GLOBAL HUMANITARIAN RESPONSE PLAN COVID-19

PROGRESS REPORT

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GLOBAL HRP
COVID-19

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Gaza, occupied Palestinian territory
A young girl steps out of her school in Gaza.
Abed Zagout/UNDP

"We are doing what we can to meet growing needs. But the humanitarian agencies are in danger of being overwhelmed by the sheer scale of the needs. And that will get worse in the absence of a lot more financial help."

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

As this report is issued, more than 33 million people worldwide have been infected with COVID-19 and one million have died. Some 11.8 million cases and 409 thousand deaths have been confirmed in the 63 countries covered in the COVID-19 Global Humanitarian Response Plan (GHRP).

However, the raw data should be treated with caution. There are well-known limitations to testing and reporting from many countries, including those in the GHRP. Many places have likely not reached peak transmission yet.

The enormity of the secondary consequences of the pandemic is also now coming into view. We are seeing increasing hunger and malnutrition. Famine is back on the agenda with warning lights flashing in South Sudan, Yemen, the Democratic Republic of the Congo, north-east Nigeria, and Africa's Sahel region to name a few.Health and education systems are collapsing in many countries, leading to a rise in preventable diseases and children dropping out of school. Women and girls face gender-based violence everywhere. The longer it takes before lockdowns and curfews can be lifted, the worse it will get. The contraction of economies is hurting everyone. But those at the bottom of the income pyramid and in the informal sector feel it most. Against a historic drop in poverty over the past three decades, the number of people in extreme poverty is set to rise again. The most vulnerable pay the biggest price - women, children, the disabled and the elderly.

All this will likely fuel grievances and in their wake conflict, instability and displacement, all giving succour to extremist groups. If left to fester, the consequences will be neither contained, nor time bound.

The GHRP is a key piece of a multi-faceted international and national response. Yet the funding to date is less than 30 per cent of the US$10 billion required. Humanitarian organizations are grateful for the money they have received and have been able to quickly adapt responses and adjust priorities to cover both new COVID-related and pre-existing needs. But overall, the current level of funding - and lack of indications regarding additional funding during the last quarter of 2020 - should jolt decision-makers into action. If your neighbour's house is on fire, you ignore it at your peril.

More support, from more donors, is urgently needed.It is a tiny proportion of what is being spent saving the strongest economies of the world. It is also necessary to ensure that national and local actors at the frontlines of response have the financial resources they need.

The world's international financial institutions led by the International Monetary Fund and the World Bank could also do more to help distressed countries, including those in the GHRP. A good place to start would be to increase lending on favourable terms and create extra reserves to help struggling economies.

This Progress Report will present the collective achievements the UN and NGOs have made thus far. It will also examine the links between the GHRP and the Global Humanitarian Overview 2021; the scourge of gender-based violence; education and child protection; and provide funding and resource mobilization analysis and an update on pooled fund support to the crisis. The next report will be issued at the end of October.

GLOBAL HRP
COVID-19

Transitioning from the GHRP to the Global Humanitarian Overview

COVID-19 has spread unevenly across the world – some countries and regions have managed to contain infections while others continue to face a massive public health emergency. In the face of continued community transmission, coupled with the socio-economic fallout, COVID-19 will aggravate existing vulnerabilities and create or exacerbate humanitarian needs far into 2021. The GHRP was established to respond to three strategic priorities:

- Contain the spread of the pandemic and decrease morbidity and mortality;
- Decrease the deterioration of human assets and rights, social cohesion, food security and livelihoods;
- Protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic.

The GHRP focused strictly on the immediate additional humanitarian needs caused by the pandemic and associated short-term responses. The pandemic will continue to have an impact in 2021 - a 'new normal' – and as the health and non-health effects of COVID-19 merge with the effects of other shocks and stresses, humanitarian programming is also adjusting to treat COVID-19 in a more integrated manner: COVID-19 will be a factor that can intensify pre-existing needs and/or create a new set of needs for people already in crisis as well as for new vulnerable groups.

As a result, for 2021, the analyses and responses to address the effects of COVID-19 will be integrated into 'regular' Humanitarian Needs Overviews (HNOs) and Humanitarian Response Plans (HRPs), as part of the Humanitarian Programme Cycle (HPC) 2021. Humanitarian country teams will analyse and plan the response to the impact of the COVID-19 pandemic together with the range of other factors that create or exacerbate vulnerabilities, i.e. looking at the intersections of vulnerability.[1] For example, while different population groups and individuals have unique vulnerabilities to the pandemic, those who present a combination of vulnerability characteristics are the most severely affected, particularly in humanitarian contexts.. The severity of the disease and death from COVID-19 are exacerbated in people with pre-existing conditions, such as diabetes, hypertension, cardiac disease, chronic lung or kidney disease, immunosuppression and cancer. This can be made worse by a lack of access to water, sanitation, health services and social protection, as is often the case for displaced populations and migrants. Women, as a group, may also have another unique combination of vulnerabilities in the face of the pandemic: they are at greater risk of contracting COVID-19 due to their predominance amongst health workers, their greater responsibility caring for sick people at home and in their communities, and their lack of access or control of resources in many settings.

[1] For further information on these concepts and practical guidance on how to integrate COVID-19 into humanitarian needs analysis and response planning, refer to the HPC Step-by-step Guidance 2021 and the Joint Inter-sectoral Analysis Framework (JIAF) Guidance.

KURIGRAM, BANGLADESH
A men has shifted his house and livestock to a higher ground due to flood. His family and 6000 others are being assisted by the WFP by providing them with mobile cash transfers.
WFP/Mehedi Rahman

Another example of the intersection of factors resulting in heightened vulnerability to the pandemic and increased fragility relates to livelihoods and food security. Reduced capacity to pay for food, essential services and housing due to loss of income and decreased remittances could increase both malnutrition and evictions, among others. In consequence, people could also suffer from discrimination and stigma associated with displacement, poverty or other marginalization characteristics showing how COVID-19 could indirectly aggravate the effects of other causes of humanitarian needs.

In preparing their 2021 HNOs and HRPs, humanitarian country teams will consider the effects of COVID-19 in the context of existing humanitarian crises rather than treating it as a stand-alone issue. In most cases, the health and socio-economic impacts of the pandemic will overlay on other health, nutrition, food security, livelihoods and protection risks faced by different population groups. Hence, while some COVID-19-specific responses may still be necessary in certain contexts, in most cases, COVID-19 will represent one of the factors of various humanitarian needs, and programming will reflect the combined effects with other shocks. Country teams will also align the humanitarian response with other ongoing or planned COVID-19 responses to avoid duplication and identify areas/groups for whom development responses are more appropriate.

The result of this integration will be the conclusion of the GHRP as a stand-alone plan, with future COVID-19 and non-COVID-19 humanitarian responses reflected together in the Global Humanitarian Overview 2021. This integration will also signal the synchronization of COVID-19 and non-COVID19 funding requirements and reporting under the regular Humanitarian Programme Cycle.

[2] Of the total, the COVID response requires $396 million with Health, Food Security and Livelihoods, WASH, Emergency Shelter and NFIs and Nutrition.

Integrating COVID-19 into humanitarian planning

ISLAM QALA, AFGHANISTAN
The Reception Center for Refugees and Returnees in the Islam Qala border crossing point between Afghanistan and Iran. *OCHA/Linda Tom*

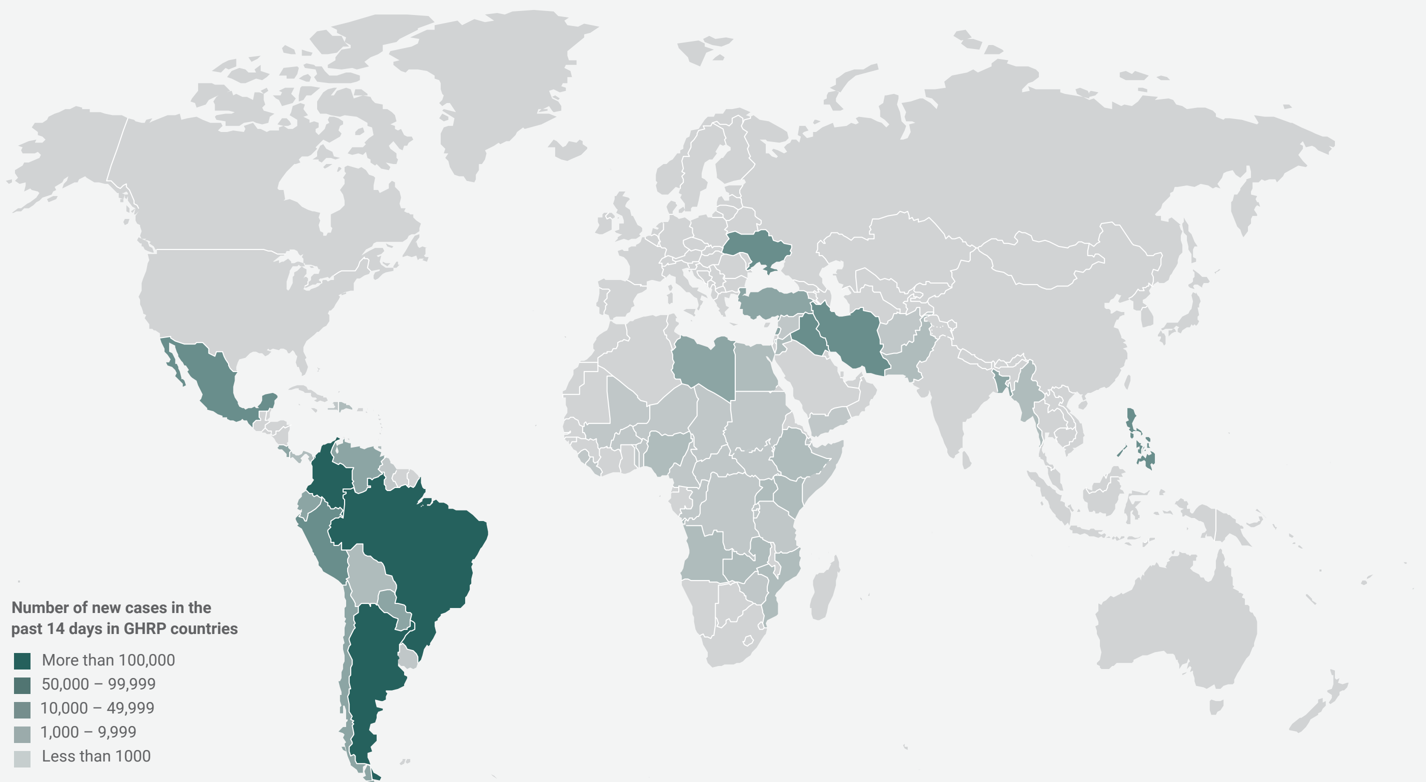
After 40 years of war, yearly natural disasters and persistent poverty, the COVID-19 pandemic has reshaped the humanitarian operating environment in Afghanistan. Afghanistan provides a best practice example of how multi-sector needs assessments will inform the Humanitarian Needs Overview (HNO) and the Humanitarian Response Plan (HRP) despite the volatile security and the constraints caused by COVID-19.

