

# Evaluating the impact of COVID-19 on multi-sectoral humanitarian needs

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**About IMPACT**

IMPACT Initiatives is a Geneva based think-and-do-tank, created in 2010. IMPACT is a member of the ACTED Group.

IMPACT's teams implement assessment, monitoring & evaluation and organisational capacity-building programmes in direct partnership with aid actors or through its inter-agency initiatives, REACH and Agora. Headquartered in Geneva, IMPACT has an established field presence in over 15 countries. IMPACT's team is composed of over 300 staff, including 60 full-time international experts, as well as a roster of consultants, who are currently implementing over 50 programmes across Africa, Middle East and North Africa, Central and South-East Asia, and Eastern Europe

## SUMMARY

In 2020, IMPACT Initiatives, along with academic partners at the University of Manchester Humanitarian and Conflict Response Institute, and the Johns Hopkins University Centre for Humanitarian Health, developed a study with the main objective of informing strategic and operational decision-makers in the humanitarian sector as to how COVID-19 has impacted the severity and magnitude of humanitarian needs. The study aims to identify:

- 1) the levels of vulnerability among crisis-affected populations prior to COVID-19;
- 2) the adoption of COVID-19 preventive measures by crisis-affected populations and the association of factors which were likely to increase or decrease adoption of such measures; and
- 3) the impacts of the COVID-19 pandemic response measures on access to services by crisis affected populations and on the severity of humanitarian needs.

The study primarily relies on an exploratory and statistical analysis of data from Multi-Sector Needs Assessments (MSNAs) conducted in 2019 and 2020 by REACH Initiative in partnership with Humanitarian Country Teams in Afghanistan, Ukraine, Bangladesh, Central African Republic, Nigeria, Iraq, and Libya, as well as on background data on each country's COVID-19 outbreak, policy measures, and related impacts on humanitarian services. It serves as a starting point for humanitarian practitioners, epidemiologists, and public policy-makers to adapt their strategic and operational responses to address the unintended negative socioeconomic impacts of COVID-19 policy measures on vulnerable households in an informed and context-specific manner.

### **Pre-COVID-19 vulnerability and resilience relating to healthcare**

**These effects have compounded existing vulnerabilities prior to the pandemic.** Analysis of MSNA 2019 data, collected prior to the onset of COVID-19, indicate that households residing at longer distances from essential and basic services, those already living under the hardships of poverty and limited development, and households with persons living with disabilities or chronic illnesses, already faced severe risks of exclusion from delivery of essential services.

### **Multi-sector impacts of COVID-19 containment measures**

Overall, the study finds clear evidence that **policy response measures enacted by governments against COVID-19, especially those related to "containment and closure", have exacerbated pre-existing vulnerabilities and the severity of needs of both displaced and non-displaced communities in crisis-affected populations.** For instance, such measures have led to increased food insecurity, unemployment and gender-based violence, decreased livelihood opportunities, unstable commodity pricing, and decreased access to healthcare facilities, education, as well as protection and other social services.

### **Adoption of preventive measures**

The report also conclusively illustrates that, despite the rapid spread of the pandemic and associated policy responses by governments and humanitarian actors, **the adoption of COVID-19 preventive measures by crisis-affected populations has been variable between different population sub-groups and across crises, highly context-specific and related to a range of interdependent demographic and socioeconomic factors, displacement status, distance from healthcare facilities, and information on humanitarian aid.**

### **Policy recommendations**

Comparisons of the country-specific responses to the COVID-19 pandemic have shown that a lack of coordination and a decreased humanitarian footprint have resulted in an increase in the severity of needs of crisis-affected households. Consequently, **there is a need for coordination between public authorities and humanitarian actors to better counteract the secondary negative effects of policies designed to curb the spread of the pandemic.** As a starting point, international aid actors,

public authorities, as well as humanitarian researchers, could share information and expertise in order to ensure that hot-spot areas with populations in severe or extreme need, are prioritised in the humanitarian response and efforts made to counteract the direct and indirect impacts of containment and closure policy measures. Further, aid actors and public institutions could also re-prioritise funds and programmes to meet the increased demand for services.

**Findings from the research also show that public authorities need to ensure that despite measures limiting human mobility, vulnerable communities can still maintain adequate levels of access to essential and basic services**, such as healthcare facilities, marketplaces, and gainful employment opportunities. Increasing availability of services closer to where communities reside, or increasing transportation services in a manner which still allows for the practice of social distancing would be a key step in mitigating the negative impacts of closure and containment policies, without a further deterioration in the levels of need or an increase in inequalities of access. In particular, governments should ensure that opportunities for the sustenance of livelihoods are increased in a manner which is coherent with the adoption of personal preventive measures, such as reducing mobility and distancing; that access to essential foods is maintained through increased transportation services or aid distribution; and that services for education, and for survivors of protection issues or gender-based violence continue to function.

**Aid actors and public institutions should also tailor information and awareness raising campaigns** by focusing on the characteristics of households and the specificities of the contexts in which they reside in order to increase the likelihood of adoption of other preventive measures. They **should also consider how the delivery of humanitarian aid can be further adapted to maintain social distancing measures**, in particular at sites of aid distribution.

**The disparity in results across countries and population sub-groups shows that while there is no single solution applicable across diverse contexts, there are meaningful avenues for public policy and humanitarian practitioners to explore based on statistically representative household-level data.** Academic and humanitarian researchers thus have a pivotal role to play in further studying the interdependent associations between the context of crises, interactive household characteristics and outcomes related to humanitarian needs, in order to inform policy-makers and practitioners with a solid evidence-base to consider which factors are most likely to lead to successful interventions.

Ultimately, humanitarian and public policy responses should be based on reliable data, feedback from affected populations and from field teams working to implement programmes, in order to both limit the spread of COVID-19 while concurrently meeting the existing humanitarian needs of vulnerable communities.

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## INTRODUCTION

In early 2020, the COVID-19 pandemic quickly spread across the globe compelling governments to enact a number of preventive policy measures to curb the loss of life. Notwithstanding policy responses to ban travel across borders, oblige the closure of businesses and public spaces, limit the number of persons at gatherings, and curfews, amongst others, many countries experienced successive peaks of the COVID-19 pandemic, leading to high rates of morbidity and mortality.<sup>1</sup>

During the course of 2020, concerns were raised about the secondary and indirect effects of the various containment and closure policy measures, and in particular their impact on vulnerable populations: how did different groups of the population respond to the policies, to what extent were policies complied with or adopted, and most importantly, what were the impacts of the COVID-19 preventive policies on the most vulnerable sub-groups?

Such questions are of even more importance in the context of on-going crises and the humanitarian response. On-going armed conflict coupled with natural shocks exacerbate the magnitude and intensity of needs of crisis-affected populations, in particular of internally displaced persons (IDPs), refugees, returnees, and vulnerable non-displaced households. Limited infrastructure, multidimensional poverty, and a lack of strong public institutions impede long-term development and recovery and leave vulnerable groups further exposed to the risks of anthropogenic and natural shocks. Within this context, crisis-affected populations often face challenges in meeting essential and basic needs in the sectors of food and livelihoods, water, sanitation, and hygiene, shelter, health, and nutrition. **Therefore, given the already fragile environments which characterize humanitarian settings, the consideration of the secondary and negative impacts of COVID-19 preventive policies is essential in order to tailor the response to the pandemic and mitigate any adverse effects.**

In 2020, IMPACT Initiatives, along with academic partners at the University of Manchester Humanitarian and Conflict Response Institute, and the Johns Hopkins University Centre for Humanitarian Health, developed a study under the grant from ELRHA, "Evaluating the impact of COVID-19 on multi-sectoral humanitarian needs." The study examines: (1) the vulnerability and resilience of crisis-affected populations prior to COVID-19 and associated correlations with socioeconomic factors, (2) the adoption of preventive measures and associated correlations with socioeconomic factors, and (3) the multisector impacts of COVID-19 prevention policy responses in Afghanistan, Ukraine, Bangladesh, Central African Republic, Nigeria, Iraq, and Libya.

The main objectives in undertaking the study was to inform strategic and operational decision-makers in the humanitarian sector as to how COVID-19 has impacted the severity and magnitude of humanitarian needs. In particular, the study seeks to:

- understand the level of pre-existing multi-sectoral vulnerability and resilience to the COVID-19 outbreak and the unintended damages of public health measures,
- evaluate how the COVID-19 pandemic, either through direct health consequences or indirect consequences, interacted with these vulnerabilities,
- identify priority sector and target population groups to inform the prioritization of humanitarian responses.

