources allowed the rapid procurement of PPE and diagnostic test kits to support field health teams that were at extreme risk. The frontline teams were able to continue delivering vital services in clinics and communities across the country. Although critical, flexible funding has not come at scale to meet all the gaps. Flexible humanitarian funding has been beneficial for investment in preparedness and has ensured the continuation of many critically underfunded programmes for children, including nutrition, health, child protection, WASH and education.

WFP has used the flexible funding that had earlier been donated to its Immediate Response Account (IRA) to sustain underfunded operations and meet new, unforeseen needs. Given the global scale of the crisis and response, this has meant that WFP could shift the areas of focus to follow the epidemiological curve and evolving partner requirements. In addition, flexible funding has supported global common services which provide critical transport and logistics services for the humanitarian and wider health response. Through the common services, WFP has complemented partners' logistics capabilities, making critical COVID-19 items available across the globe.

[7] The actual per centages are 52, 71, 89, 95, 98 and 100.

GOLONGOLONG, NIGERIA
Local NGO delivers water to internally displaced people who fled their homes. *OCHA/Eve Sabbagh*

Timely, flexible funds have been used to support **IOM** operations in countries such as Bangladesh, Mali and Somalia where the pandemic has exacerbated existing humanitarian need. Flexible funds also allowed IOM's country offices to change programme activities during the implementation period when necessary.

Contributions to **FAO**'s Special Fund for Emergency and Rehabilitation Activities (SFERA), specifically the funding window on Early Warning Early Action, allowed FAO to quickly allocate funding to country-based assessments in Afghanistan, Burkina Faso, Colombia, Iraq, Liberia, Mali, Sierra Leone, Somalia, Sudan, and Zimbabwe, and reinforce country teams in Chad, Cameroon, DRC, and Haiti. This flexible funding instrument also supported risk communication and efforts to prevent the spread of COVID-19 along the food chain in Afghanistan, Bangladesh, Colombia, Haiti, Iraq, Pakistan, the Sahel, Sudan, and Yemen.

UNHCR's rapid response was made possible by the unearmarked contributions of several donors, which enabled it to allocate funds to the operations most in need, and to scale up response according to strict protocols and via remote registration to access protection and services. Similarly, flexible funding has allowed WHO to fill critical geographic and programmatic gaps. For example, in **WHO**'s AFRO region, as a result of earmarking, some 70 per cent of the current funding received is directed to only 12 countries in Africa, spreading the remaining 30 per cent of the funds very thinly across the remaining 35 countries. Flexible funding has helped ensure a more equitable allocation of funding across the region.

Seven UN agencies also reported that an average of 62 per cent of their flexible funding has been or will be allocated to countries in the GHRP.[8] The remainder was used for global procurement and transport of supplies, of which a large portion has gone to GHRP countries.

The quantity and speed at which funding is cascading from UN agencies to frontline NGO and Red Cross/Red Crescent partners are long-standing issues that took center stage in humanitarian financing discussions at the onset of the pandemic. The aforementioned IASC guidance on these subjects outlined steps to quickly increase the flow of funding from UN agencies to NGOs as directly as possible (cascading). To ensure timely passthrough of resources through UN agencies, the guidance suggested several concrete measures to improve cascading, including no-cost extensions, simplified procedures for release of funding, budget flexibility and, where possible, cost-extensions to expand the scope of existing programming. As a concrete example, UNHCR introduced flexibility measures for the COVID-19 response to enable partners to implement business continuity plans and make the necessary adjustments to their programmes and operations, including accelerated release of financial installments, no-cost extensions, reduced reporting requirements, and the option for digital signatures.

According to five of the UN agencies responding to the August survey, on average, 19 per cent of the total funding received for the COVID-19 response, including flexible funding, will be implemented by NGOs and/or Red Cross / Red Crescent National Societies. For two agencies, this is higher than the annual average. For one agency, cash / grant pass-through funding is less than average mainly due to large sums of in-kind materials being procured and distributed to international and national partners. While it is difficult to accurately measure the speed at which funding is being made available to partners due to varying finance modalities, three agencies reported an average of 30 days, and one reported 14 days.

Despite the concrete progress made since the beginning of the pandemic, there is clearly more research, guidance and policy work to be done regarding flexible and cascading funding. At this time of record high humanitarian needs, donors and recipients are encouraged to swiftly provide more complete and transparent reporting to the Financial Tracking Service to improve the tracking of second and third tier funding flows from UN agencies to NGOs, with a special consideration to disaggregating funding allocated to national and local NGOs. This would lead to a better understanding of whether the COVID-19 response is being adequately resourced at appropriate levels and allow for early identification of blockages so that these can be quickly addressed. Next month's GHRP Progress Report will continue to explore these issues and will focus on the NGO experience and perspective.

[8] The actual per centages for individual agencies are 30, 52, 71, 89, 95, 98 and 100.

Pooled Funds
CERF and CBPFs

TOTAL ALLOCATIONS (US$)	CERF ALLOCATIONS (US$)	CBPF ALLOCATIONS (US$) [9]	COUNTRIES
309M	134M	175M	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]

42.7M

OF WHICH :
Men 11.2 M
Women 12.9 M
Boys 9.1 M
Girls 9.5 M

OCHA's pooled funds to date have allocated $309 million in 49 countries contexts supporting humanitarian partners in their response to the COVID-19 pandemic including both new allocations and reprogrammed funding.