The mid-year 2020 revision of the 2018-2021 Afghanistan HRP in June provided an early snapshot of needs and challenges generated by COVID-19. The Humanitarian Country Team (HCT) increased the number of people in need to 14 million (up from 9.4 million at the start of the year) and the number of people planned to be reached with assistance to 11.1 million (up from 7.1 million). Financial requirements also increased from the original $733 million at the start of 2020 to $1.1 billion.[2] A key driver of this increase was hunger, as a third of the country is facing acute food insecurity (12.4 million people at IPC 3 and above), including almost four million people (11 per cent of the population) at the emergency level – one of the highest figures in the world.

Responding to the inter-sectoral impacts caused the COVID-19 pandemic also drove accelerated engagement between humanitarian and development actors, resulting in a common needs analysis to reflect the full scope of COVID-19-driven and aggravated needs. This has led to the identification of people with chronic needs, outside of the humanitarian caseload, who require a social safety-net type response from the Government and development actors. Some 35 million people (93 per cent of the population) are living below the international poverty line of $2 per day and are included in this category. About one-third of this group (11.1 million people) will be assisted by humanitarian organizations but the rest remain outside of the scope of the HRP and are in urgent need of broader development assistance.

Planning for the final year of the 2018-2021 HRP began in August. A series of in-depth remote workshops has begun, as well as a new common needs analysis with development partners, building on the groundbreaking work that was done in June. In its 2021 planning, the Humanitarian Country Team and the Inter-Cluster Coordination Team are looking at the consequences of COVID-19, conflict and disaster on three 'humanitarian conditions' outlined in the new Joint Inter-sectoral Analysis Framework: physical and mental wellbeing, living standards and coping mechanisms. COVID-19 and protection needs will be mainstreamed throughout the documents. As part of planning for 2021, clusters are also looking at the implications of needs that have gone unaddressed in 2020 due to the challenges of COVID-19, conflict, and access constraints.

Operational Context



APPEALS INCLUDED IN THE GHRP[3]

CONFIRMED CASES

CONFIRMED DEATHS

409k

Source: World Health Organization. covid19.who.int

Six months into the pandemic, the secondary impacts of the crisis are exceeding the initial public health impacts. The pandemic and related mitigation measures have resulted in economic contractions, disruption of basic health services, breakdown of social protection systems and reduced household spending due to the loss of income. Particularly affected are poor households and vulnerable groups, including women and girls, persons with disabilities and the elderly. It is expected that 47 million more women and girls will be pushed below the poverty line by 2021, reversing decades of progress. According to the ILO, an estimated 495 million full-time jobs have been lost.If left unmitigated, the crisis could push between 71 and 100 million into extreme poverty and result in almost a doubling of the number of people who will be acutely food insecure by the end of 2020. As Under-Secretary-General Mark Lowcock recently remarked "…for the first time since the 1990s, extreme poverty is going to increase. Life expectancy will fall. The annual death toll from HIV, tuberculosis and malaria is set to double. The number of people facing starvation may also double."[4]

GHRP countries remain fragile with many suffering from weak health infrastructure and services on top of the pandemic. It is likely that the situation will continue to deteriorate as second waves increase in countries around the world and given that a safe and effective vaccine is not expected to be available for widespread distribution for at least six months.

With available funding for the GHRP thus far, partners were able to provide almost 1.5 million health workers with personal protective equipment (PPEs) and carry out COVID-19 messaging on prevention and access to services to more than a billion people in over 60 countries. Over 93 million children were reached using remote learning platforms. While vaccination campaigns have been disrupted in many countries, health partners have continued to vaccinate children against vaccine-preventable diseases in Ethiopia, Somalia, Central African Republic (CAR) and Mali thanks to effective planning, risk mitigation measures and physical distancing. Through the COVID-19 common services supported by WFP, over 65,000 cubic metres worth of humanitarian cargo has been delivered across 167 countries, in addition to the extensive global passenger air service facilitating humanitarian staff rotation.

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

[3] https://reliefweb.int/report/world/remarks-under-secretary-general-humanitarian-affairs-and-emergency-relief-coordinator-2

Still, the lack of funding has potentially serious consequences. A recent WHO survey on the continuity of essential health services during the COVID-19 pandemic identified the treatment of mental health disorders as one of the most frequently disrupted health services. Twenty-four GHRP countries reported that they had not received additional funding to implement mental health and psycho-social services (MHPSS) as part of their COVID-19 response. Due to the lack of funding, UNHCR will not be able to provide cash assistance for 1,500 families (7,500 refugees) to construct improved latrines in Kenya. That carries the risk that refugees remain in substandard and undignified living conditions as the use of communal latrines exposes them to environmental hazards and communicable diseases, including COVID-19. UNHCR is facing the same issue of funding for education activities and gradual reductions are in sight. In Burundi, for instance, underfunding for education was worsened due to reprioritization of funds to respond to COVID-19, exposing out of school children to protection risks, including SGBV. Crowded classrooms and increased risk of COVID-19 contamination affected some 35,000 refugee students in Burundi and 6,000 refugee students in Zambia.

Humanitarians are facing increasing access constraints to reach people in need. While the humanitarian system continues to prioritize localized response, efforts for UN and international NGO staff to deploy are delayed by visa restrictions. Through sustained advocacy, some Governments have demonstrated flexibility to allow and facilitate access to UN and INGO staff during the pandemic such as in Chad, Ethiopia, South Sudan and Zimbabwe. However, humanitarians are facing significant access challenges in other contexts such as in Myanmar and the Democratic People's Republic of Korea.

Some constraints were pre-existing, particularly those regarding insecurity and violence against humanitarians and health workers. Since January, OCHA has recorded 123 security incidents, resulting in 79 deaths and the injuries of 79 humanitarian workers. In addition, 67 staff have been kidnapped. Local humanitarian workers continue to bear the brunt of the attacks, representing 92 per cent of the casualties.

Still, humanitarians have been and continue to be flexible, nimble and innovative to counter access challenges where applicable. This includes the use of digital technology to reach people in need. UNHCR has piloted contactless biometrics through a newly developed iris scanner to register refugees and authenticate beneficiaries during cash and in-kind assistance in Bangladesh, Ethiopia, Malawi and Zambia.

It is likely that the scale of needs in GHRP countries will continue to rise due to increasing caseloads and the secondary impacts of COVID-19 which are compounded by pre-existing vulnerabilities such as food insecurity, conflict, the impact of climate change and patterns of violence. There are three key steps that would assist humanitarians to respond more efficiently. Firstly, having safe, and unimpeded access to the people in need and being able to move humanitarian goods and services in a timely and cost-efficient manner. Secondly, for Member States and non-state armed groups to adhere to their international humanitarian law and human rights law obligations. And thirdly, to ensure that humanitarian actors, both international and national, receive adequate flexible unearmarked funding to nimbly provide assistance to the most vulnerable.

The scale of food insecurity is rising

KHARAZ CAMP, YEMEN
Somali refugees receive food bags at distribution point organized by UNHCR in Kharaz camp, Lahj city. Prevention measures against COVID-19 are taken to protect beneficiaries and staff. *OCHA/Mahmoud Fadel*

Since the start of the pandemic, a toxic combination of conflict, climate change, trade disruptions and COVID-19 have threatened to push 270 million people to the brink of starvation,[4] an increase from 135 million at the beginning of the year. In response, aid agencies have scaled up interventions and efforts have been made to cushion lower and middle -income countries from further damage. However, extreme fragility resulting from years of conflict combined with the loss of jobs and disruptions in essential health services is having a devastating impact on the most vulnerable.

The scale of increasing food insecurity is raising serious and growing concerns in many places, including where there was a food crisis before the pandemic, such as in Yemen, north-east Nigeria, the Democratic Republic of the Congo, South Sudan. Recent data confirms that the situation is rapidly deteriorating, especially in areas with limited humanitarian access due to deliberate obstruction and/or violence against aid workers. The situation was recently highlighted to the Security Council in the context of resolution 2417, which requests the Secretary General to swiftly inform the Council when the risk of conflict-induced famine and widespread food insecurity occurs.

