GLOBAL HUMANITARIAN RESPONSE PLAN
COVID-19

PROGRESS REPORT

FINAL PROGRESS REPORT
22 FEBRUARY 2021

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Aden, Yemen
Children learning about the coronavirus at the UNHCR-supported Shaab IDP settlement on the outskirts of Aden. *OCHA/Giles Clarke*

COVID-19 AND THE HUMANITARIAN LANDSCAPE

2020 was a year like no other. Amidst on-going humanitarian crises, largely fuelled by conflict and violence but also driven by the effects of climate change – such as the largest locust infestation in a generation – the world had to contend with a global pandemic. In less than one year (March-December 2020), more than 82 million COVID-19 cases and 1.8 million deaths were recorded. In that timeframe, out of the global COVID-19 totals, 30 per cent of COVID-19 cases and 39 per cent deaths were recorded in GHRP countries.

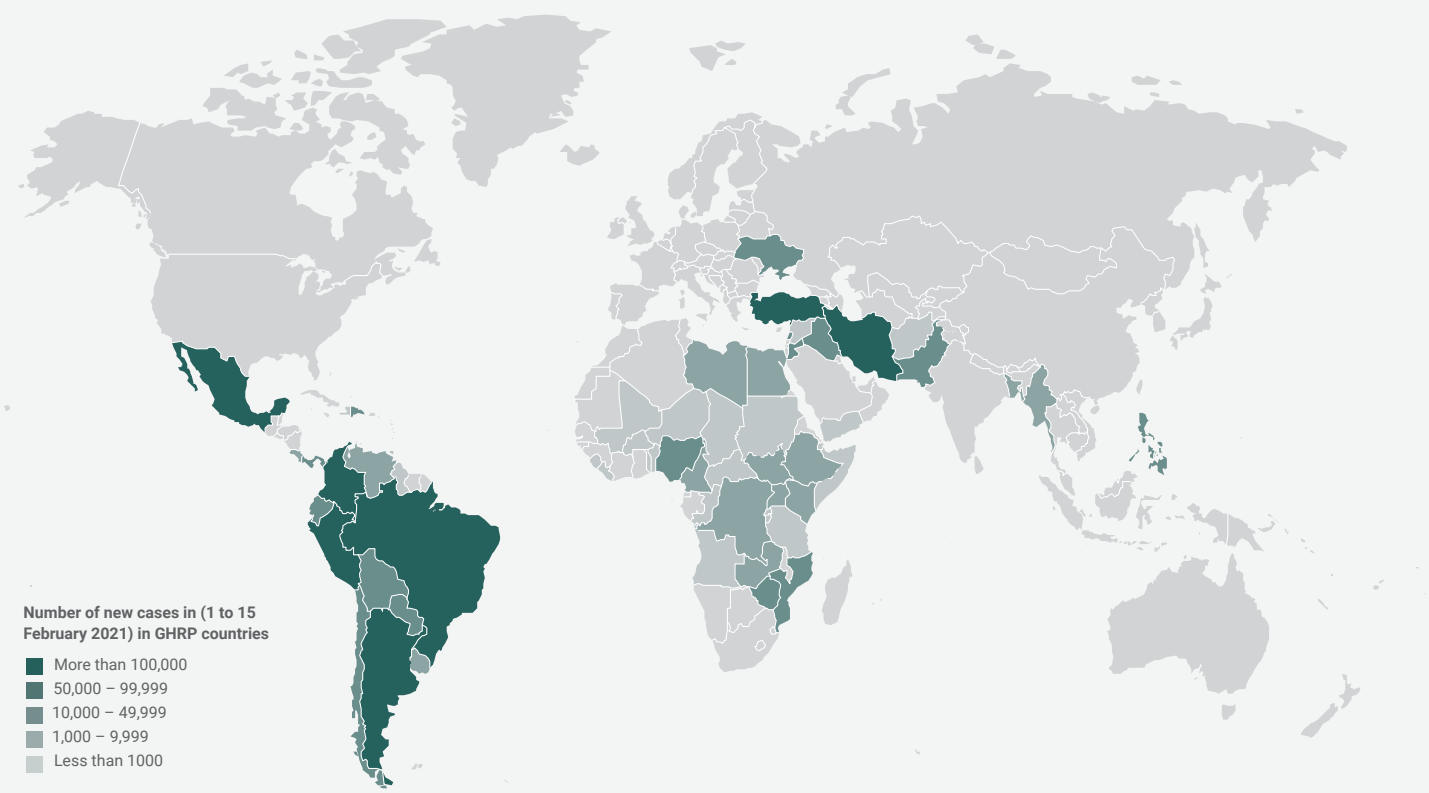
Beyond the immediate health impacts of COVID-19, the secondary effects of the pandemic were particularly grievous in humanitarian settings, and they were, unfortunately, made worse by the same travel and movement restrictions aimed at containing the pandemic. Disruptions to supply chains, movement restrictions through border closures and lockdowns, and market volatility drastically increased food insecurity, pushing over 270 million people worldwide to suffer from acute food insecurity by the end of 2020. Gender-based violence sharply increased, fuelled by the loss of referral pathways, access to information, the closures of schools and safe spaces, and the day-to-day isolation of women and girls during lockdowns. Some countries recorded a 700 per cent increase in calls to gender-based violence (GBV) hotlines in the first months of the pandemic. The pandemic also increased the abuse and neglect of older persons who are the group most at-risk of dying from COVID-19.