SUPPORT TO NGOS

The Country-Based Pooled Funds and the Central Emergency Response Fund have provided substantial support to NGOs to kick start life-saving activities. **Together, pooled funds have allocated around $152 million** to international and national NGOs, Red Cross/Red Crescent national societies and other partners.

While some initial CBPF allocations supported UN agencies for bulk procurement of medical and protective equipment in liaison with national health authorities, NGOs have swiftly moved to the centre of CBPFs response to the pandemic, with 67% of funding allocated to NGOs to date.

A first-ever CERF allocation of $25 million to NGOs via IOM reached 24 NGOs - one third of which are national NGOs. The allocation supports the implementation of 26 projects which target 1.27 million people in six countries: Bangladesh, Central African Republic, Haiti, Libya, South Sudan and Sudan. CERF funding focuses on two sectors critical to the COVID-19 response: health (including mental health and psychosocial support) and water, sanitation and hygiene. Projects include a strong consideration of gender issues, including gender-based violence, and people with disabilities.

FUNDING (US$)	COUNTRIES	PROJECTS	NGOs	PEOPLE TARGETED
25M	6	26	24	1.27M

SPEED OF RESPONSE

OCHA's pooled funds disbursed resources quickly to ensure a time-critical response. This funding allowed humanitarian organizations to start activities as early as 3 February. By the launch of the GHRP, CERF and CBPFs had released $79.4 million.

CBPFs have typically completed allocation processes within a month, and initiated disbursements within 7 days of concluding grant agreements.

IMPACT OF POOLED FUNDS

Together CBPFs and CERF have enabled humanitarian actors to deliver interventions at scale in key sectors including health, WASH and protection, and GBV.

Health-awareness campaigns and risk communication activities funded by both CERF and CBPF **have reached over 20 million people**, and over 4 million units of p**ersonal protective equipment, health kits and medical supplies** have been delivered.

With CERF funding, UN agencies and their partners have provided **critical water supplies and hygiene kits** to 2.3 million people, supported **home-based learning** for over 5 million children, and provided **sexual and reproductive healthcare** to 287,000 women and girls.

Ongoing CBPFs allocations plan to provide **safe water, good hygiene and improved sanitation access** to around 8.8 million people and aim to deliver essential **protection services** to 1.7 million people (medical and psychosocial services, emergency assistance packages, legal assistance, and protection awareness campaigns).

[9] $175.3 million has been allocated to humanitarian partners, of which $15.4M is under review for final approval.
[10] Includes people indirectly targeted, e.g. via information campaigns.
[11] Figures for people targeted may include double counting as same people may receive assistance from multiple cluster/sectors/projects.

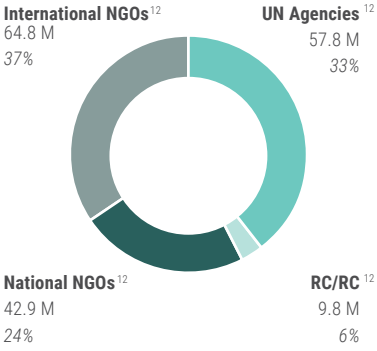
CBPFs ALLOCATIONS PER PARTNER

NO. PARTNERS
294

NO. PROJECTS
513

TOTAL ALLOCATIONS (US$)
175 M

OF WHICH: TO NGOs
67%



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*	13.7 M

TOTAL CONTRIBUTIONS TO CERF AND CBPFs

TOTAL CONTRIBUTIONS (US$)
1.18 B

OF WHICH :
TO CERF 512.4 M
TO CBPF 667.0 M

DONORS
60

TOP 10 DONORS	CONTRIBUTIONS TOTAL	CERF	CBPFs
Germany	**282.2 M**	113.4 M	168.8 M
United Kingdom	**159.8 M**	12.6 M	147.2 M
Sweden	**150.1 M**	84.4 M	65.7 M
Netherlands	**136.8 M**	89.4 M	47.4 M
Norway	**83.8 M**	50.3 M	33.5 M
Belgium	**72.7 M**	24.3 M	48.4 M
Canada	**52.6 M**	22.5 M	30.1 M
Denmark	**50.7 M**	25.2 M	25.5 M
Switzerland	**43.3 M**	24.0 M	19.3 M
Ireland	**42.3 M**	11.4 M	30.9 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.

[12] Includes funds provided to humanitarian organizations either as a primary recipient or as a sub-grantee (some organizations may sub-grant part of their funding budget to another organization).

Story from the field

SARAROGHA, PAKISTAN
Screening activity in Sarorogha, Pakistan. Credit: EHSAR

The Education Health Social Awareness Rehabilitation Foundation (EHSAR) is supporting the outpatient departments at three health facilities in Pakistan's South Waziristan District. With funding from the Pakistan Humanitarian Pooled Fund (PHPH), the Foundation carries out free medical consultations and provides much-needed medication to hundreds of patients every day.

When Pakistan declared a health state of emergency and lockdown due to COVID-19 in March, local authorities closed all outpatient departments across the district. EHSAR was quick to adapt and re-program its activities, thanks to arrangements put in place by the PHPF to support flexible response.

ESHAR was able to provide immediate, tangible support through public information campaigns and the provision of personal protective equipment (PPE), soap, masks, sanitizer and gloves, in close liaison with relevant local health departments. Along with the provision of two well-equipped ambulances, this ensured capacity to respond to COVID-19 and other critical health emergencies.