It is crucial to prevent further deterioration and the emergence of famine conditions in the countries of highest concern and worldwide. History has demonstrated that famine can be prevented. This will require the international community to address the root causes of food insecurity, including armed conflict; ensure sustained support for humanitarian operations, which remain underfunded; and scale up investments in much needed health care, social protection and other public services.

[4] Statement of David Beasley (WFP) during the Security Council briefing on the implementation of resolution 2417.
https://reliefweb.int/report/world/wfp-chief-warns-grave-dangers-economic-impact-coronavirus-millions-are-pushed-further

Thematic Focus
Gender-based Violence

"The pandemic is deepening pre-existing inequalities, exposing vulnerabilities in social, political and economic systems which are in turn amplifying the impacts of the pandemic. Across every sphere, from health to the economy, security to social protection, the impacts of COVID-19 are exacerbated for women and girls simply by virtue of their sex."

– Policy Brief: The Impact of COVID-19 on Women[5]

INCREASING WOMEN, GIRLS AND WOMEN-LED ORGANIZATIONS' ENGAGEMENT AND LEADERSHIP IN THE COVID-19 RESPONSE

COVID-19 has deepened existing vulnerabilities and inequalities, and reports of GBV have increased dramatically. As in other crises, local women-led organizations are often the first responders during a crisis They have strong networks and trust within the community which helps them identify the most vulnerable groups that need assistance. They also have the expertise with past emergencies which makes their leadership and participation critical for an effective humanitarian response.

In **Lebanon**, the continued participation of local women's organizations in the Humanitarian Country Team's response to COVID-19 and the explosion in August underlines the importance of women's leadership in influencing high-level humanitarian decisions.

In **Afghanistan** and **Yemen**, the revival of Gender in Humanitarian Action Working Groups and gender networks in country have helped to prioritise gender equality in the response. More women-led civil society organizations are participating in the gender and humanitarian coordination structures with the support of UN Women, International Rescue Committee and OCHA in both countries. Regular gender analysis and updates are developed and shared with the Humanitarian Country Teams to help keep gender and women, peace and security-related issues on the agenda.

In **Iraq**, **Libya**, **Myanmar** and **Yemen**, including internally displaced women and girls in focus group discussions and humanitarian needs assessment consultations has strengthened and informed the response of the distinct and different needs of women and girls affected by COVID-19. It has also helped to ensure that protracted displacement is addressed in the response.

CHRONIC UNDERFUNDING OF GBV IN EMERGENCIES

Although GBV services, including clinical management of rape, are critical life-saving services in emergency contexts, funding for GBV prevention and response remains unacceptably low. This is of particular concern in fragile and conflict-affected countries with an ongoing humanitarian crisis where the direct and indirect impact of the pandemic have been further amplified. In **Bangladesh**, for example, UNFPA was hampered by a lack of resources in trying to roll out GBV services. It could only provide for 2 out of the 64 targeted districts.

Since the pandemic was declared, OCHA's Country-Based Pooled Funds (CBPFs) and the Central Emergency Response Fund (CERF) have provided substantial support to ensure funding of GBV-related programmes is prioritized. CERF allocated $15.5 million from its Underfunded Emergen-

[5] www.un.org/sites/un2.un.org/files/policy_brief_on_covid_impact_on_women_9_april_2020.pdf

ELINYA, DR CONGO
A woman, survivor of sexual violence holds a flower to her face, in the Elinya site for displaced persons. *OCHA/Alioune Ndiaye*

cies Window to programs for women and girls, including GBV and reproductive health in ten countries. Most of the money ($10 million) was allocated to UNFPA in **Yemen** for programs for women and girls and the remaining $5.5 million for GBV priorities in nine countries. The CERF team worked closely with GBV lead experts to make sure the allocation was aligned with the GBV strategic objectives.

With the lockdown measures not fully lifted in countries such as **Colombia**, reports of domestic abuse continue to grow. In Colombia, calls from women survivors of violence registered an increase of 120 per cent between 25 March and 13 August 2020, compared to the same period in 2019. To help manage the growing number of cases, humanitarian and institutional GBV services have been adapted to the COVID-19 pandemic during the past 5 months through new protocols, guidelines and mechanisms. UNFPA Colombia has developed a new protocol to provide remote GBV case management through helplines in five municipalities that provide psychosocial support and safe referrals.

Several innovative initiatives on addressing GBV and sexual exploitation and abuse have been carried out in humanitarian contexts. In **Nigeria**, GBV actors continue to build upon new ways of supporting communities experiencing an increase in GBV during COVID-19. They are using new approaches to adapt to the changing environment to deliver support. UNICEF and partners in Nigeria have remodelled women and girls' safe spaces into phone booth stations, which not only helps to maintain physical distancing but also provide confidential GBV counselling in a safe environment. While on door-to-door awareness missions on COVID-19, IOM mobile teams in Nigeria also inform displaced people about GBV prevention and where to access related services. A GBV hotline in several local languages was also made available in conflict-affected states in north-east Nigeria.

In **Bangladesh**'s Cox's Bazar, UNICEF supported the development of a mobile application for adolescents to keep them engaged and informed virtually of GBV services available during COVID-19 lockdown restrictions. Since its development, more than 4,000 adolescent girls have accessed this application.

In **Kenya**, UNFPA continues to work with partners in the informal sector to strengthen male involvement in addressing female genital mutilation and teenage pregnancy. In Burkina Faso, UNFPA facilitated the integration of COVID-19, PSEA and family planning themes in the training of 40 members of women's groups.

In **Ethiopia**, IOM, WFP, UN Women and the GBV Sub-cluster are working closely with the PSEA Advisor to develop draft protocols for SEA reporting in quarantine centres.

To support the humanitarian response for Venezuelan migrants in transit, a new protocol for the provision of GBV case management during the pandemic was developed by the GBV technical team. Migrants willing to return to **Venezuela** are provided psychosocial support services and reached through other GBV activities at the Health Care Centre *Tienditas*. Women and girls' safe spaces are used for remote psychosocial activities. Women community leaders support such initiatives and distribute information about the services and helplines.

Throughout its operations globally, UNICEF has trained more than 83,000 people on GBV risk mitigation and safe referral strategies for survivors.

Protection from Sexual Exploitation and Abuse

BAMA, NIGERIA
Women gather in "women and youth friendly space" in Bama town. The women say the space gives them a sense of community, belonging and empowerment to overcome trauma and help other women. *OCHA/Leni Kinzli*

At the beginning of the COVID-19 pandemic, the Inter-Agency Standing Committee published technical guidance on integrating Protection from Sexual Exploitation and Abuse (PSEA) in the COVID response to ensure that all people remained safe from sexual exploitation and abuse while receiving humanitarian aid, including health services and treatment.

A PSEA mapping exercise of 25 GHRP countries[6] was carried out in June to collect data on the estimated number of affected populations with safe and accessible complaint channels, and access to GBV/PSEA assistance, among other key indicators. A global snapshot of this exercise will be featured on the IASC PSEA microsite in early October. The next exercise is planned for January 2021, at which time an additional eight GHRP countries will be added.[7]

[6] Afghanistan, Burkina Faso, Burundi, Cameroon, CAR, Chad, Colombia, DRC, Ethiopia, Haiti, Iraq, Libya, Mali, Myanmar, Niger, Nigeria, oPt, Somalia, South Sudan, Sudan, Syria, Ukraine, Venezuela, Yemen, and Zimbabwe.
[7] Bangladesh, Lebanon, Mozambique, Pakistan, Philippines, Yemen, Syria, and Turkey.

Thematic Focus
Education and Child Protection

"We know that beyond learning, schools provide children with vital health, immunization and nutrition services, and a safe and supportive environment. These services are put on hold when schools are closed. And we also know that the longer children remain out of school, the less likely they are to return. At least 24 million children are projected to drop out of school due to COVID-19."

– Henrietta Fore, UNICEF Executive Director[8]

Education and child protection sectors have important and complementary roles in contributing to children's needs to survive, develop, and thrive, especially in situations of humanitarian emergencies. Attending school not only promotes children's learning and wellbeing, but can also reduce children's risks of child marriage, child labour and child recruitment into armed forces and groups and is a critical platform for transmitting protective messages. Conversely, children safe from these violations are more able to access school, and healthy and happy children can learn and interact with their peers better while at school. Inter-sectoral approaches reflect these inter-connected needs of children and emphasize the collective responsibility to protect children.

COVID-19 has necessitated even greater collaboration between Education and Child Protection. School closures and home isolation exacerbate existing risks to children's protection, wellbeing and learning. At the same time, the pandemic has also required collaboration and innovation in the humanitarian response: an opportunity to generate new ways of working.

As a result of extended school closures, being confined at home, and the adoption of negative coping mechanisms by their families, children are experiencing more violence in their homes and communities (80% of Protection Clusters report an increase in violence during the pandemic),[9] with noted increases in sexual and gender-based violence. Without regular contact with trusted adults outside their home, especially their teachers, these risks and violations are going undetected and unreported. Children face greater risks of child marriage and teen pregnancy (an additional 13 million child marriages are estimated by 2030 as a result of COVID-19),[10] child labour[11] and child recruitment into armed forces and groups, with long-term health and educational consequences.[12] Being out of school for extended periods has generated unparalleled loss of learning, and increased children's risk of dropping out from school altogether (24 million children are projected to drop out of school due to COVID-19).[13] Finally, children's mental health has been affected by the loss of social contact and regularity that attending school provides[14] and school closure has limited access to other essential school-based services including school health and nutrition, information on disease prevention, and clean water and sanitation.