## METHODOLOGY

The study identified three overarching research questions, each further structured by exploratory and analytical questions. The study primarily relies on an exploratory and statistical analysis of data from the Multi-Sector Needs Assessment (MSNA) conducted by REACH Initiative in partnership with

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<sup>1</sup> World Health Organization. (2020, December 29). *Weekly Epidemiological Update - 29 December 2020*. <https://www.who.int/publications/m/item/weekly-epidemiological-update---29-december-2020>.



Humanitarian Country Teams in 2020, as well as background data on each country's COVID-19 outbreak, policy measures, and related impacts on humanitarian services.

**Research Question 1 focuses on the levels of vulnerability among populations prior to COVID-19.**

Question 1: What were the vulnerability and resilience factors of the crisis-affected populations before the COVID-19 pandemic, and whether and how were these associated with access to humanitarian needs?

- What were the pre-existing vulnerabilities in the crisis-affected population in the humanitarian context prior to the COVID-19 pandemic?
- Whether and how health and healthcare were associated with existing vulnerabilities, socioeconomic status, and humanitarian conditions in the crisis-affected population prior to the COVID-19 pandemic?

In order to answer the first research question, the researchers conducted a cross-sectional analysis of vulnerability to COVID-19 using MSNA data on factors relating to pre-existing vulnerabilities and resilience, especially regarding humanitarian needs and access to basic services.

**Research Question 2 focuses on the adoption of COVID-19 preventive measures and the association of factors which were likely to increase or decrease adoption of such measures.**

Question 2: Which factors are associated with the adoption of COVID-19 preventive measures?

- Whether and how the adoption of COVID-19 preventive measures (e.g. practice of social distancing or use of a face covering) are associated with livelihood and humanitarian vulnerabilities among the different subgroups of the crisis-affected population?

Data on humanitarian and socioeconomic factors associated with adoption of COVID-19 preventive measures were collected and analysed in three countries: Afghanistan, Bangladesh, and Ukraine. Cross-sectional analysis of vulnerability to COVID-19 based on the MSNA 2020 dataset was conducted in order to identify the different patterns of COVID-19 preventive measures and their association with vulnerabilities in the crisis affected population, which include, for example, *'Reducing movement outside the house'*, *'Stopping physical contact'*, *'Keeping distance from people'*, *'Avoiding public places and gatherings'*, *'Avoiding public transport'*, *'Wearing a face mask'*, and *'Washing hands'*.

**Research Question 3 explores the impacts of the COVID-19 pandemic response measures.**

Question 3: What are the multi-sectoral impacts of the COVID-19 pandemic in humanitarian sectors?

- Whether and how COVID-19 impact variables (e.g. questions related to perceived changes in income, debt, sickness related to COVID-19) are associated with humanitarian needs?
- What are the multi-sectoral impacts of COVID-19 response policies (and lockdown) on access to essential services in the crisis-affected populations?
- In other words, whether and what has changed in terms of access to essential services in the crisis-affected population before and after the COVID-19 pandemic (2019-20), and whether and how accessibility is associated with changes in socioeconomic status and livelihood?

In order to answer the third question, the researchers conducted a trend analysis of humanitarian needs between 2019 and 2020 using MSNA data in Afghanistan, Bangladesh, and Ukraine. Using MSNA 2020, the researchers also analysed the association between COVID-19 impacts (such as movement restrictions) and key humanitarian needs.

## Methods

The research team conducted extensive exploratory scoping reviews to collect background information to contextualize the findings of the 2019 and 2020 MSNA data sets, identify the known impacts of the COVID-19 pandemic on multisector humanitarian needs and service delivery, identify and characterize policy measures related to COVID-19 (travel restrictions, stay-at-home orders, etc.), as well as briefly describe the course of the pandemic in each country. Exploratory research on pre-COVID vulnerabilities using the MSNA 2019 datasets were conducted in all seven countries of Afghanistan, Ukraine, Bangladesh, Central African Republic, Nigeria, Iraq, and Libya.

Using a variety of statistical techniques<sup>2</sup>, the research team produced:

- Statistical estimates of population characteristics;
- Descriptive statistics summarizing households' general, socio-demographic, and health-related characteristics, and other variables of interest;
- Inter-group comparisons;
- An identification of unmeasured patterns of classification of COVID-19 preventive measures using categorical observed variables of COVID-19 in MSNA 2020.

## Limitations

The research was limited in part due to the design and approach to data collection in the MSNA. In particular, comparability between countries and crises is restricted to those variables for which data was collected in a harmonised and uniform manner. Due to logistical, financial, and security reasons, MSNAs in certain countries adopt a mix of sampling approaches, thereby leading to a complex sampling design. Most importantly, since the onset of the COVID-19 pandemic, some country teams opted to switch to remote data collection methods, thus, MSNA 2020 data contains a bias for the cases wherein only respondents with mobile phones and with access to cellular networks were interviewed. Finally, certain areas of the crisis-affected countries were excluded from face-to-face data collection due to security concerns. Therefore, strictly speaking, results should be interpreted as being statistically representative only for accessible areas where probability sampling techniques were implemented, and cannot be generalised to the entire country or population.<sup>3</sup>

Additional limitations faced during the analysis and as outlined in the wider report<sup>4</sup> include:

- Pre-existing vulnerabilities and resilience were only studied with in relation to access to healthcare facilities (Afghanistan, Bangladesh, Central African Republic, and Ukraine) and in relation to barriers to access (Iraq, Libya, and Nigeria).
- Results on factors associated with awareness of COVID-19 were only analysed for Afghanistan.
- Additionally, also in Afghanistan, non-displaced vulnerable groups were only analysed in relation to awareness of COVID-19 and proportion adopting preventive measures and not socioeconomic factors related to each preventive measure.
- Finally, given the differences in MSNA research design across countries, notably with respect to sampling and data collection, cross-country comparisons are not statistically representative but indicative only.

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<sup>2</sup> In order to produce unbiased statistical estimates of population characteristics, researchers used the Taylor-series linearization for variance estimation to account for the complex sample design of the MSNA. Descriptive statistics summarized a household's general, socio-demographic, and health-related characteristics, and other variables of interest. Inter-group comparisons were performed using the Rao-Scott corrected Chi-square test for categorical data and sampling design weighted univariable linear regression for continuous data. For dichotomous outcomes, a multivariable binary logistic regression analysis was performed, with adjusted odds ratios reported. For count outcomes, multivariable negative binomial regression analysis was performed. Latent class analysis was also conducted to identify unmeasured patterns of classification of COVID-19 preventive measures using categorical observed variables of COVID-19 in MSNA 2020. All analysis was presented with 95% confidence levels as appropriate.

<sup>3</sup> Sampling strategies for each MSNA can be found in their respective Terms of Reference available on the REACH Resource Center: <https://www.reachresourcecentre.info>

<sup>4</sup> Publication pending.

# FINDINGS

## 1. Pre-COVID-19 vulnerability and resilience relating to healthcare

The following section summarises the main findings from the analysis of MSNA 2019 data as they pertain to the levels of pre-existing vulnerabilities prior to the onset of the COVID-19 pandemic. With regards to the first research question, **the study finds that prior to the onset of COVID-19, vulnerability and resilience relating to healthcare** (as measured by access to healthcare facilities and barriers to accessing healthcare facilities) **were most commonly associated with characteristics of households and demographics** (size of households, age, gender, chronic illness, and disability in households/heads of household), **socioeconomic factors** (household income, expenditures, and debt), **displacement status, distance to healthcare facilities, and information on humanitarian aid; however, the associations are highly context-specific and dependent on interactions between variables.**

The following table previews the variables analysed for their association with access to healthcare facilities in Afghanistan, Ukraine, Bangladesh, and Central African Republic, and with barriers to accessing healthcare in Nigeria, Iraq, and Libya.