The PHPF is one of OCHA's 18 Country-based Pooled Funds (CBPFs) supporting NGOs and local partners to reach people in need as a result of the COVID-19 pandemic. The Funds have long-standing partnerships with national and international NGOs, which has expedited the prioritization and allocation of funds for front line activities.

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/COVID19.

POOLED FUNDS ALLOCATIONS BY COUNTRY

COUNTRY / POOLED FUND	TOTAL ALLOCATIONS	OF WHICH: CERF	UN AGENCIES	INT'L NGOs	NAT'L NGOs	OF WHICH: CBPFs [13]	UN AGENCIES	INT'L NGOs	NAT'L NGOs	RC/ RC[9]
Global Logistics	42.1 M	**42.1 M**	42.1 M	–	–	**–**	–	–	–	–
Afghanistan	33.1 M	**2.6 M**	2.6 M	–	–	**30.6 M**	12.1 M	15.8 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	14.2 M	**6.8 M**	1.8 M	5.0 M	–	**7.4 M**	1.7 M	4.6 M	1.0 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	5.2 M	**1.1 M**	1.1 M	–	–	**4.1 M**	2.4 M	1.5 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	12.0 M	**0.7 M**	0.7 M	–	–	**11.2 M**	1.9 M	9.0 M	0.3 M	–
Jordan	8.1 M	**2.4 M**	2.4 M	–	–	**5.7 M**	0.3 M	3.0 M	2.1 M	0.3 M
Lebanon	15.2 M	**6.6 M**	6.6 M	–	–	**8.6 M**	0.1 M	3.8 M	4.7 M	–
Lesotho	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	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	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Niger	1.7 M	**1.7 M**	1.7 M	–	–	**–**	–	–	–	–
Nigeria	8.8 M	**1.9 M**	1.9 M	–	–	**6.7 M**	3.7 M	2.6 M	0.4 M	–
oPt	7.1 M	**0.9 M**	0.9 M	–	–	**6.2 M**	5.0 M	0.9 M	0.3 M	–
Pakistan	4.2 M	**1.3 M**	1.3 M	–	–	**2.9 M**	0.4 M	–	2.5 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	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	20.2 M	**9.3 M**	6.2 M	2.6 M	0.4 M	**11.0 M**	4.5 M	5.5 M	1.0 M	–
Syria	24.4 M	**1.8 M**	1.8 M	–	–	**22.6 M**	14.1 M	4.6 M	2.9 M	1.0 M
Syria Cross Border	26.1 M	**0.4 M**	0.4 M	–	–	**25.7 M**	5.4 M	4.0 M	8.1 M	8.1 M
Tanzania	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Uganda	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Ukraine	4.8 M	**0.9 M**	0.9 M	–	–	**3.9 M**	0.1 M	2.3 M	1.5 M	–
Uzbekistan	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Venezuela	4.4 M	**4.4 M**	4.4 M	–	–	**–**	–	–	–	–
Venezuela Regional	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Yemen	0.3 M	**–**	–	–	–	**0.3 M**	–	0.1 M	0.1 M	–
Zambia	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Zimbabwe	1.1 M	**1.1 M**	1.1 M	–	–	**–**	–	–	–	–
TOTAL	**309.0 M**	**133.7 M**	**110.8 M**	**18.2 M**	**4.7 M**	**175.3 M**	**64.1 M** [15]	**69.6 M** [16]	**31.7 M** [17]	**9.8 M**

[13] This table includes funds provided to humanitarian partners as primary recipients only. See p.17 for global levels inclusive of sub-grants.
[14] Red Cross / Red Crescent
[15] UN Agencies received $64.1 million as primary recipients, and sub-granted $6.3 million to other humanitarian organizations. See p.18 for funding inclusive of sub-grants.
[16] International NGOs received $69.6 million as primary recipients, before sub-granting part of their budget to local partners, and before receiving sub-grants from UN Agencies as their sub-implementing partners. See p.18 for funding inclusive of sub-grants (total: $64.8 million).
[17] National NGOs received $31.7 million as primary recipients, before receiving some sub-grants from other organizations as their sub-implementing partners. See p.18 for funding inclusive of sub-grants (total: $42.9 million).

Progress of the response: **Strategic Priorities**

GHRP STRATEGIC PRIORITIES

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

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

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

Since the last update of the GHRP, humanitarians have continued to work to mitigate the spread of COVID-19 despite the increasing numbers of reported infections and ongoing challenges due to mobility restrictions. The vast majority of GHRP countries have a functional, multisectoral, multi-partner coordination mechanism in place. However, funding shortfalls and travel restrictions continue to be two of the greatest impediments to programmes outlined in the GHRP.

This section summarizes progress against the targets set in the GHRP Monitoring Framework, providing narrative to illustrate changes in targets and nuanced examples, as well as the monitoring framework itself with quantitative reporting against indicators as provided by agencies. Indicators show cumulative values since the launch of the GHRP (25 March – mid-August), while the narrative concentrates on updates since the launch of the GHRP July update (mid-July – mid-August). The response monitoring results reflect progress as tracked per the indicated responsible agency. NGOs and clusters were also invited to report against these indicators (as appropriate to their operations) and where material was provided, it has been included in the monitoring framework and/or the narrative. IASC partners are exploring ways to improve reporting against strategic priorities by better capturing the full breadth of collective efforts. This monitoring data will continue to be provided in the subsequent September and October Progress Reports.