[8] www.unicef.org/press-releases/unicef-executive-director-henrietta-fore-remarks-press-conference-new-updated
[9, 10, 12] Key Protection Advocacy Messages COVID-19, IASC Results Group 3 on Collective Advocacy, September 2020, accessed here.
[11] *As COVID-19 Closes Schools, the World's Children Go to Work*, New York Times, September 27, 2020, accessed here and UNICEF press release, 11 June 2020 accessed here.
[13] UNICEF press release, 15 September 2020, accessed here.
[14] Protect a generation: the impact of COVID-19 on Children's Lives, Save the Children, September 2020, accessed here.

MUNUKI, SUDAN
A girl is tuning in on the educational radio lessons. She is in primary 8, and the lessons today are covering English and Science. *UNICEF/Helene Ryeng*

Strong inter-sector collaboration is required more than ever to address these compounding multi-sector needs and operational constraints created by COVID-19. Education and Child Protection sectors across GHRP countries, regions and globally, have stepped up and worked together to jointly address children's needs and risks during the pandemic. To strengthen the adoption and coordination of inter-sector approaches, the Global Education Cluster and Child Protection Area of Responsibility have jointly developed a Collaboration Framework and provide support to enhance Child Protection-Education in Emergencies (CP-EIE) collaboration during the current response and beyond. There are key opportunities to collaborate in the following areas:

- **Delivering messages and services together through new remote modalities maximizes the available opportunities to reach children in need.** For example, child protection messages and psycho-social services (PSS) sessions were integrated into the distance learning broadcasts, and joint child hotlines were established.
- **School re-opening represents both a resumption in learning and also a critical opportunity to identify and address the harms to children's protection and wellbeing** experienced during lockdown, and therefore is another critical opportunity for Education and Child Protection to work together:
    - Prolonged school closures increase the risk of children not returning to school, and marginalized children are the most likely to drop out; through collaboration in back to school campaigns, absence monitoring and outreach to children at risk, Education and Child Protection sectors worked together to mitigate this.
    - Once children are back in school, teachers are among the first trusted adults outside of the home to spend time with children and are well-placed to identify signs of child protection concerns. Extensive collaboration has occurred between CP and Education sectors to prepare schools and teachers to identify, respond to and report these concerns through school-based referral mechanisms.
    - Psychosocial support through schools and referrals from schools to more specialised MHPSS services is a key area of the COVID-19 response underpinned by inter-sector collaboration, and new response modalities have provided an opportunity to clarify, and where necessary reconfigure, sector roles on delivering MHPSS to ensure added value.

New ways of working were required to respond to the COVID-19 pandemic, and collaborative inter-sector approaches manifestly emerged across GHRP countries. The COVID-19 guidance and resources developed at all levels promote and support integrated responses to children's needs in the face of COVID-19.[15]

The new approaches and learning and resources generated to date in the COVID-19 response have strengthened both Education and Child Protection responses. We must continue this coordinated and integrated approach to respond holistically to children's needs. This will require coherent coordination of common and complementary response areas (as outlined in the CP-EiE Framework) to enhance quality, coverage, efficiency and accountability of both sectors' responses.

Looking towards 2021 HRP planning and preparedness for new waves of COVID-19, the Global Education Cluster, Global Child Protection Area of Responsibility and its partners are committed to continue to apply and support these collaborative approaches and ensure that the safe return to learning features prominently in 2021 Humanitarian Response Plans.To sustain and expand these achievements, continued flexible and unearmarked funding that can be applied cross-sectorally is required, as is support for quality proposals linking the protection of children with education and championing of good examples that show that integrated programming is not only possible but prudent in times of COVID-19 and beyond.

[15] Resources include: CP-EiE Collaboration in Coordination Framework; CP-EiE Framework - Checklist for Reopening Schools; COVID-19: Integration of CP in Return to School resources; Safe Back to School Guide; Weighing up the risks: School closure and reopening under COVID-19; Framework for Reopening Schools and supplemental Emerging lessons from country experiences in managing the process of reopening schools; Considerations for school-related public health measures in the context of COVID-19.

Stories from the field

RWANDA
Students take classes at home due to coronavirus-related school closures, listening to his lessons on the radio every day. Each radio lesson is approximately 20 minutes long and focuses on interactive learning. Lessons are designed so students can participate on their own, but parents and caregivers are encouraged to listen in and support learning at home. *UNICEF*

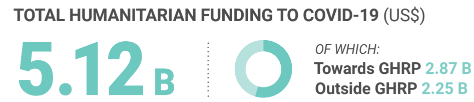
East Asia and Pacific

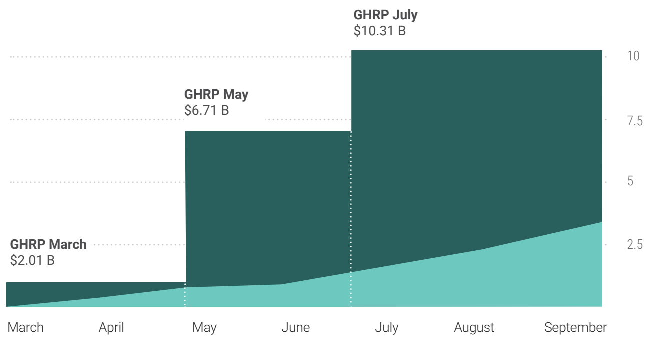
Returning to school after COVID-19 closures is a critical opportunity to work collectively towards learning, wellbeing and protection outcomes. Recognising the central role of teachers and schools in protecting and supporting students during this time, the UNICEF East Africa and Pacific Regional Office developed a suite of practical materials, targeted at the school-level, to support the integration of Child Protection during school re-opening. Resources include Tips for Teachers and School Management, Messages for Children and Adolescents Return to School and a Template for Child Protection Referral Pathway between Schools and Child Protection Authorities.

Somalia

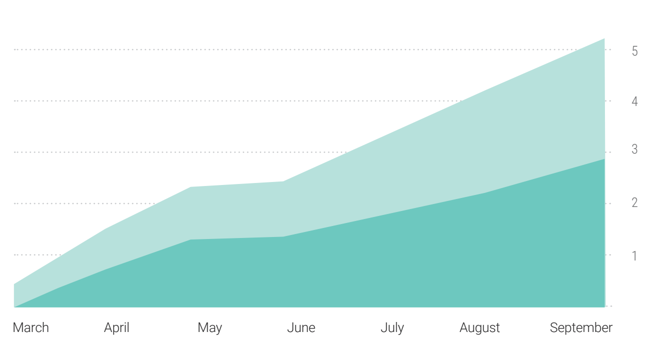
Closure of schools, child friendly spaces, and other community facilities required innovative and collaborative responses to reach children in need during the COVID-19 pandemic. Schools in Somalia established a system of remote follow-up to children on an individual basis through a network of head teachers and teachers. This channel provided continued access to children during school closures, so Education and Child Protection sectors in Somalia maximized this opportunity to re-establish connection to child protection and PSS services to children through the through this system. Teachers were prepared and supported to deliver PSS and CP messages to their students via Whatsapp, and could identify and report children in need of child protection services through updated referral pathways and their school child protection focal point. The Guidelines for Remote Psychosocial Support to children and Teachers during COVID-19 were developed by the Education and Child Protection Sectors, together with the Ministry of Education, to be implemented on a national scale.

Financial Overview





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



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

The COVID-19 crisis continues to necessitate strong financial and political commitment to fund the GHRP and coordinated humanitarian action. Without more funding, humanitarian partners will not be able to provide the much-needed assistance to vulnerable groups, including older persons, IDPs and refugees, women and girls and persons with disabilities.

As of 30 September, funding for the GHRP requirements, including the financial needs for 63 countries, is $2.87 billion, or 28 per cent, leaving $7.32 billion of requirements unmet. This is only $520 million more than reported in the second GHRP Progress Report at the end of August. Coverage varies widely by country, with only four plans funded above 50 per cent: Libya, Mali, Myanmar and Ukraine. The highest increases in coverage since last month are in Burkina Faso, CAR, Iraq, Libya, Syria, Yemen, Ecuador and Lebanon. Twenty-nine of the country response plans are funded less than the 28 per cent global average, leaving significant gaps. Twelve plans are funded under 10 per cent: Benin, Colombia, DRC, DPRK, Horn of Africa, Jordan, Kenya, Liberia, Tanzania, Uganda, the Burundi Regional Refugee Response Plan and the DRC Regional Refugee Response Plan.

The GHRP financial requirements have decreased to $10.2 billion since the July update, when requirements were listed as $10.3 billion. This is due to changes in country-level requirements: Burundi increased its GHRP requirements after redistributing its COVID-19 and non-COVID-19 activities within the Education, Protection, Nutrition and WASH sectors, though its overall humanitarian ask remains the same. oPt increased its GHRP financial requirements to respond to large increases of COVID-19 community transmission. Colombia, Ethiopia and South Sudan all decreased their financial requirements after clusters in-country redistributed their requirements between COVID-19 and non-COVID-19 activities or adjusted their figures to avoid overlaps with other response plans or Government-led responses.

In addition to the $2.87 billion reported for the GHRP, $2.25 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 for non-GHRP countries, including more than $640 million to WHO's Strategic Preparedness Response Plan, Contingency Fund for Emergencies, and other activities which cover countries beyond those identified in the GHRP. Some of this funding has been provided flexibly to organizations and may eventually be recorded against the GHRP requirements as projects are implemented and more details are received.