**Table 1 Overview of variables analysed for their association with ‘access to healthcare facilities’ or ‘barriers to accessing healthcare facilities’ across countries. “Yes” denotes a statistically significant association**

What were the vulnerability and resilience factors of the crisis-affected populations before the COVID-19 pandemic, and whether and how were these associated with access to humanitarian needs?								
Dependent variable	Access to healthcare facilities					Barriers to accessing healthcare facilities		
	Afghanistan	Ukraine	Bangladesh (refugee)	Bangladesh (host)	Central African Republic	Nigeria	Iraq	Libya
Household size	Yes	No	No	No	NA	Yes	Yes	No
Age (elderly head of household)	No	No	Yes	Yes	No	NA	NA	No
Gender (head of household)	No	Yes	Yes (Male head of household)	No	No	Yes	NA	No
Marital Status (head of household)	Yes	No	No	No	NA	Yes	NA	NA
Education	Yes	No	No	Yes	NA	NA	NA	NA
Disability (head of household)	No	NA	Yes	Yes	NA	NA	NA	NA
Chronic illness	No	Yes	NA	NA	NA	NA	NA	Yes
Members sick in the 2 weeks prior to data collection	NA	NA	NA	NA	NA	Yes	NA	NA
Employment	Yes	NA	NA	NA	NA	NA	NA	NA
Income	Yes	No	NA	NA	Yes	NA	NA	No
Debt	No	No	No	No	NA	Yes	Yes	NA
Expenditure	NA	NA	NA	NA	Yes	NA	Yes	NA
Displacement Status	Yes (displaced populations)	No	NA	NA	Yes (Host community)	Yes (Host community)	No	Yes (Host community)
Phone SIM	Yes	NA	NA	NA	NA	NA	NA	NA
Information on humanitarian assistance	Yes	No	NA	NA	NA	NA	NA	NA
Type of information requested	NA	NA	NA	NA	NA	NA	Yes	Yes (Priority needs)
Received humanitarian aid	NA	No	Yes	No	NA	NA	NA	Yes
Distance to healthcare facility	Yes	Yes	NA	NA	NA	Yes	Yes	Yes
Distance to nearest market	NA	NA	NA	NA	No	NA	Yes	NA
Food coping (spent a full day and night without eating)	NA	NA	NA	NA	No	NA	NA	NA

### 1.1. Household demographic factors

While no single factor was found to be associated with pre-existing vulnerabilities and resilience across all countries, **the results suggest that the age and gender of the head of household, or the presence of disability or chronic illnesses within the household, interacted with each other in different context-specific pathways, to predict the levels of pre-existing vulnerabilities in certain population groups.** The results suggest that the prioritisation and targeting of the humanitarian response should further examine the interactive effects between the gender of the head of household, displacement status, and marital status, to better understand how such demographic factors may impact vulnerability.

### **Some examples of how household demographic factors were found to be associated with access and barriers to healthcare:**

- With regards to household characteristics and demographics, in Afghanistan, Nigeria, and Iraq, larger households were found to have greater needs in terms of healthcare access or faced more challenges to access healthcare. Household size was not significantly associated with access-related needs in other countries.
- Elderly-headed households were found to be more vulnerable and have greater access needs only in Bangladesh – in both refugee and host community households.<sup>5</sup>
- While female-headed households report having greater healthcare access needs in Ukraine, and Nigeria, the results are inversed for Bangladesh, where male-headed refugee households reported greater needs in terms of access to healthcare. The association between the gender of the head of household and healthcare access was not found to be statistically significant for other countries.
- The marital status of the head of household was only statistically significant in its association with healthcare access needs in Afghanistan and Nigeria, with married heads of household reporting having greater access needs or facing more barriers, respectively.

**Households with vulnerable members or heads of households, such as households with disabled or sick household members, may have, at the same time, both higher levels of needs to access healthcare facilities, and face more challenges in doing so,** likely also due to the fact that such households may need to access healthcare facilities more often than households without chronically ill or disabled members. **For example:**

- In Bangladesh, households with persons with disabilities were significantly more likely than households without persons with disabilities to report having gone into debt to cover health expenses in the 30 days prior to data collection.
- Households in Nigeria with at least one sick member in the two weeks preceding MSNA data collection also reported facing more barriers to access to healthcare. However, the same characteristics are not associated with greater healthcare access needs in Afghanistan.

## **1.2. Socioeconomic factors**

**Lower-income households<sup>6</sup> and those that spend a greater proportion of their income on basic necessities also tend to have lower levels of access and face more challenges to access healthcare services when needed.** Households with lower levels of income and higher proportions of expenses on basic goods and services, or higher levels of debt, are at a heightened risk of exclusion from essential services. Households already facing challenges to make ends meet are less likely to be resilient and more vulnerable, especially given the indirect and secondary socioeconomic impacts of COVID-19 prevention policies such as lockdown, closures, and restrictions on movement. The results indicate that the delivery of humanitarian assistance in the different crisis-affected countries should thus take into account the multidimensional aspects of poverty, socioeconomic variables, and limited development.

### **For example:**

- Lower-income households and those that spend a greater proportion of their income on basic necessities also tend to have lower levels of access and face more challenges to access healthcare services when needed. Notably, in Afghanistan where households with only one employed member or with lower monthly incomes were found to have greater access needs.
- In Central African Republic lower-income households or those spending a greater proportion of their income on basic items and services such as food, fuel, and transport reported having greater needs. A similar result was found for Iraqi households spending a higher proportion of income on basic goods and services.

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<sup>5</sup> The exact definition of which age group is considered 'elderly' may vary from country to country.

<sup>6</sup> The exact definition of 'lower-income households' may vary from country to country.

- Households with members having completed lower levels of education (such as elementary or below, or high school) reported having greater healthcare access needs in Afghanistan, and within the Bangladeshi host community population.<sup>7</sup>
- Finally, household debt was found to be significantly associated with more barriers to healthcare access in Nigeria and Iraq.

### 1.3. Displacement status

Depending on the country and context, displaced and non-displaced populations have either similar or significantly different pre-existing vulnerabilities and levels of access to healthcare services. Contrary to common assumptions, **host community households may have similar or higher levels of needs in terms of access to healthcare or barriers to healthcare facilities, and thus more severe underlying vulnerabilities and lower levels of resilience compared to displaced population groups.**

While displaced population groups often tend to have fewer resources, safety nets, and tend to face greater challenges due to the consequences of displacement, non-displaced populations may have similar levels of need due to limited development, multidimensional poverty, and armed conflict in both urban and rural areas. The finding has important implications for the prioritisation of the humanitarian response, which should further take into account the specific needs and characteristics of non-displaced population groups as well.

#### A few specific examples:

- In Afghanistan and Bangladesh, displaced population groups were found to have more needs in terms of access needs healthcare facilities, while in Iraq, they were found to face more barriers to access.
- However, in Central African Republic, Nigeria, and Libya, the non-displaced crisis affected population were found to have higher levels of need in terms of access to healthcare facilities and/or face more barriers to access.

### 1.4. Distance to healthcare facilities

In terms of factors influencing vulnerability and how they relate to humanitarian needs, the distance between households and healthcare facilities is the predominant factor which hinders access, and consequently renders populations increasingly vulnerable to the impacts of natural and anthropogenic shocks. Unsurprisingly, **households residing further away from healthcare facilities reported having greater access needs or facing more barriers than households residing closer to facilities.**

Households at greater distances from healthcare facilities face greater challenges in terms of access when needed, implying that they may also face greater challenges due to the distance from essential services for other related needs such as livelihood opportunities, humanitarian aid, and access to markets. **Therefore, reducing distance-related barriers, or increasing transportation services is key to increasing households' resilience to shocks, and reducing vulnerabilities.** Importantly, COVID-19-related prevention policies which inhibit mobility will likely tend to exacerbate the levels of needs, and vulnerabilities of the same households.

The results are statistically significant for all countries for which data on the distance to healthcare facilities was collected in a comparable manner (Afghanistan, Ukraine, Nigeria, Iraq, and Libya). The distance to healthcare facilities was not analysed for the cases of Bangladesh or Central African Republic.

### 1.5. Humanitarian aid related factors

Finally, the report brings to light certain factors related to humanitarian aid and vulnerability, as measured in terms of accessibility to healthcare services. **Households with greater information needs**

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<sup>7</sup> The results are not significant for the Bangladeshi refugee population, or other countries.

**concerning water, cash, and health services, or those whose self-reported priority needs were water and cash tended to be more vulnerable.** For example, households requesting information on humanitarian aid, or identifying their self-reported priority needs in the sectors of cash and water, were found to face greater challenges in accessing healthcare in Afghanistan, Iraq, and Libya.

## 2. Results – Adoption of preventive measures

Governments across all countries introduced a series of preventive policy measures at different times in order to stem the spread of the COVID-19 pandemic. However, as the report illustrates, **the adoption and practice of preventive measures are differentially associated with livelihood and humanitarian vulnerabilities among the different subgroups of crisis-affected populations.** The following section summarises the main findings from the analysis of MSNA 2020 data as they pertain to the levels of adoption of COVID-19 preventive measures by country and population sub-group as well as associated factors which increase or decrease the likelihood of adoption. The analysis was only conducted for Afghanistan, Bangladesh and Ukraine, for which data was available.