CARACAS, VENEZUELA
A plane carrying 90 tons of medical and water, sanitation and hygiene supplies for the COVID-19 response arrives in Venezuela. *UNICEF*

Progress of the response
Strategic Priority 1

INFECTION PREVENTION AND CONTROL AND COMMUNITY OUTREACH

Since the onset of the pandemic, 220,814 health workers have been trained in infection prevention and control and 729,429 health workers have been provided with personal protective equipment (PPE). These interventions have been accompanied by provision of clear guidelines on the use of PPE. IOM has continued to work with health actors and authorities to facilitate isolation, physical distancing and, where appropriate, quarantine. This includes repurposing existing health facilities to become isolation and treatment facilities in displacement sites. Fifty-nine GHRP countries have developed costed water, sanitation and hygiene (WASH) plans and are providing essential WASH supplies, including hygiene items, to help protect populations and reduce the risk of disease transmission. UNICEF and partners globally are working to ensure that all WASH facilities and interventions are gender sensitive and inclusive of persons with disabilities.

Over one billion people in 59 GHRP countries have been reached with COVID-19 messaging on prevention and access to services since the onset of the pandemic. Multiple platforms are being leveraged, including traditional media (television and radio), social media, and announcements through megaphones and mosques, to reach people with locally and culturally appropriate messages. National communication campaigns have been rolled out, reaching 8.3 million caregivers of children under two years old with messages on the importance of breastfeeding, advice on young child feeding, and healthy diets.

The Emergency Telecommunications Cluster (ETC) worked to support vital communications services, particularly for the health response. In Bangladesh, the ETC is coordinating the provision of data connectivity services in 20 treatment centres. In Central African Republic and Libya, call centres established and managed by the ETC, in partnership with national authorities, provide support and advice on COVID-19-related issues. And in Yemen, the ETC has extended its internet connectivity services to all designated quarantine centres.

EMERGENCY CARE AND PROVISION OF SUPPLIES

The COVID-19 outbreak has led to shortage of essential supplies, including personal protective equipment, diagnostics, and materials for clinical management. WHO has shipped 57 million masks to 56 countries as of 17 August. Over three million diagnostic sample kits have been delivered, along with increased supplies of biomedical items, including oxygen concentrators, infrared thermometers and adult and pediatric oxygen masks. IOM has also dispatched PPE, thermometers, hand sanitizers, surgical masks, sterile gloves, and other protective equipment to targeted countries. The Emergency Global Supply Chain System catalogue[18] was updated on 10 August, listing all medical devices that may be requested through the COVID-19 Supply Portal. In total, UNHCR has delivered some 250 metric tons of PPE and medical equipment to GHRP countries. This includes 12 metric tons of hospital tents and the procurement of 2,000 oxygen concentrators and 1.4 million gowns.

In Brazil, the hospital ship "Solidarity", operated by World Vision and the Presbyterian Church of Manaus, is reaching the most remote communities in the Amazon region with urgent medical care and hygiene supplies.

Sixty-seven per cent of GHRP countries have now established a working group on mental health and psychosocial support (MHPSS). An inter-agency rapid deployment mechanism of country-level MHPSS Coordinators has been initiated. The IASC has also launched a new website compiling all MHPSS resources.

GENDER-BASED VIOLENCE (GBV) AND PREVENTION OF SEXUAL EXPLOITATION AND ABUSE (PSEA)

COVID-19 has increased risks associated with gender-based violence. UNFPA, alongside IASC partners, is working closely with field networks to adapt existing reporting channels and ensure referral pathways are updated and functioning. Since the onset of the pandemic, 6.9 million children and adults have been provided with a safe place and accessible channels to report sexual exploitation and abuse.

To strengthen the capacity of country offices and ensure PSEA remains core to the COVID-19 response, UNFPA developed a five-point checklist for PSEA Focal Points and Managers. UNFPA has also supported the development of communications materials on PSEA that have been adapted to the COVID-19 context, e.g. in Nigeria, UNFPA has developed audio clips/podcasts to adapt training modules. UNFPA, UNICEF and the IASC Secretariat hosted a webinar for PSEA coordinators/networks from 32 high-risk countries on measurement of PSEA in the COVID-19 context.

OVERCOMING MOVEMENT RESTRICTIONS

COVID-19 continues to affect global mobility in complex and unprecedented ways. IOM regularly updates the mobility database to map, track and analyze the impact of the COVID-19 pandemic on Points of Entry (POE) and other key locations. As of 8 August, IOM had assessed 3,835 POEs (including 936 airports, 2,302 land border crossing points and 597 blue border crossing points) in 173 countries and territories. IOM also conducted multi-sectoral assessments at POEs with national authorities in Burkina Faso, Burundi, Cameroon and Sudan.

GLOBAL SUPPORT SERVICES

WFP established air passenger services to transport health and humanitarian personnel into affected countries where safe and reliable commercial operations are not available. The passenger service launched on 1 May has reached 60 destinations throughout Africa, Asia and the Middle East. As of 30 August, WFP had transported 21,177 health and humanitarian personnel on behalf of 325 organisations during 1,183 flights. Of those, 9,390 are NGO partners (44 per cent). This represents 97 per cent of the passenger movement requests received.

WFP established the planned network of eight humanitarian response hubs to facilitate cargo movement on a free-to-user basis.[19] As of 19 August, 35,350 m^3 of COVID-19 response items and other humanitarian cargo have been moved as part of the free-to-user services, reaching 153 countries on behalf of 41 organisations through 643 flights.