As seen below, there is disparity among regions in terms of funding for GHRP requirements. The most serious shortfall is still in Latin America and the Caribbean, with an average of only 14 per cent covered, despite continued rising numbers of cases in this region. GHRP coverage in South and East Africa (19 per cent) is also significantly below the global average of 28 per cent.

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

REGION	GHRP REQUIREMENTS	FUNDING	COVERAGE
Asia and Pacific	**1.15 B**	361.5 M	**31%**
Eastern Europe	**46.9 M**	28.5 M	**61%**
Latin America and Caribbean	**1.00 B**	136.3 M	**14%**
Middle East and North Africa	**2.25 B**	745.7 M	**33%**
South and East Africa	**2.45 B**	462.9 M	**19%**
West and Central Africa	**1.46 B**	430.8 M	**29%**

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	132.8 M	34%	1.13 B	369.7 M	33%
Burkina Faso	HRP	105.9 M	45.9 M	43%	424.4 M	159.0 M	38%
Burundi	HRP	71.4 M	9.8 M	14%	197.9 M	61.9 M	31%
Cameroon	HRP	81.7 M	33.4 M	41%	390.9 M	117.5 M	30%
CAR	HRP	152.8 M	71.7 M	47%	553.6 M	274.7 M	50%
Chad	HRP	124.2 M	31.1 M	25%	664.6 M	212.9 M	32%
DRC	HRP	274.5 M	89.4 M	33%	2.07 B	468.8 M	23%
Ethiopia	HRP	374.2 M	71.0 M	19%	1.65 B	483.1 M	29%
Haiti	HRP	144.4 M	24.9 M	17%	472.0 M	74.4 M	16%
Iraq	HRP	264.8 M	117.3 M	44%	662.2 M	450.4 M	68%
Libya	HRP	46.7 M	35.7 M	77%	129.8 M	76.8 M	59%
Mali	HRP	75.4 M	40.5 M	54%	474.3 M	175.1 M	37%
Myanmar	HRP	58.8 M	33.6 M	57%	275.3 M	115.4 M	42%
Niger	HRP	82.3 M	26.3 M	32%	516.1 M	213.0 M	41%
Nigeria	HRP	242.4 M	59.9 M	25%	1.08 B	423.3 M	39%
oPt	HRP	72.4 M	35.2 M	49%	420.4 M	186.1 M	44%
Somalia	HRP	225.6 M	68.1 M	30%	1.01 B	584.1 M	58%
South Sudan	HRP	383.0 M	85.0 M	22%	1.90 B	699.8 M	37%
Sudan	HRP	283.5 M	93.9 M	33%	1.63 B	755.7 M	46%
Syria	HRP	384.2 M	161.8 M	42%	3.82 B	1.61 B	42%
Ukraine	HRP	46.9 M	28.5 M	61%	204.7 M	71.8 M	35%
Venezuela	HRP	87.9 M	20.5 M	23%	762.5 M	67.3 M	9%
Yemen	HRP	385.7 M	146.6 M	38%	3.38 B	1.32 B	39%
Zimbabwe	HRP	85.0 M	27.5 M	32%	800.8 M	158.5 M	20%
Burundi Regional	RRP	65.4 M	5.9 M	9%	275.4 M	19.9 M	7%
DRC Regional	RRP	155.7 M	10.5 M	7%	638.7 M	30.1 M	5%
Nigeria Regional	RRP	-	-	-	-	-	-
South Sudan Regional	RRP	128.8 M	21.1 M	16%	1.34 B	71.7 M	5%
Syria Regional	3RP	758.3 M	136.7 M	18%	6.00 B	1.50 B	25%
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	48.4 M	11%	1.41 B	329.0 M	23%
Rohingya Crisis	Other	181.4 M	64.3 M	35%	1.06 B	508.4 M	48%

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

Funding per Appeal (2/2)

INTER-AGENCY APPEAL		GHRP/GHO REQUIREMENTS	FUNDING	COVERAGE
Benin	COVID	**17.9 M**	0.2 M	10%
Colombia	COVID	**283.9 M**	27.0 M	10%
DPR Korea	COVID	**39.7 M**	3.5 M	9%
Iran	COVID	**117.3 M**	57.2 M	49%
Lebanon	COVID	**136.5 M**	54.6 M	40%
Liberia	COVID	**57.0 M**	4.1 M	7%
Mozambique	COVID	**68.1 M**	13.6 M	20%
Pakistan	COVID	**145.8 M**	69.9 M	48%
Philippines	COVID	**121.8 M**	12.8 M	11%
Sierra Leone	COVID	**62.9 M**	12.3 M	20%
Togo	COVID	**19.8 M**	3.0 M	15%
Bangladesh Intersectoral	COVID	**205.9 M**	44.6 M	22%
Djibouti Intersectoral	COVID	**30.0 M**	4.4 M	15%
Ecuador Intersectoral	COVID	**46.4 M**	15.6 M	34%
Jordan Intersectoral	COVID	**52.8 M**	0.3 M	1%
Kenya Intersectoral	COVID	**254.9 M**	22.4 M	9%
Rep. Of Congo Intersectoral	COVID	**12.0 M**	0.9 M	7%
Tanzania Intersectoral	COVID	**158.9 M**	9.9 M	6%
Uganda Intersectoral	COVID	**200.2 M**	10.3 M	5%
Zambia Intersectoral	COVID	**125.6 M**	19.9 M	16%
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**	232.0 M	23%
TOTAL		10.19 B	2.87 B	28%

Note: GHRP funding not yet identified for a specific activity or country response plan: $454.4 M.
Intersectoral plans include the humanitarian component of existing intersectoral COVID-19 response plans in countries already included in the GHRP through a Regional Refugee Response Plan, a Regional Migrant Plan or a Joint Response Plan. This covers stand-alone plans for Bangladesh, Djibouti, Ecuador, Jordan, Kenya, Republic of the Congo, Tanzania, Uganda and Zambia.

Funding the Response: **Flexible and Unearmarked Funding**

THE BENEFITS OF FUNDING FLEXIBILITY

Flexible and timely funding, particularly to frontline responders, has been a key issue since the beginning of the pandemic. The generosity of donors in providing flexible funding and quick action by agencies to adapt business practices is widely recognized. However, according to an ongoing monthly 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 percentage of total COVID funding received between 1 March and 31 August varies from 12 per cent to 64 per cent, with an average of 32 per cent.[17] This is less than the 42 and 37 per cent averages reported in June and August, respectively, indicating that less flexible funding is being given now than at the onset of the pandemic.

Six UN agencies also reported that an average of 85 per cent of their flexible funding has been or will be allocated to countries in the GHRP.[18] 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 remains an important issue. As described in last month's progress report, many concrete measures were taken to improve cascading. According to five of the UN agencies responding to the latest survey, on average, 14 per cent of the total funding received for the COVID response, including flexible funding, will be implemented by NGOs and/or Red Cross / Red Crescent National Societies.[19]

InterAction and ICVA have undertaken survey work within the NGO community to gather feedback on the use and impact of flexible funding for GHRP activities and provide a more robust picture of the current state of affairs. These efforts have helped to highlight the ways in which NGO partners have adjusted their work in response to the needs posed by the COVID-19 pandemic, as well as which flexibility measures have worked well from the NGO perspective. The IASC Humanitarian Finance Results Group has also tracked funding flexibility as part of the actions undertaken to improve the flow of funds to frontline responders under the GHRP.

One of the most common reflections from NGO partners on funding flexibility has been the value of additional budget flexibility. As part of the IASC guidance on flexibility, UN agencies agreed to allow additional flexibility between budget categories of up to 30% (depending on the individual agency).

NGOs reported several programmatic benefits from this flexibility:

- Increased ability to "adapt and pivot" and a significant decrease in the need for contract amendments;
- Quicker response to changes in context in field operations which reduces administrative burdens and increases speed and effectiveness.
- For UNHCR partners, the ability to release funding instalments early, combined with greater flexibility to manage spending within budget outputs (increased from 20 to 30%).

NGOs also highlighted no-cost extensions, simplified due diligence and risk management, and simplified reporting requirements as flexibility measures that enabled more rapid response, and in many cases were aligned with donor practices. For the most part, there was ongoing work prior to COVID-19 to simplify approaches in these areas and COVID-19 provided additional motivation to fast-track efforts. NGO colleagues and some UN agencies have already expressed support for the adoption of many of these measures as standard practice moving forward, and an IASC discussion will take place before the end of 2020.

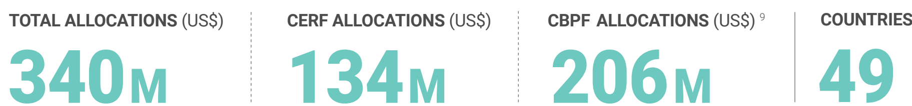
CHALLENGES

COVID-19 and the importance of funding to frontline responders have highlighted the continued need to improve transparency and tracking. Despite the positive feedback shared by NGO colleagues, there are several challenges regarding funding flexibility, including the lack of quantitative data on the actual amount of funding cascading through the system for the GHRP and COVID-19 response. While the Financial Tracking Service is able to track flows of funding – flexible and other – as it is passed from first recipients to implementing partners, this information is often not reported. Markers for funding characteristics, such as flexibility, are also not universally defined or tracked, making it even more difficult to quantify. NGO consortia members reporting on use of funds at the country level also highlighted the lack of transparency on funding flows and the difficulty of tracking or identifying funds that are part of larger, flexible grants. While this does not necessarily mean that funds are not reaching partners in the field, the inability to track funding in a granular manner makes robust analysis difficult.