The following two tables summarise the overall prevalence of adoption of various preventive measures. The first table displays proportions of households that reported adopting specific preventive measures and only focuses on measures that directly relate to the prevention of contracting or spreading COVID-19. The red-shaded cells indicate the two lowest values whereas the green-shaded cells indicate the two highest values by column, that is by population group within each country. The second table displays proportions of households that reported adopting preventive measures by type of preventive measure. It also includes all response options contained in the survey questionnaire administered during MSNA data collection. The orange-shaded cells indicate below average values whereas the green-shaded cells indicate above average values by row, that is by preventive measure across all population groups and countries. Values in bold indicate highest and lowest value by row.

**Table 2 Proportion of households reporting adoption of preventive measures**

Preventive measure	Bangladesh		Ukraine		Afghanistan				
	Refugee	Host	Displaced	Non-displaced	Non-recent IDPs	Recent IDPs	Refugees	Returnees	Non-displaced vulnerable
Wearing a face mask	98.1	97.9	87.3	88.5	33.4	40.3	30	49.6	35.8
Washing hands more regularly	67.3	69.7	69.4	75	65.6	74.3	76.9	77.4	81.4
Stopping handshakes or physical contact	7.8	23.4	15.2	18.9	NA	NA	NA	NA	NA
Keeping distance from people**	21	50.8	38	40.4	46.3	47.1	69.3	57.6	55.8
Not leaving the house at all***	9.4	11.6	3.2	1.8	NA	NA	NA	NA	NA
Reducing movement outside the house***	45.5	67.7	34.6	33.1	66.2	70.7	69.2	68.4	77.9
Avoiding public places and gatherings*	27.5	19.6	29.6	34.1	22.7	32.3	39.7	37.2	18
Avoiding public transport*	4.4	12.8	17.2	23.1	NA	NA	NA	NA	NA

**Table 3 Proportion of households reporting adoption of preventive measures by type of preventive measure**

Type of action	Preventive measure/Population group	Bangladesh		Ukraine		Afghanistan				
		Refugee	Host	Displaced	Non-displaced	Non-recent IDPs	Recent IDPs	Refugees	Returnees	Non-displaced vulnerable
No action	No action taken <sup>°°°</sup>	0.4	<b>0.2</b>	3.7	3.9	<b>14.8</b>	11.1	11.7	7.9	7.5
PPE	Wearing a face mask	<b>98.1</b>	97.9	87.3	88.5	33.4	40.3	<b>30</b>	49.6	35.8
	Wearing gloves	<b>1.2</b>	3.1	8.6	13.6	NA	NA	NA	NA	NA
Hygiene	Washing hands more regularly	67.3	69.7	69.4	75	<b>65.6</b>	74.3	76.9	77.4	<b>81.4</b>
	Keeping surfaces clean	<b>34</b>	<b>8.4</b>	30.8	32.5	NA	NA	NA	NA	NA
Social distance	Stopping handshakes or physical contact	<b>7.8</b>	<b>23.4</b>	15.2	18.9	NA	NA	NA	NA	NA
	Keeping distance from people**	21	50.8	38	40.4	46.3	47.1	<b>69.3</b>	57.6	55.8
Reducing mobility	Not leaving the house at all***	9.4	<b>11.6</b>	3.2	<b>1.8</b>	NA	NA	NA	NA	NA
	Reducing movement outside the house***	45.5	67.7	34.6	33.1	66.2	70.7	69.2	68.4	<b>77.9</b>
	Avoiding public places and gatherings*	27.5	19.6	29.6	34.1	22.7	32.3	<b>39.7</b>	37.2	<b>18</b>
	Avoiding public transport*	<b>4.4</b>	12.8	17.2	<b>23.1</b>	NA	NA	NA	NA	NA
Other measures	Having specific foods (lemon water, hot water, cardamom, honey, etc.)	<b>3.2</b>	<b>12.6</b>	NA	NA	NA	NA	NA	NA	NA
	Increasing the number of baths/showers a day	<b>4.8</b>	3	NA	NA	NA	NA	NA	NA	NA
	Praying to God	<b>24.3</b>	17	9.5	<b>8.2</b>	NA	NA	NA	NA	NA
	Staying away from animals	1.6	0	1.2	<b>3.7</b>	NA	NA	NA	NA	NA
	Other	0.1	0	0.2	0	1.7	2	0.5	<b>2.6</b>	1.9
	Don't know	0	0	<b>0.3</b>	0	0.2	0	0	0.1	<b>0.3</b>

**N.B.:** Excluded from the first table: no action taken, wearing gloves, keeping surfaces clean, having specific foods, increasing number of showers a day, praying to god, staying away from animals, other, don't know  
Red-shaded cells indicate two lowest values whereas green-shaded cells indicate two highest values by column.

Orange-shaded cells indicate below average values whereas green-shaded cells indicate above average values by row. Values in bold indicate highest and lowest value by row.

Results are not statistically comparable across countries and should be viewed as indicative only.

°°°Cannot select response along with any other option - Colour scheme is inverted so that higher proportions reporting not taking any action are shaded in orange, while lower proportions are shaded in green.

\* Afghanistan: does not distinguish between avoiding public places and gatherings and avoiding public transport (hence results are grouped for AFG under 'avoiding public places and gatherings'); \*\* Afghanistan: Keeping distance from people = social distancing; \*\*\* Afghanistan: does not distinguish between not leaving the house at all and reducing movement outside the house (hence results are grouped for Afghanistan under 'reducing movement outside the house')

## 2.1 Overall prevalence of adoption of preventive measures

- Across the three countries analysed, **'washing hands more regularly', was the commonly adopted preventive measure**, followed by the 'use of facemasks' (predominantly in Bangladesh and Ukraine for both displaced and non-displaced households), and 'reducing mobility outside the house' (predominantly in Afghanistan across all population sub-groups). Thus, the results point to the role of information and awareness raising undertaken by governments, public institutions and humanitarian actors in the uptake of personal hygiene measures.
- **A higher proportion of households across all population sub-groups in Afghanistan took no preventive measures, compared with Bangladesh and Ukraine.** However, with regards to personal hygiene, a higher proportion of households in Afghanistan reported 'washing hands more regularly' compared to households in Bangladesh and Ukraine.
- **The results also seem to indicate that there are limits to the influence of information and awareness raising, as households may not be able to reduce mobility significantly due to their dependence on marketplaces, essential services, and income generating activities.** The least adopted measure across all population sub-groups in Afghanistan was 'avoiding public places

and gatherings' while in Bangladesh and Ukraine the least adopted measure was 'not leaving the house at all', 'avoiding public transport', and 'stopping handshakes or physical contact'.

- Finally, certain population sub-groups which may live in crowded camp-like conditions, such as IDPs or refugees, who may depend on commuting to places where people normally gather, such as markets, may find it difficult to practice social distancing. Notably, the data shows that non-recent and recent IDP households in Afghanistan and refugee households in Bangladesh were less able to practice social distancing in comparison with other displaced and non-displaced population groups (refugees and returnees).

## **2.2. Prevalence of using personal protective equipment and of personal hygiene**

- The use of face masks was reportedly highly prevalent in Bangladesh and Ukraine across population sub-groups, while less than half of households in all sub-groups in Afghanistan reported wearing them. Gloves were reportedly used only by small minorities in Bangladesh and Ukraine, while there was no information for Afghanistan.

## **2.3. Prevalence of practicing social distancing**

- **Refugee, returnee, and non-displaced vulnerable households in Afghanistan, and Bangladeshi host-community households reported maintaining social distance in relatively greater proportions** than non-recent and recent IDP households in Afghanistan as well as refugee households in Bangladesh, and both displaced and non-displaced households in Ukraine.
- The findings are equally mixed with regards to reducing mobility, with all population sub-group households in Afghanistan limiting all movement outside the house in relatively greater proportions than households in Bangladesh or Ukraine.
- However, refugees and non-displaced vulnerable Afghani households were most and least to avoid public places and gatherings, respectively. In comparison, households in Ukraine reported avoiding reducing mobility in greater proportions relative to households in Bangladesh.

## **2.4. Snapshot: Awareness of COVID-19 and associated factors in Afghanistan**

Researchers also explored how awareness of COVID-19 varied across population sub-groups and associated factors, but only in the case of Afghanistan, for which there was available data.

- Awareness was similarly high across all population groups with non-displaced vulnerable groups and returnees having the highest and lowest levels of awareness (99% and 96%, respectively).
- **Households with employed members were more likely to be aware of COVID-19**, especially in the non-recent IDP and returnee population groups, compared to households with unemployed members in the same population groups. Returnee households with a positive job status were the most likely to be aware of COVID-19.
- **Recent IDPs and returnees were more likely to be aware of COVID-19 if the households had received information on how to access humanitarian aid**, with the highest likelihood reported for returnee households.
- **Most surprisingly, households living at further distances from healthcare facilities were more likely to be aware of COVID-19.** This finding is statistically significant for all three population groups (non-recent IDPs, recent IDPs, and returnees), with the likelihood of awareness increasing with distance to the healthcare facility.