Essential health services have also been affected: at the end of 2020, 35 GHRP countries (56 per cent of the 63 countries) had at least one vaccine-preventable disease mass immunization campaign postponed due to COVID-19.[1] Health service disruptions also led to a 30 per cent reduction in the global coverage of essential nutrition services, leaving nearly seven million additional children at risk of suffering from acute malnutrition. The closure of schools led to the loss of important early intervention opportunities for protection, mental health and psychosocial support, and nutrition programmes. The economic contractions worldwide brought about the first increase in extreme poverty since 1998. In January 2021, it was estimated that between 119 million and 124 million people could have fallen back into extreme poverty in 2020 due to COVID-19, with an additional increase of between 24 million and 39 million people in 2021, potentially bringing the number of new people living in extreme poverty to between 143 million and 163 million.[2]

THE GLOBAL HUMANITARIAN RESPONSE PLAN FOR COVID-19

In response to the COVID-19 outbreak, the United Nations launched the Global Humanitarian Response Plan (GHRP) for COVID-19 on 25 March to address the immediate humanitarian consequences of the pandemic. This was just two weeks after WHO's announcement of a global pandemic. A joint effort by the Inter-Agency Standing Committee and coordinated by OCHA, the GHRP was the humanitarian community's first event-specific global appeal, and it demonstrated how quickly the international community could come together to tackle an emergency without borders. Despite the highly fluid context and limited information, the humanitarian community quickly identified and developed responses to address the devastating impact that lockdowns and mobility restrictions were having on the most vulnerable, including the increase in gender-based violence, mental health and disruptions to vital health services and livelihoods. The GHRP enabled the needs of the most vulnerable from the pandemic to be brought the forefront of the COVID-19 response.

The unprecedented plan originally appealed for $2 billion to respond to urgent needs in 54 countries. As the humanitarian situation rapidly evolved and the full scale of the needs from the field, the response required and the challenges in delivering assistance were revealed (including the increased cost of essential health supplies and air and sea transportation), the GHRP was revised in May and July to 63 countries and the amount



APPEALS INCLUDED IN THE GHRP[3]

52

OF WHICH:
HRP 25
RRP 4
RMRP 2
OTHER 21

CONFIRMED CASES

29.5M

CONFIRMED DEATHS

827k

Source: World Health Organization. covid19.who.int

requested to $9.5 billion. As of 15 February 2021, reported funding for the GHRP had reached $3.73 billion. The GHRP also provided a global plan with indicators of progress that most agencies and some NGOs actively sought to report against each month – a first for the global humanitarian community. While improvements could be made in the future to data collection and reporting, the monthly reports provided a global, consistent and timely effort to demonstrate collective achievements.