In addition to tracking of funding, NGOs have also identified consistency in application of flexibility measures as a key challenge. The commitments achieved at the global level to implement flexibility measures did not always translate into the same level of understanding and implementation at the field level. This echoes survey feedback received by ICVA in which NGO partners have reported varying practices and results between countries and agencies regarding the speed and degree of flexibility.

[17] The actual percentages for five reporting agencies are 12, 12, 25, 38 and 64.
[18] The actual percentages for individual agencies are 62, 89, 91 and 100. This does not include WFP's flexible funding which was primarily used for global operational support.
[19] These figures do not take into account supplies procured and transported by agencies and passed on to partners for local distribution.

Funding the Response
Pooled Funds



TOTAL ALLOCATIONS (US$)	CERF ALLOCATIONS (US$)	CBPF ALLOCATIONS (US$) [9]	COUNTRIES
340M	134M	206M	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]

41.8M

OF WHICH :
Men 11.4 M **Women** 12.7 M **Boys** 8.6 M **Girls** 9.0 M

OCHA's pooled funds have allocated $340 million in 49 country contexts to support humanitarian partners in their response to the COVID-19 pandemic, including both new and reprogrammed funding.

CHANNELING RESOURCES TO NGOS FOR FRONT LINE RESPONSE

The Country-Based Pooled Funds (CBPFs) and the Central Emergency Response Fund (CERF) have provided substantial support to NGOs to kick start and sustain lifesaving activities. Together, the two instruments have allocated around $162.7 million to international and national NGOs, Red Cross/Red Crescent National Societies and other local partners as direct recipients or sub-grantees of other organizations.

CBPFs are playing a critical role in the delivery of urgently needed front-line humanitarian assistance. Some $128 million, 62 per cent of all funding, has been allocated to NGO partners, including 123 INGOs, 118 NNGOs, and four Red Cross/Red Crescent Societies, altogether targeting over 23 million people.

Under CERF's first-ever allocation to NGOs, $25 million was alloca ted for COVID-19 response in six countries (described in last month's update), 16 INGOs and eight NNGOs have received funding under this allocation and will provide assistance to 1.38 million people.

EARLY RESULTS ON COVID-19 RESPONSE

Together CBPFs and CERF have enabled humanitarian organizations to scale up response in key sectors including health, WASH and protection, including GBV.

Health-awareness campaigns and risk communication activities funded by both CERF and CBPF, as reported last month, have reached more than 20 million people, and over four million units of personal protective equipment, health kits and medical supplies have been delivered.

With CERF funding, partners have provided critical water supplies and hygiene kits to 2.3 million people, supported homebased learning to over 5 million children, and provided sexual and reproductive healthcare to 287,000 women and girls. In addition, 44,000 people have received cash assistance to pay for essentials like food, water, utilities and rent. Funding has also enabled WFP to establish three humanitarian response hubs to facilitate cargo movements, set up two field hospitals in Accra and Addis Ababa, and operate hundreds of cargo flights.

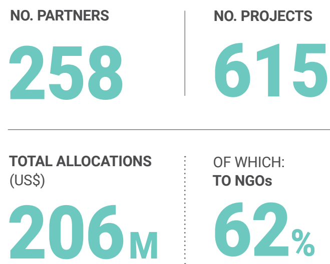
CBPFs have supported the establishment of 107 isolation facilities and intensive care units for COVID-19. Support is ongoing to another 7,000 health care facilities, including testing and emergency health services to around 300,000 people. CBPFs are also supporting health screening and contact tracing for over 700,000 people, and training for around 200,000 health workers on early detection and case management in support of national health authorities. Almost 500,000 units of medical supplies and equipment, including masks, ventilators, and PPE have been distributed, and 20 million units are being procured.

ADDRESSING GBV DURING THE COVID PANDEMIC

Twice a year, CERF allocates funding to underfunded crises. The latest allocation – totalling $100 million – will support frontline agencies to deliver life-saving assistance in ten countries where COVID-19 is exacerbating humanitarian needs, placing pressure on livelihoods and increasing the risk of domestic and gender-based violence. The ERC has earmarked at least $5.5 million of the allocation for programming that addresses key issues related to gender-based violence. The funding will incentivize additional, innovative programming, aiming to have a catalytic effect on the wider humanitarian response. Humanitarian Country Teams in the respective countries have increased the amount targeted for GBV programming to more than $10 million.

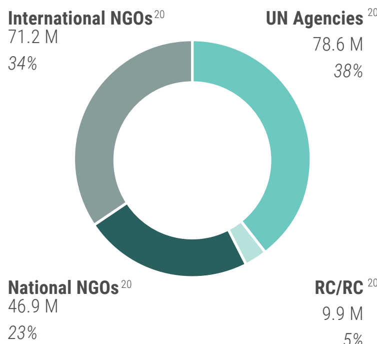
DAMAZIN, SUDAN
13-year-old Nouraldin, uses the knowledge he gains through listening to radio about COVID-19 to educate his family members and friends. *WVI/Mutwakil al Jamry*

CBPFs ALLOCATIONS PER PARTNER



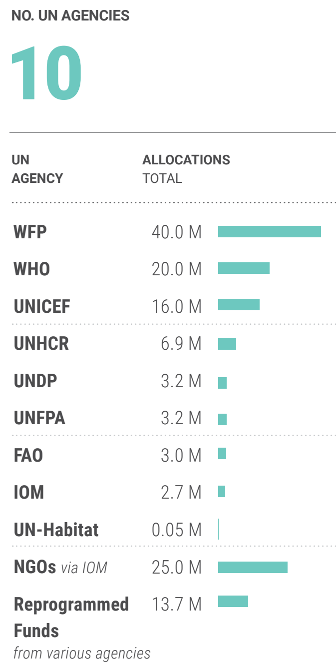
NO. PARTNERS **258** | NO. PROJECTS **615**

TOTAL ALLOCATIONS (US$) **206M** | OF WHICH: TO NGOs **62%**



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$)[21] **1.21B** | DONORS **60**

TOP 10 DONORS	CONTRIBUTIONS TOTAL	CERF	CBPFs
Germany	282.4 M	113.4 M	169.0 M
United Kingdom	160.1 M	12.6 M	147.5 M
Sweden	150.9 M	84.4 M	66.5 M
Netherlands	149.1 M	89.4 M	59.8 M
Norway	85.0 M	50.3 M	34.7 M
Belgium	73.6 M	24.3 M	49.3 M
Canada	52.6 M	22.5 M	30.1 M
Denmark	50.7 M	25.2 M	25.5 M
Switzerland	46.5 M	24.0 M	22.5 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.

[20] 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).
[21] Donors' contributions as of 18 September 2020

Awareness campaigns supported by Pooled Funds

CERF allocations in Haiti

When Haiti declared its first two cases of COVID-19 in March, the country adopted preventive measures, including the closing of schools, to curb the spread of the virus. Wisphania Metellus is one of four million Haitian children who have not been to school for months. "Children are forced to stay at home. They no longer have access to their playgrounds, their classrooms, or their friends," said Jean Stenio Pierre, UNICEF Haiti.

In February, CERF allocated funding through UNICEF to support the work of ACTED. Following a communication strategy developed by the Ministry of Public Health and Population, with the support of UNICEF, community mobilizers began working to raise awareness about how to protect against COVID-19. ACTED has distributed tap buckets to facilitate hand washing and has broadcast messages on the radio and with megaphones to sensitize the population. Wisphania has attended sensitization sessions at her home and is familiar with the physical barriers and action required to stay healthy. "To avoid getting the disease, you have to wash your hands all the time, not shake hands or kiss each other, and keep two meters away." Wisphania dreams about the end of the pandemic and returning to school because she has a specific goal. "I want to continue my studies and become a medical doctor to treat people."

Sudan Humanitarian Fund (SHF)

As millions of children in Sudan remain out of schools due to the coronavirus pandemic, they are finding meaningful ways to spend their time at home. Thirteen-year-old Nouraldin is promoting about how to keep safe during the pandemic among his peers. It all started in May, when he heard messages about the highly infectious coronavirus being broadcast from a loudspeaker mounted on a moving vehicle in his community.

Since March, World Vision and partners, in collaboration with the State Ministry of Health in Blue Nile state, have been carrying out COVID-19 awareness campaigns by broadcasting messages through radio and television; and educating community members on the risks and how they can contribute to preventing its spread. Funding through OCHA's SHF has made this possible.

The SHF supported COVID-19 related response activities with $12.2 million in all parts of Sudan. The CERF complemented this with a grant of $3 million for COVID-19 response. SHF funding facilitated a range of response activities such as awareness raising, support to isolation centres, and care of COVID-19 patients, among others.