[18] www.who.int/publications/i/item/emergency-global-supply-chain-system-(covid-19)-catalogue

[19] The hubs are located in Guangzhou (China), Liege (Belgium), Dubai (UAE), Panama City, (Panama), Kuala Lumpur (Malaysia), Johannesburg (South Africa), Accra (Ghana), and Addis Ababa (Ethiopia).

To ensure the wellbeing of health and humanitarian personnel and to minimise the burden on host country healthcare systems, the UN Secretary-General activated a common COVID-19 Medical Evacuation (MEDEVAC) System on 22 May. MEDEVAC services are available for all UN staff and eligible dependents worldwide, and all staff of eligible international NGO partners and their eligible dependents in countries covered under the Global Humanitarian Response Plan. As part of this system, WFP has access to a global network of contracted air ambulances which have carried out 39 evacuations on behalf of humanitarian personnel worldwide as of 19 August.

IOM entered into an agreement with the UN Department of Operational Support (DOS) to provide critical health services to eligible UN personnel, dependents, and other persons referred by the UN. The Medical Health Assessment Clinics will operate in 20 locations[20] initially and will provide a wide range of services for COVID-19 patients and other non-COVID-19 conditions.

Progress of the response
Strategic Priority 2

GENDER-BASED VIOLENCE (GBV)

Results of UNFPA's GBV survey showed that, in general, GBV services (in-person and/or remote), have been maintained with fewer disruptions than in the previous reporting period thanks to improved remote modalities.[21] In Pakistan, tele-psychosocial services have been provided, with special focus on GBV. In the Dominican Republic, continuity of GBV care services was achieved by expanding access through telephone lines, mail and messaging. In Somalia, psychosocial assistance and referrals are provided in quarantine sites for returning international migrants. IOM has adapted its GBV prevention and response efforts to recognize and address the impact of COVID-19 on women and girls, specifically. For example, in Cox's Bazar, Bangladesh, men and boys have been engaged in a curriculum on equal gender roles during COVID-19, which promotes their participation in maintaining and upholding sanitation and hygiene processes, as well as in shouldering care and domestic responsibilities. UNHCR also supported the creation of safe spaces such as in Arauca, Colombia where a new protection space serves pregnant and breastfeeding women, as well as survivors of sexual violence. Over 500 pregnant and breastfeeding women have benefitted and numerous other GBV cases were identified and referred to safe houses for assistance.

Despite GBV services remaining largely in place, some countries saw a substantial decrease in the uptake of services (in Ethiopia, for example, partners reached 50 per cent fewer people in May despite availability of basic services). This is likely linked to the false belief that services are discontinued. Messaging to ensure communities were aware of GBV risks and services was carried out in all targeted areas.

FOOD SECURITY AND LIVELIHOODS

Refer to thematic section on food security earlier in the Progress Report.

CASH-BASHED PROGRAMMING

Cash-based programming is increasingly being used as a method to provide livelihoods support. WFP is supporting Governments in 35 countries to provide cash-based transfers to mitigate the socioeconomic impacts of COVID. WFP is also collaborating to support the cash-based transfer operations of other humanitarian actors by allowing them to transfer funds to beneficiaries using WFP's financial systems, platforms and established contracts. WFP is now supporting 26 partners in 13 countries, transferring a cumulative total of over $190 million to over 3 million beneficiaries. IOM delivered livelihood support, including cash transfers, to vulnerable populations affected by COVID-19 in over 40 countries. UNICEF provided cash transfers to 17,816 households and reached a further 6.1 million households through enhancing and expanding social assistance programmes provided by Governments. FAO has supported 200,641 households (approximately 1.1 million people, of whom 47 per cent are women) with cash-based assistance. FAO used the Cash + approach (cash together with agriculture, livestock or fisheries support) for 50 per cent of these households. UNDP facilitated cash-transfers in Togo (through the "NOVISSI" programme), benefitting 567,002 people, of whom 65 per cent were women. Between March and July 2020, 914,251 Palestine refugees received cash and food assistance in UNRWA field of operations. UNRWA reached more people than its original target as more Palestine refugees than planned sought assistance from UNRWA in Lebanon, and UNRWA expanded its food parcel assistance in the West Bank due to the spike in the number of COVID-19 cases. The Danish Refugee Council also provided multi-purpose cash assistance to refugees and migrants. UNFPA is using cash and voucher assistance to contribute to women's sexual and reproductive health access, including local direct purchase of essential items and transportation, and to meet the urgent needs of GBV survivors and women and girls at risk of GBV. In Syria, UNFPA is leveraging an existing WFP e-voucher programme with a top-up value to enable pregnant and lactating women to purchase essential hygiene items in selected shops. UNHCR has successfully advocated for the inclusion of over 500,000 refugees in national social protection schemes and is bridging the gap between humanitarian and development assistance through cash grants. Some three million displaced people have now received cash grants from UNHCR, which is an increase of two million since the July GHRP update.

CONTINUATION OF ESSENTIAL HEALTH CARE AND SUPPORT TO HYGIENE

COVID-19 is overwhelming health systems and efforts are underway to maintain and re-build community trust in health services and reverse the drop in both the availability and utilization of services. IOM supported the continued provision of essential health care services

[20] The 20 countries include: Bangladesh, Burundi, Cambodia, Democratic Republic of Congo Egypt, Ethiopia, Ghana, Jordan, Kenya, Kazakhstan, Nepal, Nigeria, Philippines, Rwanda, South Africa, Sri Lanka, Tanzania, Thailand, Uganda and Ukraine (as of 19 August 2020).