Despite the initial shocks to supply chains and challenges of mobility restrictions, humanitarians quickly adapted, enabling them to scale-up operations within months of the pandemic and continue delivering aid to the most vulnerable. Even with limited funding, this scale-up was possible due to the rapid initial injection of flexible funding, innovative approaches to aid delivery, and a dynamic prioritization process that highlighted the immediate needs of the most vulnerable. In the Central African Republic, for example, humanitarian organizations reorganized internally displaced persons (IDP) camps, creating zones to isolate cases, and grouping families with cases into designated zones within camps to provide specific and specialized assistance. In Somalia, WFP launched a home delivery e-Shop which became a key component of the COVID response. In Afghanistan, OCHA, WFP and the Cash and Voucher Working Group worked with the World Bank on a complementary national cash/food assistance programme aimed at reaching non-humanitarian caseloads with safety-net support due to the impact of COVID. UNICEF vaccine shipments dropped to half between March and May, but were back to pre-COVID levels by June and July.

Some highlights of assistance provided through the GHRP include the provision of personal protective equipment (PPE) in 87 per cent of GHRP countries (55 out of 63); GBV prevention messaging to address the spike in gender-based violence in 100 per cent of GHRP countries; distance learning for 129 million children in 60 GHRP countries who benefitted from virtual or home-based education; and essential health services for 57 million people in 60 GHRP countries. Importantly, funding for the GHRP was fundamental for the design and establishment of the unparalleled Global Common Services to transport humanitarian staff and cargo and overcome travel restrictions. The Common Services System – the first of its kind - played a vital role in enabling the UN and NGOs to resume services and demonstrated flexibility and agility to scale-up and draw-down as commercial air travel resumed. Between March and January 2021, through the Global Common Services, WFP transported almost 28,000 health and humanitarian personnel from 426 organizations.[4]

[1] This is an improvement from June 2020, when 70 per cent of GHRP had at least one mass immunization campaign affected.
[2] Updated estimates of the impact of COVID-19 on global poverty: Looking back at 2020 and the outlook for 2021 – www.worldbank.org
[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
[4] For more details, see section on Progress and achievements.

The GHRP ran between March and December 2020, with the response to COVID-19 being integrated into 'regular' Humanitarian Needs Overviews and inter-agency coordinated plans for 2021. While some pandemic-specific responses may still be necessary in certain contexts, in most cases, COVID-19 represents one of the many factors influencing humanitarian needs, and programming will reflect the combined effects of COVID-19 with other shocks. Country teams have worked to align the humanitarian response with on-going or planned pandemic responses, particularly with development partners. As a result of this integration, COVID-19 and non-COVID-19 humanitarian needs, planned responses, and financial requirements are combined in the Global Humanitarian Overview for 2021.

COVID-19 has been an unprecedented crisis. The pandemic has proven the necessity of flexible humanitarian response and funding, particularly in periods of high uncertainty. The need to continue to find more meaningful ways to engage national and local NGOs from the outset and to ensure they receive adequate support and financing has again been highlighted as a critical area of improvement. An evaluation of the COVID-19 humanitarian response will be conducted by the Inter-Agency Humanitarian Evaluation Group in 2021 and will identify further lessons learned and recommendations should the international community face another global emergency.

OUTLOOK FOR 2021

The future spread and impact of COVID-19 is not entirely predictable, and it will certainly continue to have a major impact in 2021, especially with the emergence of new variants. The record development of several efficacious and approved vaccines and the accelerated roll-out of vaccine doses in many high-income countries are positive steps forward, however, the pandemic's trajectory will not change significantly in the first half of 2021, especially in humanitarian contexts.

Towards the end of 2020 and into 2021, the pandemic accelerated with daily cases and deaths repeatedly surpassing records across much of the Americas, Sub-Saharan Africa and Europe. It took almost five months to reach the first 500,000 cases in Africa, yet by the end of 2020, it took only 48 days for half a million additional cases to be confirmed. Many governments have re-enacted nationwide or localised lockdowns and travel restrictions which are likely to continue off and on for the foreseeable future depending on levels of community transmission, vaccine roll-out and new variants. If all goes well, many high-income countries may have vaccinated a large proportion of their populations by the end of the year or sooner. However, with most current and future vaccine supplies purchased by high-income countries, sufficient vaccine coverage remains a distant prospect for low-income countries where vulnerable populations will have to wait many months or even years before getting access to vaccines. The ACT Accelerator and COVAX Facility are essential tools to promote fair and equitable global access to vaccines, diagnostics and treatments. Looking ahead, strong support for these mechanisms – including by channelling surplus vaccine doses through COVAX – will be crucial. Member States must also uphold their responsibility to include in their national vaccination plans all high-risk populations within their territories, including refugees, migrants, IDPs and people living in areas controlled by non-state armed groups. It will also be critical to ensure that any COVID-19 vaccine roll-out does not divert critical financial or human resources from routine immunizations, which continue to be suspended or cancelled in many humanitarian contexts.