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

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

POOLED FUNDS ALLOCATIONS BY COUNTRY

COUNTRY / POOLED FUND	TOTAL ALLOCATIONS	OF WHICH: CERF	UN AGENCIES	INT'L NGOs	NAT'L NGOs	OF WHICH: CBPFs [22]	UN AGENCIES	INT'L NGOs	NAT'L NGOs	RC/RC[23]
Global 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	14.5 M	**6.8 M**	1.8 M	5.0 M	–	**7.6 M**	1.7 M	4.8 M	0.9 M	–
Chad	2.9 M	**2.9 M**	2.9 M	–	–	**–**	–	–	–	–
Colombia	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Djibouti	1.4 M	**1.4 M**	1.4 M	–	–	**–**	–	–	–	–
DPR Korea	0.9 M	**0.9 M**	0.9 M	–	–	**–**	–	–	–	–
DRC	10.2 M	**–**	–	–	–	**10.2 M**	1.6 M	7.1 M	1.2 M	0.4 M
Ecuador	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Eritrea	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Ethiopia	6.6 M	**1.1 M**	1.1 M	–	–	**5.5 M**	3.9 M	1.4 M	0.1 M	–
Haiti	6.9 M	**6.9 M**	2.9 M	2.9 M	1.2 M	**–**	–	–	–	–
Iran	2.8 M	**2.8 M**	2.8 M	–	–	**–**	–	–	–	–
Iraq	12.3 M	**0.7 M**	0.7 M	–	–	**11.6 M**	1.9 M	9.3 M	0.3 M	–
Jordan	8.6 M	**2.6 M**	2.6 M	–	–	**6.0 M**	0.6 M	3.0 M	2.1 M	0.3 M
Lebanon	18.5 M	**6.6 M**	6.6 M	–	–	**11.9 M**	0.1 M	6.1 M	5.7 M	–
Lesotho[24]	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Libya	5.0 M	**5.0 M**	2.0 M	2.5 M	0.5 M	**–**	–	–	–	–
Mali	2.4 M	**2.4 M**	2.4 M	–	–	**–**	–	–	–	–
Mauritania	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	11.7 M	**1.9 M**	1.9 M	–	–	**9.8 M**	5.7 M	3.2 M	0.9 M	–
oPt	13.5 M	**0.9 M**	0.9 M	–	–	**12.6 M**	5.2 M	4.4 M	3.0 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[24]	0.5 M	**0.5 M**	0.5 M	–	–	**–**	–	–	–	–
Somalia	6.5 M	**2.6 M**	2.6 M	–	–	**3.9 M**	3.6 M	–	0.3 M	–
South Sudan	17.3 M	**6.9 M**	2.0 M	3.8 M	1.1 M	**10.4 M**	5.5 M	3.3 M	1.6 M	–
Sudan	21.8 M	**9.2 M**	6.2 M	2.6 M	0.4 M	**12.6 M**	4.5 M	6.8 M	1.2 M	–
Syria	24.8 M	**1.8 M**	1.8 M	–	–	**23.0 M**	14.5 M	4.6 M	2.9 M	1.0 M
Syria Cross Border	23.6 M	**0.4 M**	0.4 M	–	–	**23.2 M**	5.4 M	3.3 M	6.2 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	–	–	**–**	–	–	–	–
Yemen	17.1 M	**–**	–	–	–	**17.1 M**	16.8 M	0.1 M	0.1 M	–
Zambia	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Zimbabwe	1.1 M	**1.1 M**	1.1 M	–	–	**–**	–	–	–	–
TOTAL	**340.5 M**	**133.7 M**	**110.9 M**	**18.2 M**	**4.7 M**	**206.8 M**	**85.4 M** [25]	**77.2 M** [26]	**34.1 M** [27]	**9.8 M**

[22] This table includes funds provided to humanitarian partners as primary recipients only. See p.15 for global levels inclusive of sub-grants. / [23] Red Cross / Red Crescent
[24] Non-GHRP countries are included when funds were reprogrammed toward COVID response
[25] UN Agencies received $64.1 million as primary recipients, and sub-granted $6.3 million to other humanitarian organizations. See p.16 for funding inclusive of sub-grants.
[26] 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.16 for funding inclusive of sub-grants (total: $64.8 million).
[27] National NGOs received $31.7 million as primary recipients, before receiving some sub-grants from other organizations as their sub-implementing partners. See p.16 for funding inclusive of sub-grants (total: $42.9 million).

Progress of the response

Monitoring and reporting are key elements of any robust humanitarian plan, ensuring that activities remain relevant and appropriate to a context. The nature of the GHRP as a global inter-agency plan addressing a global pandemic has brought to light the challenges of reporting comprehensively on the humanitarian response. This is partly because the GHRP is linked to several other plans, including existing Humanitarian Response Plans, WHO's Country Preparedness and Response Plans, and the emerging socio-economic plans.

From the outset, the GHRP aimed to ensure accountability to both affected populations and donors supporting the response. Recognizing the unique context in which the GHRP was established, and the short time available to do it, IASC partners established a framework for monitoring the response, with indicators to measure changes in the operational context (situational analysis), as well as progress in the response against the GHRP's three strategic priorities. Agencies identified indicators for each category and agreed to report against them. Agencies' headquarters, international NGOs and global clusters have coordinated in-country data collection, aggregated the country-level reporting, and provided global figures and accompanying narrative. OCHA, in turn, has consolidated the data against the monitoring framework and synthetized it in this monthly progress report.

The first round of data collection and narrative reporting took place in June 2020, ahead of the GHRP July Update. However, a number of challenges quickly became evident: ongoing restrictions on mobility and travel limit the ability of humanitarian organizations to conduct field assessments; methodologies to report against the same indicator vary from country to country and between humanitarian organizations, so aggregation is difficult; most organizations only report on their own achievements and not on behalf of a group; and finally, the biggest challenge was the absence of humanitarian inter-agency coordination mechanisms, such as clusters or an OCHA country office in about half of the GHRP countries.

GHRP participants have learned from experience and overcome some of the challenges presented by the first two rounds of monitoring in July and August. Agencies, NGOs and clusters have made efforts to report against the full monitoring framework. They have actively updated targets to reflect changes in context and programming. OCHA country offices too have enhanced monitoring, offering remote support to Resident Coordinator Offices in countries without a humanitarian inter-agency coordination mechanism. These efforts have yielded a trove of information and insight into the magnitude of the response and the achievements and struggles of the humanitarian community. Above all, aid organizations have demonstrated unwavering commitment to continue to deliver aid to the most vulnerable, despite access constraints, challenges in securing supplies, and limited financial resources.

The information available through the GHRP monitoring framework does nonetheless have limitations, stemming from the challenges outlined above. The monitoring framework does not measure the full scope of the collective response by all actors in all 63 countries. It is limited to reporting organizations and only in certain countries. Most of the reporters are UN agencies, though the response involves a plethora of organizations. In the absence of common methodologies to measure the same indicators, it is not possible to aggregate figures. Finally, analysis of how achievements can be attributed to specific funding cannot be conducted in a meaningful way at the global level, due to the large variety of contexts, projects, actors, and types of interventions. Such analysis can, however, be conducted within an organization, or within a country, and can be found in reports produced by these organizations.

The following pages present progress on the indicators for the GHRP's three strategic priorities based on information provided by humanitarian partners. Indicators show cumulative values since the launch of the GHRP on 25 March. More detailed, narrative reporting on collective achievements can be found here. A special focus on regional achievements in Africa can be found here. As the quantitative and qualitative data show, there has been tremendous progress in addressing the pandemic. Yet, as noted above, this is not consistent across all sectors and considerable gaps remain, putting lives and livelihoods at risk.

Monitoring indicators
Situation and needs

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	SEPTEMBER REPORT
Spread and severity of the pandemic	Number of confirmed COVID-19 cases in GHRP countries	WHO	11,801,730[27]
	Total number of deaths among confirmed cases in GHRP countries	WHO	409,018[28]
	Number and proportion of new confirmed cases in health care workers	WHO	–
Sexual and reproductive health	Number of institutional births in COVID-19 affected areas globally	UNFPA	Decline in 15 of 32 countries
		WHO	–
	Proportion of countries where pre-COVID-19 levels of family planning/ contraception services are maintained	UNFPA	–
		WHO	28% no disruption 63% partial disruption 7% complete disruption
	Proportion of countries where pre-COVID-19 levels of institutional births are maintained	UNFPA	Maintained in 17 out of 32 countries; 6 countries showed declines in more than 50% of health facilities; 9 countries showed declines in 10-25 % of health facilities.[29]
		WHO	48% no disruption 48% partial disruption
Mobility, travel and import/export restrictions in priority countries	Number of priority countries with international travel restrictions in place	IOM	62
		WHO	54[30]
		WFP	Overview is available here
	Number of priority countries with partial or full border closures in place	IOM, WHO	53[31]

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

[27, 28] As per World Health Organization on 29 September 2020. Accessd at https://covid19.who.int/
[29] Of the 41 countries reporting birth data, 9 were excluded from the analysis because of data quality issues.
[30] 54 GHRP countries with either flight or ship or border restrictions. Source: WHO database for IHR reporting under Article 43 on additional health measures.
[31] As of 17 September 2020, 53 GHRP countries have full or partial border closures in place (oPt is not included when looking at status of border closures).

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	SEPTEMBER 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	207,681,735 (31.4%) [32]
	Number of people adopting crisis level coping strategies (Reduced Coping Strategy Index)	WFP	160,867,452 (24.3%) [33]
	Number of priority countries with reduced availability of agricultural inputs	FAO	20 of 34 countries [34]
	Number of people in IPC Phase 3+ in priority countries (in countries where new analyses are available)	FAO/IPC	62,661,736 people [35]
Education	Number of children and youth out of school due to mandatory school closures in GHRP countries	UNESCO	1,048,817,181 affected learners (60%) [36]
		UNHCR	1,743,350 refugee children and youth (31 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%
Gender-based Violence	Number and proportion of countries where GBV services have been interrupted	UNFPA	5 out of 43
Child protection	Number and per centage of countries integrating a monitoring system able to measure changes and to identify child protection needs	CP-AoR	35 (78%)
Nutrition	Number of countries that have activated the Nutrition Coordination mechanism in response to COVID-19 and/or its impacts	UNICEF (Global Nutrition Cluster)	30
Protection	Number of countries reporting incidents of COVID-19 pandemic-related xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons	UNHCR	49% (28 of 57 countries reporting)

[32, 33] Compiled from 16 GHRP countries (Afghanistan, Burkina Faso, Cameroon, CAR, Chad, Colombia, Democratic Republic of the Congo, Haiti, Iraq, Mali, Mozambique, Niger, Nigeria, Syria, Tanzania, Yemen)

[34] This figure represents the perceptions of a sample of farmers and key informants surveyed in 34 FAO priority countries: Afghanistan, Bangladesh, Burkina Faso, Colombia, Ethiopia, Haiti, Iraq, Liberia, Myanmar, Nigeria, Pakistan, Palestine, Sierra Leone, Somalia, South Sudan, Sudan, Syria, Togo, Venezuela, Zimbabwe.