## **2.5. Factors associated with the adoption of COVID-19 preventive measures**

Researchers also explored which factors were associated with an increase or decrease in the likelihood of adoption of different preventive measures across countries and population sub-groups. In several crises, **certain demographic or socioeconomic characteristics, while not able to predict overall adoption of preventive measures, were able to predict adoption of specific preventive measures, such as social distancing, the use of protective equipment and avoiding public transport or public gatherings.** This suggests that analysis focusing on which demographic or socioeconomic characteristics result in a higher likelihood of adoption of certain preventive measures should be conducted in each crisis-affected country in order to enable more targeted information and awareness raising campaigns.

## **2.6. Household demographic characteristics as well as displacement status were significantly associated with adoption of preventive measures. For example:**

- In Afghanistan, larger households,<sup>8</sup> female and elderly-headed households, or households with disabled members were less likely to adopt most preventive measures.
- In Ukraine, in contrast to Afghanistan, larger households, female headed and vulnerable-headed households were more like to use protective equipment, maintain social distance, and reduce mobility, but only among the non-displaced population.
- In Bangladesh, elderly headed-households and larger households were found to be associated with an increased likelihood of avoiding public places and transport, reducing movement outside the home and increased social distancing.

**Generally, higher income households and households with members having higher education levels were also more likely to adopt preventive measures.**<sup>9</sup> Higher income households may be better suited to adopt various preventive measures as they may be less dependent on regular access to essential services and care, and better situated to practice social distancing and use personal protective equipment. Higher levels of education are also associated with an increased likelihood of adoption of preventive measures but only to a certain point (and with the notable exception of the example of Bangladeshi host community populations). The relationship is most evident for households with members having completed middle and high-school levels. For example:

- In Afghanistan, higher income households and households with members owning a phone with a SIM card were more likely to adopt all preventive measures studied.
- In Ukraine, higher income was significantly associated only with the preventive measure of avoiding physical contact in both displaced and non-displaced groups.
- In Bangladesh, female-headed host community households as well as host community households with members having a higher level of education were more likely to avoid public transport yet less likely to avoid public gatherings.

Similarly, **distance to healthcare facilities influenced adoption of preventive measures in varying degrees and in opposite directions across countries and population groups. For example:**

- In Afghanistan, households residing further from healthcare facilities were more likely to maintain social distance, but less likely to wear protective equipment, notably among the recent and non-recent IDP sub-groups.

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<sup>8</sup> The definition of 'large' households may vary from country to country.

<sup>9</sup> The definition of 'higher incomes' and 'higher levels of education' may vary from country to country.

- In contrast, in Ukraine, displaced households at further distances from healthcare facilities were less likely to avoid physical contact whereas non-displaced households living at intermediate distances to healthcare facilities were more likely to wear protective gear.
- The association is also present for Bangladeshi refugee households living further from healthcare facilities which increased their likelihood of avoiding public places.

Finally, **having received information on humanitarian assistance is a factor which was found to be associated with a likelihood of increasing use of personal protective equipment but decreasing adoption of social distancing**. The results indicate that households that may be reliant on humanitarian assistance (as measured through the targeting or request of information on humanitarian assistance) are less likely to adopt social distancing, potentially due to the fact that while individuals may wear protective gear at points of humanitarian aid delivery, they may be less likely to maintain physical distance. For example:

- In Bangladesh, among the refugee population, households having received information on food assistance were less likely to reduce movement outside the house while households having received information on health services were less likely to limit mobility.
- In Afghanistan, households across all displaced population sub-groups were more likely to wear protective gear if they received information on how to access humanitarian aid, but less likely to practice social distancing if they received information on how to access humanitarian aid. However, further research is required to better understand these observations.

### 3. Multi-sector impacts of COVID-19 containment measures

The following section synthesises the findings concerning the impacts of COVID-19 and preventive policy measures across the humanitarian sectors of livelihoods, food security, water, sanitation, and hygiene, education, shelter, access and utilisation of healthcare services, gender-based violence, and coordination among actors. The research study evaluated the multi-sectoral impacts of COVID-19 containment measures across countries and humanitarian sectors. Using the analysis of 2019 and 2020 MSNA datasets and literature reviews of policy measures, the authors found that **the COVID-19 pandemic and its preventive measures have had significant impacts on the crisis-affected population “resulting in inadequate and uneven access to essential humanitarian needs...particularly in the areas of income, food security, access to basic services, education, and health”**.<sup>10</sup> As per the results of the research across the seven study countries, it is evident that the impacts of the pandemic and the preventive policies have affected all sectors, with secondary negative effects on one sector spilling over to compound the effects in others. Further country-specific highlights per sector may be found in the annex.

#### 3.1. Impact on livelihoods

The implementation of containment and closure policies designed to curb the spread of the COVID-19 pandemic had a significant impact on the livelihoods of crisis-affected populations and widespread ramifications for the economy. Across all countries studied, **COVID-19 and the various preventive policies led to a self-reported loss of jobs, reductions in household income, employment opportunities as well as a reduced ability for vulnerable households to meet basic needs**, including a reduced ability to borrow money, an increased reliance on daily precarious forms of employment, and an increase in the use of negative coping mechanisms.

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<sup>10</sup> Cha, J., Robinson, C., Mieth, K., Noh, J., & REACH Initiative. (2021). “Multi-sectoral Impacts of COVID-19 in Humanitarian Contexts”. Forthcoming.

### 3.2. Impact on food security

The impacts on food security were characterised by a deterioration of food security outcomes, such as Food Consumption Scores. For instance, in Bangladesh, at the time of the MSNA data collection 2020, only 43% of host community households were found to have acceptable Food Consumption Scores, compared to 72% of households during the same time period in 2019, while in camps, the proportion of households with acceptable Food Consumption Scores dropped from 54% in 2019 to 35% in 2020. In some countries, households and retailers reported an increase in the prices of basic food items, likely due to supply chain issues and restrictions on mobility. Such outcomes were exacerbated by lockdowns and movement restrictions, resulting in an increase in food prices and a lack of access to food.

### 3.3. Impact on water, sanitation, and hygiene (WASH)

The impact of COVID-19 and preventive policy measures was mostly observed in the WASH sector through the disruption of WASH services and deterioration of infrastructure, e.g. in camp contexts, such as Bangladesh, where the reduced presence of humanitarian actors led to increased gaps in WASH facility maintenance being reported, or Iraq, where the provision of WASH services reportedly also reduced during the lockdown. **Although personal hygiene practices increased in certain cases, the overall need for improved drinking water sources and safe and dignified latrines continued to be plagued by lingering issues from previous years.** Worsening outcomes in the WASH sector, and the inability to access sufficient water or practice hygienic sanitation often compounds the spread of other diseases and leads to poor health and nutrition outcomes.

### 3.4. Impact on education

Due to the closures of schools, children across countries were forced to switch to remote learning modalities, where services and access to remote learning existed – in contexts where overall enrolment and attendance rates were already low. **Although a certain proportion of school-aged children were able to continue learning at distance, school drop outs or challenges accessing remote learning were reported across countries.** For instance, in Libya, 81% of enrolled students were reported as being unable to access distance learning. In Nigeria 12% of households reported children as having dropped out of school between Ramadan 2020 and the time of the MSNA data collection, while in Afghanistan, 66% of 120 hard-to-reach settlements were reportedly unaware of remote learning opportunities. Longer term effects include exacerbating already existing barriers to education, attrition from educational programmes, and an increased exposure to, and heightened child protection risks.

### 3.5. Impact on shelter

Needs in the shelter sector remained particularly high among the displaced population or households living in camps. **Over-crowded shelter conditions increased the likelihood of transmission of COVID-19, and reduced the ability to practice social distancing,** while disruptions in services and livelihoods implied that households were unable to repair damages, or maintain adequate shelter conditions offering dignified living spaces or protection against the natural elements.

### 3.6. Impact on access to healthcare services

While in some countries presence of healthcare services did increase or remain stable due to increased funding in response to the pandemic, access, especially to already-vulnerable groups or those residing further from healthcare facilities remained low. In other countries, **already low levels of availability of healthcare services implied that the successive waves of the COVID-19 pandemic overwhelmed existing services, and further reduced access and availability.** A reprioritisation of healthcare services towards dealing with COVID-19 implied a shortage of available services for communicable diseases, individuals with chronic illnesses or other health issues. Movement restrictions exacerbated the effects of distance and mobility-related barriers to healthcare.