[21] UNFPA's July survey of 988 GBV service points in 49 GHRP countries had 79 new services with less interruptions than the previous report.

and information for migrants, IDPs, refugees, and host populations by focusing on the establishment and management of isolation centres (Bangladesh) and supporting the provision of primary health-services, treatment of ongoing conditions, and existing clinics in Afghanistan, Libya, Mozambique and Yemen, among others. UNICEF and its partners have reached at least 25.6 million children and women with essential healthcare services including antenatal, delivery and postnatal care, essential newborn care, immunization and support for common childhood illnesses. In Colombia, UNHCR's support of local authorities included the delivery of equipment, such as 18 intensive care unit beds that were distributed to hospitals in Arauca.

WASH needs have increased in some countries with the easing of confinement measures and increased risk of virus transmission. This has resulted in organisations reviewing their original targets for assistance. UNICEF reached 43.6 million people with critical WASH interventions, including personal hygiene items and services. IOM has scaled up its WASH operations and reached an additional 10 million people since May 2020. It is also distributing COVID-19-specific hygiene items, with additional soap, detergent and chlorine. The Danish Refugee Council reached at least 130,000 people with WASH supplies and services.

UNFPA continues to work with national and international partners to support sexual and reproductive health (SRH) services through providing PPE and training staff in maternity wards, setting up mobile clinics to reach vulnerable communities, and procuring life-saving SRH commodities. UNFPA reached 9.7 million women and 4.6 million adolescents with SRH services in 52 GHRP countries between January and July 2020. In Afghanistan, Libya, oPt and Syria, UNFPA works with partners to support integrated GBV/SRH mobile teams that continue to provide psychosocial support services (individual counselling and consent-based referrals) and SRH services (with referrals to static facilities).

CHILD PROTECTION AND EDUCATION

Despite confinement measures easing and schooling resuming in some countries, a large portion of children remain unable to access education and associated child-protection programmes. Currently, 58 countries included in the GHRP report that minimum child protection services have been operational throughout the COVID-19 crisis. WFP has given take-home rations to nearly seven million schoolchildren in 45 countries affected by school closures. Since the start of the pandemic, 12.3 million children, parents and primary caregivers have been reached with community-based mental health and psychosocial services. Through strengthened capacity and a community-based approach, at-risk children who require specialized care are more likely to be identified and appropriately supported.

UNICEF and partners have supported 93.6 million children and youth with distance/home-based learning in 55 countries. UNHCR has adjusted its target for the number of children it aims to support with distance or home-based learning to 1.2 million. As of 19 August, it had supported 782,790 children in 29 countries. In Zimbabwe, World Vision is delivering distance education to 10,000 learners via mobile phones. From March until the end of the 2019-2020 school year, UNRWA continued to support the education of children and students enrolled in UNRWA schools and technical and vocational training centres (TVET).

Progress of the response
Strategic Priority 3

Refugees, IDPs, migrants and host communities are at high risk of contracting COVID-19 due to living in high-density settlements and having limited access to basic services. To date, UNHCR has assisted some 27 million people through ensuring access to health services and advocating for inclusion in the national health response. During the reporting period (July-August), some additional 3.3 million people have been able to access health services, including in refugee and IDP camps and in remote areas. The Danish Refugee Council has reached approximately 2.3 million people with their programmes, and IOM reached over 18 million people in its 60 countries of operation. World Vision reached over 150,000 people with soap and established groups to manufacture face masks.

Organisations have conducted assessments to adjust their programming to respond to emerging vulnerabilities and adapt to changing operational contexts. In Latin America, UNHCR, IOM and partners conducted new needs assessments on mid- to long-term needs and perspectives. In Colombia, the priority was to guarantee preventative isolation of refugees and migrants. In Ecuador, IOM produced an analysis about LGBTI+ migrants and refugees to identify their differentiated needs, capacities and protection gaps. UNRWA established a comprehensive monitoring mechanism in Gaza so Palestinian refugees could provide feedback on the new home distribution modality for food assistance. The information was used to improve the home delivery modality during the second quarter.

While specific funding for GBV has not been received, UNHCR has allocated over $13 million from flexible funding sources to assist persons with special needs, including extending GBV services to more than 445,500 persons, predominantly women and girls. In a similar manner, money has been allocated to ensure over 203,000 people were able to access mental health services.

RISK COMMUNICATION

Risk communication and information is key to enable community-led responses. UNHCR reached 77 per cent of areas inhabited by refugees, IDPs and migrants with risk communication. In South Sudan, IDPs used creative means to share public health information, such as pictorial materials suitable for children and people with communication challenges. In Zimbabwe, UNHCR, partners and the Ministry of Health strengthened COVID-19 awareness among youth and persons with disabilities through structured small group discussions. IOM reached 49 countries with information campaigns. UNFPA and national partners disseminated information on COVID-19 risks in 638 target areas in 34 GHRP countries. Printed media (posters, pamphlets and leaflets) was reinforced with social media to reach younger people and to maintain awareness where lockdown measures restricted women's movements. In Uganda, World Vision implemented a range of innovative health education measures to help ensure South Sudanese refugees were informed about the risks of COVID-19. Adolescent and adult volunteers used megaphones and public address systems to highlight the importance of handwashing and physical distancing. Youth journalists trained by World Vision developed news stories about COVID-19 and shared these through social media, even creating rap music played at food distribution points.