[35] This figure takes into account all IPC and CH numbers (current and projected) that are valid as of September 2020 in the countries referenced. This number represents an increase compared to the previous reporting period (52,175,190). However, extreme caution should be taken when comparing these figures due to major changes in the countries covered (expiration of some IPC numbers reported in the previous period (all West Africa and Sahel countries, Burundi, Central African Republic and Pakistan) and addition of new IPC numbers (Democratic Republic of the Congo (DRC), Ethiopia, Haiti and Kenya). This figure covers the following countries: Afghanistan* (10,313,185), DRC (21,834,710), Ethiopia* (8,505,687), Haiti* (3,988,968), Kenya* (739,101), Mozambique* (499,739), Somalia* (3,500,000), Sudan*(9,578,685), Tanzania** (488,661) and Yemen* (3,213,000). *indicates an analysis taken between March and September 2020; ** indicates an analysis undertaken prior to March 2020, the results of which do not take into account the impact of COVID 19 and other unforeseen shocks/changes.

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

Monitoring indicators
Strategic Priority 1

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
Ensure essential health service and systems	Number of passenger movement requests fulfilled	WFP	90%	97%
	Number of cargo movement requests fulfilled	WFP	90%	94%
	Number of hubs established for consolidation and onward dispatch of essential health and humanitarian supplies	WFP	8	8
	Number of GHRP countries with multisectoral mental health and psychosocial support technical working groups	WHO	100%	67%
	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	10,360,882
	Number of 3 plies/medical masks distributed against need (or request)	UNFPA	25,000,000	1,792,115 (since June)
		UNHCR	16.6 million	10.3 million (62%) (50 countries reporting)
		WHO	100%	78,000,000 shipped (as 16/09/ 2020)
	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	7,095,939 (70%)
	Number of health workers provided with PPE	UNICEF	1,405,349	1,054,802 in 46 countries [37]
		UNRWA	3 month's supply of PPE for more than 3,000 UNRWA front line health workers	100%
		World Vision International (WVI)	–	409,099
Learn, innovate and improve	Percentage of countries implementing sero-epidemiological investigations or studies	WHO	20%	29%

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.

[37] 21 GHRP countries, and 25 non GHRP countries

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
Prepare and be ready	Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	UNICEF	60	59
	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%	25%
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%	95%
	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%	95%

Monitoring indicators
Strategic Priority 2

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
Preserve the ability of people most vulnerable to the pandemic to meet their food consumption and other basic needs, through their productive activities and access to social protection and humanitarian assistance	Number of people/households most vulnerable to/ affected by COVID-19 who have received livelihood support, e.g. cash transfers, inputs and technical assistance	FAO	–	2,388,344 households/ 13,347,097 people[38]
		WVI	–	1,930,886 people
		CARE	–	629,855 (food) and 433,885 (cash and voucher assistance) in 33 GHRP countries
		UNHCR	2,467,400 people	-
		UNICEF	1.3 million households	141,363 households
		UNDP	20 million people	23,734,845 people
		IOM	1,502,546 people	595,701 people
		Danish Refugee Council (DRC)	–	805,786 people

[38] This figure takes into account the livelihood assistance provided by FAO and partners through provision of inputs for crop, vegetable and livestock production, as well as cash-based assistance (cash not delivered through government systems). Overall, women represent approximately 47% of individuals assisted by FAO and partners, based on the average household composition.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
	Number of people/households most vulnerable to/ affected by COVID-19 who benefit from increased or expanded social protection	FAO	–	511,756 households [39]
		UNICEF	15.4 million households	7,981,218 households
		UNDP	4 million people	2,480,000 people
		UNRWA	850,000 Palestine refugees	118,459 Palestine refugees received cash assistance in Lebanon and Jordan in August 2020; 3,108 food baskets and 1,727 hygiene kits were distributed to quarantined families in the West Bank
		UNHCR	640,000 people	–
Ensure the continuity of and safety from infection of essential services including health, water and sanitation, nutrition, shelter, protection and education for the population groups most exposed and vulnerable to the pandemic	Number of people (girls, boys, women, men) who are receiving essential healthcare services	IOM	5,287,627	2,059,673
		UNHCR	6 million	3,442,710 (34 countries reporting)
		UNICEF	43,450,524	33,637,702
		UNRWA	–	513,452 in August
	Number of people reached with critical WASH supplies (including hygiene items) and services	UNICEF	61,816,915	48,585,992
		WVI	–	6,296,967
		CARE	–	2.8 million people benefitted from increased access to safe water; 1.6 million received hygiene kits; 45,444 handwashing stations with soap and water were installed
		IOM	21,437,225	18,289,056
		DRC	–	337,110
	Number of children and youth supported with distance/home-based learning	UNICEF	178,336,631	93,610,033
		UNHCR	1.2 million	–
	Number of children and youth in humanitarian and situations of protracted displacement enrolled in pre-primary, primary and secondary education levels	UNHCR	–	132,030 in 24 countries
		UNRWA	533,000	Figures for the 2020/2021 school year still being consolidated

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

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
	Number of people (including children, parents and primary caregivers) provided with mental health and psychosocial support services	UNICEF	17,658,974	17,706,466
		UNHCR	390,000	231,820 (38 countries reporting)
		IOM	574,599	273,393
	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	2,014,591
		UNHCR	55,000	31,450 (19 countries reporting)
	Number of children 6-59 months admitted for treatment of moderate acute malnutrition (MAM)	UNHCR	140,000	79,900 (18 countries reporting)
	Number of women and girls who have accessed sexual and reproductive service	UNFPA	Women Youth	8,861,238 women in 47 countries 4,314,505 youth in 43 countries
		UNHCR	710,000	424,750 (28 countries reporting)
		CARE	–	1.46 million [40]
	Number and proportion of countries where messages on gender-based violence risk and available gender-based violence services were disseminated in all targeted areas	UNFPA	100%	100%
		UNICEF	30	30
		CARE	–	26
	Number and proportion of countries where GBV services are maintained or expanded in response to COVID-19	UNFPA	All GHRP countries	88% (38 out of 43 countries) [41]
		UNHCR	All GHRP countries	74% (43 out of 58 countries) [42]
		CARE	–	32 countries

[40] 1.46 million women and girls received continued SRHR services in CARE-supported health facilities during the COVID19 crisis. 1,925 health facilities/service delivery points (e.g. mobile clinics) supported by CARE to provide health /SRHR COVID-19 related services

[41] Gaps in services remain in target areas in 22 countries.

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

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
	Number of people who have accessed protection services	UNHCR	10.7 million	8.73 million
		IOM	1,305,203	555,047
		DRC	–	995,458
		CARE	–	1.3 million people [43]
		WVI	–	1,335,445
Secure the continuity of the supply chain for essential commodities and services such as food, time-critical productive and agricultural inputs, sexual and reproductive health, and non- food items	Number and per centage of countries that have had requested consignments of reproductive health kits and other pharmaceuticals, medical devices and supplies to implement life-saving sexual reproduction and health services shipped since 1 March 2020	UNFPA	100%	41 out of 45 GHRP requesting countries (91%) had their requests fulfilled 36 of those requests (88%) have arrived in country 34 of those requests (94%) have been distributed to implementing partners.

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

Monitoring indicators
Strategic Priority 3

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	SEPTEMBER REPORT
Advocate and ensure that refugees, migrants, IDPs, people of concern and host population groups who are particularly vulnerable to the pandemic receive COVID-19 assistance	Number of refugees, IDPs and migrants particularly vulnerable to the pandemic that receive COVID-19 assistance	IOM	25,992,258	21,649,691
		UNHCR	67 million people	30.4 million people [44]
		DRC	–	2,751,551
Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia towards refugees, migrants, IDPs and people of concern by enhancing awareness and understanding of the COVID-19 pandemic at community level	Number and proportion of countries where areas inhabited by refugees, IDPs, migrants and host communities are reached by information campaigns about COVID-19 pandemic risks	IOM	60	49 countriies
		UNFPA	100%	45 reporting countries
		UNHCR	100%	66% (37 of 56 countries reporting)
		UNICEF	–	6 countries [145]
		DRC	–	25 countries have reached 1.6 million people by the end of August.
	Proportion of countries inhabited by IDPs, refugees and migrants with feedback and complaints mechanisms functioning	UNHCR	All GHRP countries	100% (60 of 60 countries reporting)
		UNRWA	Palestine refugees in all 5 fields of operation	Hotlines operational in all 5 fields of operation

[44] Approximately 30.4 million refugees and IDPs have received COVID-19 assistance, including access to protection services, shelter, health, nutrition, education, cash, in-kind and livelihoods support etc. This figure includes over 3 million individuals who received cash assistance.
[45] This figure counts only the few countries that report data disaggregated by refugee/IDPs. However, most countries do not disaggregate, hence the low number.

“We have to act in time to make a difference. Unfortunately, in too many places, time is now running out.”

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