### 3.7. Impact on utilisation of healthcare services

**Access to healthcare facilities and services was significantly reduced due to restrictions on movement, low financial resources, fears around contracting the virus, and use of alternative healthcare seeking behaviours such as visiting pharmacies or negative coping strategies.** Decreased access to healthcare services also affected rates of enrolment in nutrition programmes, which may be anticipated to have longer-term effects on the health and well-being, especially of pregnant and lactating women and children under the age of five.

### 3.8. Impact on gender-based violence

The restrictions in movement, coupled with reduced economic and livelihood opportunities, and the use of negative coping mechanisms, such as early marriage, **exposed female household members to domestic and gender-based violence (GBV), leading to an increase in protection issues.** For example, in Nigeria, an increase in early and forced marriage for girls was reported due to diminishing livelihood, rising food insecurity, and as a means to reduce residential crowding to improve ability to socially distance.

### 3.9. Impact on coordination among actors

While in some countries a lack of coordination among humanitarian actors and public institutions led to a decrease in the number of needs assessments and coordinated policy responses, in other countries, an increase in coordination ensured that measures were implemented to counteract the secondary negative effects of containment and closure prevention policies.

While strict policy measures limited the spread of the virus in Bangladesh, the decreased humanitarian presence resulted in increased severity of needs and pre-existing issues, whereas in Ukraine, **the exemptions made for humanitarian actors from the most restrictive policies and the government's willingness to mitigate the secondary indirect effects of preventive policies, mitigated the inequalities in access and severity of needs among the populations.** The study underscores the need for increased coordination among actors in service delivery.

## CONCLUSION

As the global community continues to discover the extent and intensity of the impact of the pandemic on vulnerable communities, the present research provides a first step in understanding the unintended and indirect effects of containment and closure policies, which while stemming the spread of COVID-19, have aggravated existing severity of needs. The current research therefore serves as a starting point for humanitarian practitioners, epidemiologists, and public policy-makers to adapt their strategic and operational responses to be context-specific, and enhance the outreach and impact of their field teams working with vulnerable households across diverse crises.

Overall, the study finds that **policy response measures enacted by governments, especially those related to “containment and closure”, have exacerbated pre-existing vulnerabilities in crisis-affected populations through complex socioeconomic mechanisms leading to increased unemployment, decreased livelihood opportunities, unstable commodity pricing, increased food insecurity, and decreased access to healthcare facilities, education, and other social services.** There is an increasing need for humanitarian actors to address the unintended negative socioeconomic impacts of COVID-19 policy measures, which aggravate poor social and health outcomes, and the severity of humanitarian needs.

The findings from the analysis of MSNA 2019 data, collected prior to the onset of COVID-19, indicate that crisis-affected populations, especially displaced communities and those residing in camps, are relatively more vulnerable and exposed to the impacts of potential anthropogenic or climate-induced shocks. In particular, **households residing at longer distances from essential and basic services, those already living under the hardships of poverty and limited development, and households with persons living with disabilities or chronic illnesses, face severe risks of exclusion from delivery of essential services.**

Thus, given the existing levels of inequality of access prior to COVID-19, which were subsequently exacerbated by the policy response to the pandemic, international aid actors, public authorities, as well as humanitarian researchers, would do well to share information and expertise in order to ensure that hot-spot areas with populations in severe or extreme need, are prioritised in the humanitarian response and efforts made to counteract the direct and indirect impacts of containment and closure policy measures.

The report also conclusively illustrates that, despite the rapid spread of the pandemic and associated policy responses by governments and humanitarian actors, COVID-19 preventive measures have been adopted to varying degrees by population sub-groups and across crises. **Adoption of preventive measures is highly context-specific and found to be related to a range of interdependent demographic and socioeconomic factors, displacement status, distance from healthcare facilities, and information on humanitarian aid.** While adoption of handwashing and personal hygiene measures was widespread, compliance with social distancing and reducing mobility vary differentially and are statistically significant in their association with certain socioeconomic and health-related characteristics of households. Moreover, there are notable differences between displaced and non-displaced populations per preventive measure.

Thus, both international aid actors and public institutions should pay close attention to the associated factors which increase or decrease the likelihood of adoption of preventive measures. Humanitarian actors should consider tailoring information and awareness raising campaigns by focusing on the characteristics of households and the specificities of the contexts in which they reside in order to increase the likelihood of adoption of other preventive measures. They should also consider how the delivery of humanitarian aid, in particular at sites of aid distribution, can be further adapted to maintain social distancing measures. Public authorities should ensure that despite measures limiting human

mobility, vulnerable communities can still maintain adequate levels of access to essential and basic services, such as healthcare facilities, marketplaces, and gainful employment opportunities. Increasing availability of services closer to where communities reside, or increasing transportation services in a manner which still allows for the practice of social distancing would be a key step in mitigating the negative impacts of closure and containment policies, without a further deterioration in the levels of need or an increase in inequalities of access.

The comparisons between MSNA 2019 and MSNA 2020 data-sets also conclusively illustrate that the **pandemic and its preventive measures have had a considerable impact on the severity of needs of both displaced and non-displaced communities, resulting in an increase in inequality of access to essential needs such as livelihoods, food security, and healthcare.** Containment and closure policy measures have also significantly affected other sectors, with notable impacts on the education and protection sectors, and in particular on gender-based violence. Comparisons of the country-specific responses to the pandemic have also shown that there is an increasing need for coordination between public authorities and humanitarian actors, to better counteract the secondary negative effects of policies designed to curb the spread of the pandemic.

**The pandemic and its associated policy responses have undoubtedly shifted the locus of humanitarian needs within and across communities.** The increase in the severity of needs in livelihoods, food security, access and utilisation of healthcare services, continued education, and protection services implies that both aid actors and public institutions re-prioritise funds and programmes to meet the increased demand for services. Counteracting the impact of measures designed to curb the spread of the pandemic is vital to limiting an increase in the severity of needs. In particular, governments should ensure that opportunities for the sustenance of livelihoods are increased in a manner which is coherent with the adoption of personal preventive measures, such as reducing mobility and distancing; that access to essential foods is maintained through increased transportation services or aid distribution; and that services for education, and for survivors of protection issues or gender-based violence continue to function.

There is also an argument to be made for increasing the role played by humanitarian researchers and epidemiologists in addressing both the severity of needs of vulnerable communities, and the public policy response. Researchers should further assist policy-makers and practitioners with a solid evidence-base to consider which factors are most likely to lead to successful interventions. **The disparity in results across countries and population sub-groups shows that while there is no single solution applicable across diverse contexts, there are meaningful avenues for public policy and humanitarian practitioners to explore based on statistically representative household-level data.** Academic and humanitarian researchers thus have a pivotal role to play in further studying the interdependent associations between the context of crises, interactive household characteristics and outcomes related to humanitarian needs.

Finally, the research study has also brought to the forefront an increased need for coordination among all actors: public authorities, humanitarian organisations, and researchers. As the research study has demonstrated, in cases where public policies have effectively slowed the pace of spread of COVID-19, a lack of coordination and a decreased humanitarian footprint have resulted in an increase in the severity of needs of crisis-affected households. Therefore, **increased coordination is likely to ensure that future interventions also counteract the secondary and negative effects of measures aimed to curb the spread of the pandemic.** Ultimately, humanitarian and public policy responses should be based on reliable data, feedback from affected populations as well as field teams working to implement programmes, in order to both limit the spread of COVID-19 while concurrently meeting the existing humanitarian needs of vulnerable communities.