Monitoring indicators
Situation and needs

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	AUGUST REPORT [22]
Spread and severity of the pandemic	Number of confirmed COVID-19 cases in GHRP countries	WHO	8,859,184 [23]
	Total number of deaths among confirmed cases in GHRP countries	WHO	321,284 [23]
	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	Institutional births data from 38 countries shows declines in 28 of them
		WHO	–
	Proportion of countries where pre-COVID-19 levels of family planning/ contraception services are maintained	UNFPA	–
		WHO	–
	Proportion of countries where pre-COVID-19 levels of institutional births are maintained	UNFPA	Institutional births were maintained in 10 out of the 38 countries. 3 countries showed declines in less than 10% of targeted health facilities, 8 in 10 to 25%, and 17 in 25 to 88%.[24]
Mobility, travel and import/export restrictions in priority countries	Number of priority countries with international travel restrictions in place	IOM, WHO	62 [25]
		WFP	Overview is available here
	Number of priority countries with partial or full border closures in place	IOM, WHO	54 [26]

Note: Information with a dash (–) indicates information that is not reported or not yet available.

[22] Indicators show cumulative values since the launch of the GHRP (25 March) until 19 August, unless otherwise noted. The response monitoring results reflect progress as tracked per the indicated responsible agency. NGOs and clusters were also invited to report against these indicators (as appropriate to their operations) and where material was provided, it has been included in the monitoring framework and/or the narrative. Data for some indicators was not available at the time of collection. Agencies are planning on reporting against these in subsequent reports.

[23] Number of confirmed cases and deaths as of 28 August.

[24] This indicator only applies to 38 countries out of UNFPA's 61 GHRP countries, where baseline data was available to enable the analysis.

[25] Of the priority countries with international travel restrictions in place, in 35 countries, entry to passengers arriving from certain countries, territories or areas are banned, and in 23 countries medical measures (mandatory quarantine upon entry) are in place only. Seventeen countries have recorded exceptions to the travel restrictions for entry pertaining to the UN, international and humanitarian organizations, 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).

[26] oPt is not included when looking at status of border closures.

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	AUGUST 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	Number = 183,381,441 Proportion = 27.6%
	Number of people adopting crisis level coping strategies (Reduced Coping Strategy Index)	WFP	177,191,954
	Food and crop production estimates in GHRP countries	FAO	–
	Food Insecurity Experience Scale (FIES) in GHRP countries	FAO	–
	Number of priority countries with reduced availability of agricultural inputs	FAO	17 [26]
	Number of people in IPC Phase 3+ in priority countries (in countries where new analyses are available)	FAO/IPC	52,175,590 [27]
Education	Number of children and youth out of school due to mandatory school closures in GHRP countries	UNESCO	1,058,824,335 affected learners, 60.5% of total enrolled learners [28]
		UNHCR	1,645,000 refugee children and youth (29 countries reporting)
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	60.3%
Gender-based Violence	Number and proportion of countries where GBV services have been interrupted	UNFPA	17/49 [29]
Child protection	Number and per centage of countries integrating a monitoring system able to measure changes and to identify child protection needs	CP-AoR	29
Protection	Number of countries that have activated the Nutrition Coordination mechanism in response to COVID-19 and/or its impacts	UNICEF (Global Nutrition Cluster)	28
Nutrition	Number of countries reporting incidents of COVID-19 pandemic-related xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons	UNHCR	47% (27 of 57 countries reporting)

[26] Information available based on preliminary data.

[27] This figure takes into account all IPC and *Cadre Harmonisé* numbers (current and projected) that are valid as of August 2020 in the countries referenced hereunder. This number represents an increase compared to the previous reporting period (42,369,601). However, extreme caution should be taken when comparing these figures due to major changes in the countries covered (addition of 9 CH countries, expiration of some IPC numbers reported in the previous period (Ethiopia, Haiti, Kenya, South Sudan, Zimbabwe) and addition of new IPC numbers (Mozambique, Sudan, Yemen). This figure covers the following countries: Afghanistan* (10,313,185), Benin (14,578)**, Burkina Faso* (3,376,265), Burundi* (858,960), Cameroon** (2,126,114), Central African Republic* (2,362,737), Chad** (1,017,358), Mali** (1,340,741), Mozambique* (499,739), Niger** (2,012,367), Nigeria* (8,650,608), Pakistan** (1,236,107), Sierra Leone** (1,304,985), Somalia* (3,500,000), Sudan*(9,578,685), Tanzania** (488,661), Togo* (281,500), Yemen* (3,213,000). **indicates an analysis done between March and July 2020; ** indicates an analysis done prior to March 2020, the results of which do not take into account the impact of COVID-19 19 and other unforeseen shocks/changes.*

[28] Available at: https://en.unesco.org/covid19/educationresponse

[29] Out of UNFPA's 61 GHRP countries, 49 completed the data survey for this indicator.