## Annex 1: Country examples of multi-sectoral impacts of COVID-19 and preventive policy measures<sup>11</sup>

### Impact on livelihoods

#### Afghanistan:

- 55% households reported job loss
- 59% households reported reduced income
- Extreme drop in job opportunities within the informal sector

#### Bangladesh:

- 93% of host community households compared to 73% of refugee households reported diminished or lost source of income as a result of COVID-19
- Increased reliance on 'daily-wage work' rather than full-time employment, and increase in daily hours worked to compensate for lower daily wages for host community households
- 41% of surveyed refugee households "considered income-generating activities as a 'priority need' as compared to 22% in 2019
- Drop-in employment rates for refugee households (from 64% to 24%) likely due to lack of 'cash-based work opportunities within camps'
- 280% increase in unemployment for refugee households due to loss of employment, diminishing incomes, and increasing numbers of women unsuccessfully attempting to join the previously male-dominated workforce to support their families
- Diminished ability to borrow money due to economic hardship within communities
- Increase in draining savings, selling assets, reducing spending on critical items
- Employed women in refugee households seemed to be 'more protected from job loss' than employed men; with men more often working physically demanding jobs in camps, when opportunities stopped with the lockdown

#### Ukraine:

- Reduced income in 18.84% households across Ukraine
- Job loss (of at least one member) in 43% households across Ukraine
- 3.5-4 million service industry jobs cut due to 700,000 small businesses closures
- 2 million in unclaimed pension and social service funds due to closure of contact line
- Increase in negative financial coping mechanisms including depletion of savings, selling possessions, increasing debt, and engaging in costly and "legally-challenging" means for obtaining pension funds

#### Nigeria:

- Increased national unemployment rate
- Women, youth, and IDPs were more susceptible to unemployment
- Decreased access to labour opportunities and reduction of incomes due to movement restrictions and stay-at-home orders
- 78% of households in Borno, Adamawa, and Yobe (BAY) areas reported insufficient income to meet needs
- 20% of households reported using negative coping mechanisms, for example, the sale of productive assets and borrowing food

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<sup>11</sup> Cha, J., Robinson, C., Mieth, K., Noh, J., & REACH Initiative. (2021). "Multi-sectoral Impacts of COVID-19 in Humanitarian Contexts". Forthcoming.

- 52% cash voucher assistance recipients reported persistent livelihood-related needs even after receiving humanitarian aid

#### **Iraq:**

- 41% increase in need of emergency livelihood support
- Halted job creation due to COVID-19 and decrease in oil prices
- 56% returnees in debt due to job loss and shrinking income, compared to 46% in 2019
- Women, youth, and those with disabilities most vulnerable
- Decreased access to livelihood opportunities worsened by lockdowns
- Increase in negative coping mechanisms, for example, selling personal items, incurring debt, early marriage, and child labour

#### **Libya:**

- 27% unemployment among migrants compared to 17% prior to COVID-19
- 22% of migrant and refugee households reported that COVID-19 disrupted a household's member's livelihood often due to movement restrictions, workplace closures, and employers' inability to pay workers

### **Impact on food security**

**Afghanistan:** More than a 20% increase in price of some basic food items, as well as 55% of households incurring debt cited the need to pay for food

#### **Bangladesh:**

- 66% of host community households reported 'limited access to food' as a result of COVID-19, compared to 23% of refugee households
- 76% of host community households reported using at least one of the following negative coping mechanisms with:
  - 69% of households eating less preferred or less expensive foods
  - 49% of households reducing portion sizes
  - 23% of households borrowing or relying on help
  - 22% of households reducing number of daily meals
- 43% of host community households reported 'acceptable' Food Consumption Scores in 2020 as opposed to 72% in 2019, while 35% of refugee households reported 'acceptable' Food Consumption Scores in 2020 as opposed to 54% in 2019
- 8% of host community households reported 'poor' Food Consumption Scores in 2020 as opposed to 4% in 2019, while 10% of refugee households reported 'poor' Food Consumption Scores in 2020 as opposed to 5% in 2019
- 60% of surveyed refugee households "considered income-generating activities as a priority need", compared to 42% in 2019
- Decrease in diversity of foods due to supply chain issues

#### **Ukraine:**

- 93% retailers reported increased food prices
- Decreased access to markets for conflict-affected individuals due to closure of the 'contact line'
- 1.2 million children left without free school meals
- Nearly 33% of families affected by conflict reported borrowing food, compared to 20% in 2019 and 16% in 2018

#### **Nigeria:**



- Increase in food insecurity with 32% of households in BAY states estimated to be food insecure
- 52% of households named food as a priority need
- Increased food prices due to decreased availability, rising production costs, and inflation
- Women reported eating last or missing meals in order to reduce exposure to the virus when procuring food for the family
- Female-headed households were less able to access food-related services due to marital status

#### **Iraq:**

- Decrease in number of those in need of food assistance
- Increase in number of people in acute need due to COVID-19 measures (i.e. movement restrictions, lockdowns)
- IDPs residing in camps were most vulnerable
- 22% increase in average expenditure for food since 2019

#### **Libya:**

- 24% of migrants and refugees were food insecure
- Refugees and migrants in Eastern and Southern regions were most vulnerable
- 10% increase in price of essential foods as compared to previous year

## **Impact on water, sanitation, and hygiene (WASH)**

#### **Afghanistan:**

- 73% of rural households most affected by WASH needs
- Refugee households and households headed by a person with a disability report higher levels of need in hygiene and sanitation

#### **Bangladesh:**

- Most host community and refugee households continued to have access to improved drinking water sources; however, among host community households 23% did not have sufficient water to meet daily needs; 14% sometimes practiced open defecation, and 11% had visible waste in vicinity of home
- Increase in percentage of refugee households with sufficient water to meet daily needs, 88% in 2020 compared to 44% in 2019
- 99% of refugee households reported having increased handwashing since COVID-19; however, 40% of respondents could not mention three critical times to wash hands
- Only 6% refugee of households reported a 'loss of or diminished access to clean water and sanitation' as a result of COVID-19
- Decreased presence of humanitarian staff prevented regular maintenance and repair, leading to an increased number of failures in WASH infrastructure in camps

#### **Ukraine:**

- Continued disruption of running water supply due to established issues such as unpaid debts
- Unreliable WASH-related infection control measures reported in Donetsk and Luhansk facilities
- Vulnerability depends on demographic characteristics: 78% of the rural population have sanitation needs as compared to 15% of the urban population
- Higher vulnerability in households with elderly (30%), people with disabilities (36%) and children (25%) compared to an average 21% in the government-controlled areas.

#### **Nigeria:**

- WASH needs (especially access to clean, safe water) in the BAY States increased in scale, severity, and complexity in 2020

- Combination of low awareness of personal hygiene practices and lack of access to WASH goods such as soap contributed to increasing susceptibility of contracting COVID-19
- Rain and windstorms damaged 3,891 shelters and WASH facilities in BAY State camps, affecting 2,500 households (10,000 individuals) & contributing to increased issues with sanitation and personal hygiene

#### **Iraq:**

- COVID-19 related lockdowns in camps have reduced provision of WASH related services
- Pre-existing WASH needs made vulnerable groups more susceptible to contracting COVID-19
- Increase in demand for WASH-related items due to COVID-19

**Libya:** Continued water and electricity outages & insufficient resources at the municipal level to improve hygiene and sanitation hindered compliance of COVID-19 prevention measures

## **Impact on education**

#### **Afghanistan:**

- 10 million children forced to remote learning for 6 months
- Already low levels of enrolment rates exacerbated by school closures
- 66% of 120 hard-to-reach settlements were unaware of remote learning opportunities
- Some extended school closures due to limited availability of handwashing stations and ability to socially distance

#### **Bangladesh:**

- Continued low levels of enrolment with 40% of 4-24 year olds in host community and refugee households not attending school for four or more days a week in the month prior to COVID-19
- Enrolment rates may have increased for the 5-11 and 12-17 age groups in host community households (Note: 2020 results may be biased towards more educated households)
- Increase in use of negative coping mechanisms in host community households with 49% reporting increased child labour in their community, and 20% reporting an increase in child (under 18) marriage, compared to 16% reporting increased child labour in their community and 9% reporting an increase in child (under 18) marriage among refugee households
- 27% of households reported lost or diminished access to education as a result of COVID-19
- 20% of refugee households whose children had attended schooling prior to COVID-19 closures were not attending school remotely
- 62% of refugee households reported 'having faced challenges in supporting their child's remote study', while some qualitative evidence suggests that at-home schooling was not very effective
- 6% of host community households with children who were in school before households reported not planning to send them back to school
- Child protection risks increased likely due to school closures
- Children from lower income and least educated households more vulnerable

#### **Ukraine:**

- 6.5 million children forced into distance learning
- 25% of children and 33% of adolescents in rural houses unable to afford a laptop.
- 10% of urban children did not have sufficient living space for home schooling
- Increase inequalities, reduced social cohesion, and hampered learning and health outcomes overall due to school closures

#### **Nigeria:**

- 4.2 million children not attending school in BAY States, as compared to 1.5 million in 2019

- Of the BAY States, the highest education-related 'Living Standard Gaps' found in Adamawa (despite better attendance figures than Borno)
- 12% of households reporting children dropping out since Ramadan 2020
- 18% of households reported inability for child to participate in remote learning due to inability to afford it and/or child began working rather than studying

**Iraq:** Movement restrictions and moving to online learning formats exacerbated previous barriers to education, for example, mobility restraints, or a lack of access to technology, particularly for girls and children with disabilities