Monitoring indicators
Strategic Priority 1

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	AUGUST REPORT
Ensure essential health service and systems	Number of passenger movement requests fulfilled	WFP	90%	97%
	Number of GHRP countries with multisectoral mental health and psychosocial support technical working groups	WHO	100%	42 (67%)
	Number of cargo movement requests fulfilled	WFP	90%	91%
	Number of hubs established for consolidation and onward dispatch of essential health and humanitarian supplies	WFP	8	8
	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	8,364,228
	Number of 3 plies/medical masks distributed against need (or request)	UNFPA	25,000,000	1,792,115 (since June)
		UNHCR	100%	7 million/14.4 million, 49%
		WHO	100%	57,046,164
	Number and per centage of children and adults that have access to a safe and accessible channel to report sexual exploitation and abuse	UNFPA	–	–
		UNICEF	10,127,158	6,975,916
	Number of health workers provided with PPE	UNICEF	1,405,349	729,429
		UNRWA	3 month's supply of PPE for more than 3,000 UNRWA front line health workers	3,124
		World Vision International (WVI)	–	220,825
Learn, innovate and improve	Percentage of countries implementing sero-epidemiological investigations or studies	WHO	20%	15.9%
Prepare and be Ready	Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	UNICEF	60	49
	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%	38%

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	AUGUST REPORT
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%	98.4%
	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%	98.4%

Monitoring indicators
Strategic Priority 2

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	AUGUST 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	–	11,825,447 people /2,039,284 households [30]
		WVI	–	100,963 people
		CARE	–	459,000 people
		UNHCR	2,467,400 people	809,970 people [31]
		UNICEF	1.3 million households	17,816 households
		UNDP	2 million people	0.8 million people
		IOM	1,330,464 people	432,188 people
		Danish Refugee Council (DRC)	–	754,363 people
	Number of people/households most vulnerable to/affected by COVID-19 who benefit from increased or expanded social protection	FAO	–	510,556 households [32]
		UNICEF	15.4 million households	6,120,249 households
		UNDP	4 million people	2.4 million people

[30] Women represent approximately 40 per cent of those benefitting from FAO's livelihood assistance. Estimate based on average household composition in intervention areas.

[31] UNHCR's livelihoods indicator does not include cash assistance. UNHCR reports all cash delivered under the GHRP assistance indicator in under Priority 3 rather than under livelihoods. 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.

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

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	AUGUST REPORT
		UNRWA	850,000 Palestine refugees	914,251 Palestine refugees[33]
		UNHCR	640,000 people	521,520 people[34]
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 healthcare services	IOM	5,013,696	1,759,610
		UNHCR	5,400,000	3,212,760
		UNICEF	43,450,524	25,652,905
		UNRWA	–	525,164[35]
	Number of people reached with critical WASH supplies (including hygiene items) and services	UNICEF	61,816,915	43,632,018
		WVI	–	7,889,194
		CARE	–	2.48 million
		IOM	18,602,290	14,462,368
		DRC	–	138,270
	Number of children and youth supported with distance/ home-based learning	UNICEF	178,336,631	93,610,033
		UNHCR	1.2 million	782,790
	Number of children and youth in humanitarian and situations of protracted displacement enrolled in pre-primary, primary and secondary education levels	UNHCR	–	–
		UNRWA	533,000	Target refers to 2019/ 2020 school year. Enrolment figures for the 2020/2021 school year are under finalization
	Number of people (including children, parents and primary caregivers) provided with mental health and psychosocial support services	UNICEF	17,658,974	12,352,248
		UNHCR	115,000	203,000
		IOM	719,674	225,550
	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	1,267,864
		UNHCR	34,117	20,440

[33] Data from March to July 2020.
[34] The target for social protection may change in the next reporting cycle based on consultations with government partners.
[35] During the month of July 2020, 525,164 patients visited UNRWA Health Centres across five fields of operation.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	AUGUST REPORT
	Number of children 6-59 months admitted for treatment of moderate acute malnutrition (MAM)	UNHCR	63,083	52,910
	Number of women and girls who have accessed sexual and reproductive service	UNFPA	Women Youth	9,668,443 women 4,858,349 youth
		UNHCR	375,000	–
		CARE	–	1.38 million
	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%	49 of 49 (100%)
		UNICEF	100%	–
		CARE	–	26
	Number and proportion of countries where GBV services are maintained or expanded in response to COVID-19	UNFPA	63 GHRP countries /100%	48/49
		UNHCR	63 GHRP countries /100%	40 of 52 (77%) [36]
	Number of people who have accessed protection services	UNHCR	–	6.7 million
		IOM	1,252,949	432,377
		DRC	–	457,388
		WVI	–	1,237,568
Secure the continuity of the supply chain for essential commodities and services such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non- food items	Number of cargo movement requests fulfilled	WFP	90%	91%
	Number of passenger movement requests fulfilled	WFP	90%	97%
	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%	33/41 had their consignment arrive and 29/33 distributed the supplies to imple-menting partners

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

Monitoring indicators
Strategic Priority 3

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	AUGUST 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	21,671,996	18,018,281 people
		UNHCR	67 million people	27.3 million people [37]
		DRC	–	2.3 million people
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	49
		UNFPA	100%	34/34
		UNHCR	100%	71% (39 of 55 countries reporting)
		UNICEF	–	5
		DRC	–	COVID-19 messages and risk information have been integrated in most operations under CCMS whereas just Community Engagement statistics amount to about 660,000 people in 13 countries
	Proportion of countries inhabited by IDPs, refugees and migrants with feedback and complaints mechanisms functioning	UNHCR	100%	100% (60 of 60 countries reporting)
		UNRWA	Palestine refugees in all 5 fields of operation	5 fields of operations

[37] Approximately 27.3 million refugees and IDPs have received COVID-19 assistance, including access to protection services, shelter, health, nutrition, education and livelihoods support. This figure includes over three million individuals who received cash, in-kind, and other assistance.

“This cannot be business as usual. Extraordinary measures are needed to tackle the extraordinary problem we face.”

Mark Lowcock
Under-Secretary-General for Humanitarian Affairs
and Emergency Relief Coordinator, United Nations