**Libya:** 81% of enrolled students report being unable to access distance learning via television and online resources

## Impact on shelter

### Afghanistan:

- Increased threat of eviction after income reductions and job losses
- Increasing number of people in need of shelter - highest among refugees, IDPs, and cross-border returnees
- Increasing vulnerability to pandemic due to insufficient housing conditions, including increasingly crowded living conditions, lack of availability to WASH, and access to additional services

### Bangladesh:

- Situation remains relatively unchanged since pre-COVID times for host community households
- 63% of surveyed refugees "considered shelter materials as a 'priority need', compared to 47% in 2019
- Continuing issues from 2019: 69% of refugee households reported problems with their shelter while 24% of refugee households reported lack of money prevented them from making needed improvements in their housing
- Decreased presence of humanitarian staff prevented regular maintenance and repair of shelters, leading to shelters being 'left unrepaired for extended periods of time' and an increasing number of families forced to live in damaged shelters

### Nigeria:

- Increase in negative coping mechanisms related to increasing housing instability in IDPs/Returnees populations
- More than 600,000 individuals live or reside somewhere without tenure security or documentation
- 24,000 individuals that reside within host communities do not have stable income to pay rent
- Reported coping mechanisms: child labour, child marriage, and commercial sex (especially among women and girls)
- Congested living conditions increased susceptibility to spread of COVID-19 with approximately 400,000 IDPs residing shelters in camps which did not meet Sphere standards for space allotment per resident
- Increase in evictions due to COVID-19, from 6-10 households per month in 2019 to 100 households per month in 2020
- Rain and windstorms damaged 3,891 shelters and WASH facilities in BAY State camps, affecting 2,500 households or 10,000 individuals and contributing to increased crowding in some camps

**Iraq:** Crowded housing in camps increased vulnerability to catching COVID-19

**Libya:** Displaced, migrants, and refugees living in crowded conditions less able to comply with COVID-19 prevention measures

## **Impact on access to healthcare services**

### **Afghanistan:**

- Overall health services delivery increased during the pandemic due to increasing funding
- Overall access remained limited due to ongoing conflict, COVID-19, cultural barriers, distance to healthcare facilities, health workers contracting COVID-19, and inability to provide the same volume of services in smaller facilities due to social distancing measures
- 35% of displaced and 30% of vulnerable non-displaced households reported 'loss of, or severely diminished access to services due to COVID-19'

### **Bangladesh:**

- Closure of health centres and reduction of staff due to COVID-19 exacerbated ongoing barriers to care seeking, for example distance to facilities or monetary resources
- 48% of households reported 'never having been consulted on needs, preferences, or the delivery of humanitarian assistance since the COVID-19 outbreak'; female-headed households were found more likely to report this and were also 'less likely to receive awareness information clear enough to meet their information needs'
- Most households reported not receiving sufficient information on types of and availability of humanitarian assistance (excluding food assistance) since the beginning of COVID-19, likely reflecting humanitarian programs being less available in host communities as compared to refugee communities
- In contrast, among refugee households, there was a reportedly greater continuity and less gaps in assistance in the food security, health, and WASH realms during the pandemic; although a reported reduction in assistance in the areas of livelihood, shelter, education, and nutrition
- Reduction in humanitarian actors and activities led to significant access barriers for refugee households who had moved immediately prior to the pandemic due to difficulties in registration and updating assistance documentation
- Movement restrictions prevented refugee households from travelling for better quality care

### **Ukraine:**

- Closed "contact line" threatens access to sufficient hospital and laboratory services for those on the non-government-controlled side
- Widespread lack of healthcare workers, tests, and beds throughout the year
- Reprioritization, personnel shifts and increased workloads due to the pandemic limited other services such as: "mental health, HIV/AIDS and tuberculosis treatment, safe delivery and new-born childcare, dialysis and treatment of other chronic diseases treatment requiring continuous care in health facilities" and vaccine-preventable disease surveillance
- Rural areas along the "contact line" lost access to first aid stations due to loss of public transportation
- 52% of IDPs living in rural areas (as opposed to 36% in urban areas) reported not going to health facilities due to poor public transportation

### **Nigeria:**

- COVID-19 is straining a healthcare system already overwhelmed with high rates of communicable disease in BAY States
- Ongoing attacks and looting of health facilities by armed groups continues to challenge health service delivery

- Host community particularly suffers from closures and abandonment of health facilities due to conflict

**Iraq:** Disruption of immunization and maternal and child health programs due to COVID-19 with movement restrictions exacerbating access issues

**Libya:**

- Less than 50% of health facilities remain open (HNO)
- Health facilities are unable to meet COVID-19 health needs in addition to normal health services due to shortages of supplies, equipment, human resources (HNO)
- Increased staff shortages due to a lack of protective equipment and control measures leading to high COVID-19 infection rates, high rates of COVID-19 leading to frequent suspension of hospital operations, continued conflict-related attacks and damage to health facilities further exacerbating access, and a reprioritization to COVID-19 efforts decreased access to women’s reproductive health services

### Impact on utilisation of healthcare services

**Afghanistan:** Reduced utilization (particularly in nutrition services, antenatal care, in-patient, and outpatient services) due to fears of catching COVID-19 and financial hardship

**Bangladesh:**

- Host community satisfaction with humanitarian assistance has remained similarly low to 2019 levels
- Observed reduction in health-seeking behaviour in host community and refugee households, with host community households reporting a decrease in visits to private clinics from 47% to 36% as compared to 2019, 41% of host community households seeking treatment at pharmacies or drug shops rather than clinics (similar to 2019) – while 27% of refugee households reported choosing cheaper and/or lower quality care, for example, at a pharmacy rather than a clinic, compared to 12% in 2019
- Only 64% of refugee households sought care from NGO-run clinics, compared to 79% in 2019
- Among refugee households, persistent fears remain regarding contracting COVID-19 and the possibility of having to go to an isolation centre if positive, preventing utilization of health services and testing
- Persistent gaps in utilization of nutrition feeding programs, likely due to reductions in services including consultations at nutrition facilities and outreach activities during the lockdown as well as low levels of awareness of available programming
- Reports of people being turned away without consultation at certain health centres within the camps
- 100% of households reported engaging in health-related coping strategies, for example, home treatment, taking on debt to pay for treatment, compared to 23% in 2019

**Ukraine:**

- Movement restrictions, strained medical capacity, and increased economic strain have exacerbated utilization issues
- Rural population living within 20km of the ‘contact line’ and who have the lowest access to healthcare most affected
- 87% of population report not seeking care due to out-of-pocket costs such as medicines, compared to 65% in 2019
- 52% of population reported transportation issues prevented them from seeking care

**Libya:** Low utilization of COVID-19 testing services due to stigma and fear of contracting the virus

## Impact on gender-based violence

### **Afghanistan:**

- 12.8 million in need of protection assistance due to loss of livelihood, increasing debt, and ongoing conflict
- 35% increase in GBV - 91% increase in verbal and 51% increase in physical abuse

### **Bangladesh:**

- 13% of host community households with female respondents, and 6% of all households, reported they would not know where to refer someone with a sexual and gender-based violence issue
- Decreased volume of humanitarian actors restricted access to GBV services among the refugee population
- 33% of refugee households reported they would not seek services if faced with GBV
- 74% of refugee households indicated they would refer someone with GBV issues to a 'mahjee' who often functions as a gatekeeper to access, basic services, and other camp-related aspects
- Limited repairs to WASH facilities that are not gender-separated due to limited physical presence of humanitarian actors increased risk of GBV

### **Ukraine:**

- Forced confinement and the increasing stressors of the pandemic have increased household tensions
- Reports of domestic violence have doubled since 2017
- Recovery resources, such as counselling, were limited due to reprioritization of efforts and funding to address the pandemic

**Nigeria:** Increase in early and forced marriage for girls due to diminishing livelihood, rising food insecurity, and as a means to reduce residential crowding to improve ability to socially distance, with adolescent girls in male-headed households most at-risk

- **Iraq:** Increase in reports of GBV, often related to increase in loss of livelihoods
- **Libya:** Movement restrictions exacerbated women's access to GBV services

## Impact on coordination among actors

**Afghanistan:** Increased coordination due to alignment of goals under COVID-19 pandemic

**Bangladesh:** Establishment of shared "remote management systems" between many humanitarian actors to streamline the delivery of services and combine distributions of certain goods and services to limit face-to-face interactions and decrease exposure within communities.

**Ukraine:** Increased engagement on the part of the government in humanitarian response efforts within government-controlled areas

**Nigeria:** Decrease in the number of humanitarian partners participating in regular coordination activities, such as needs assessments

**Iraq:** Increase in coordination between both national and international actors facilitated by the government and the World Health Organisation