The economic effects on the pandemic will be particularly hard-felt in lower middle- and lower-income countries. Debt was already at record high levels pre-pandemic, and the COVID-19 crisis is pushing it even higher. The pandemic is adding to government spending as low-income countries seek to mitigate the health and economic effects of the crisis, while revenues are falling due to lower growth and trade, and debt burdens increase. Many countries are expected to lose a decade or more of per capita income gains.[5] And the global economic recovery is forecast to be slow – putting pressure on donors as they deal with their own crises at home.

The COVID-19 response for 2021 builds on a growing culture of collaboration across humanitarian and development actors. Resident and Humanitarian Coordinators and Country Teams have collaborated to create a joint understanding of the immediate and long-term impacts of COVID-19. This joint analysis, for example, in Afghanistan, Burkina Faso, Chad, Cameroon and Somalia, among others, has examined the drivers of need across humanitarian and development sectors. Assessments and response plans to address the pandemic's socioeconomic impact more regularly include international financial institutions and complement humanitarian response efforts. Of the 53 countries covered in the GHO 2021, 23 also have a socio-economic plan in place for 2021.

Concrete evidence regarding transmission of COVID-19 and mortality in humanitarian contexts is scarce, which makes forecasting difficult. Studies in Syria, Yemen and Sudan indicate cases and mortality have been vastly underestimated. The murky picture is expected to persist, with reporting and testing in humanitarian settings unlikely to significantly improve or even deteriorate in some places in 2021. Topping it off, conflict, displacement, and the effects of climate change continue unabated, making adaptable humanitarian response essential.[6]

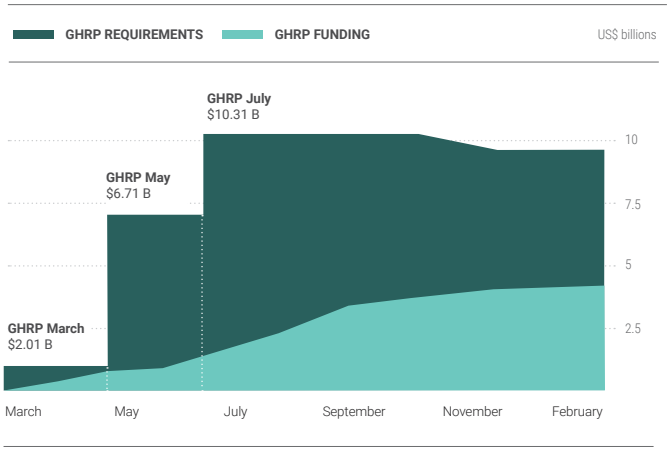
[5] World Bank Global Economic Prospects.
[6] For a comprehensive outlook on global trends and how they are affecting the humanitarian landscape, see the Global Humanitarian Overview 2021.

Financial Overview

GHRP REQUIREMENTS (US$)
9.50 B

FUNDING (US$)
3.73 B

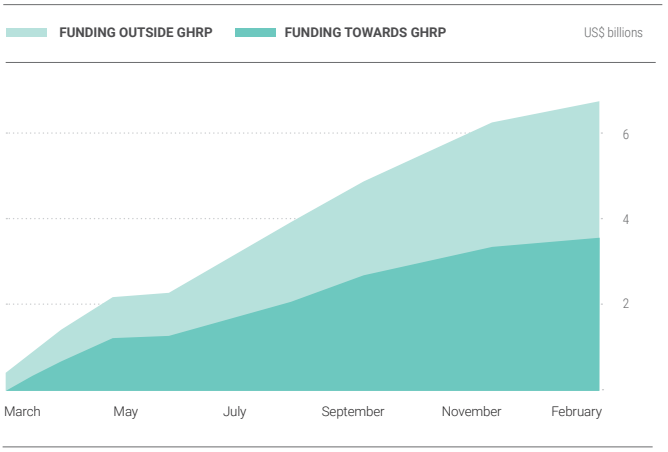
COVERAGE
39%



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

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

OF WHICH:
Towards GHRP 3.73 B
Outside GHRP 2.87 B



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

Funding for global inter-agency coordinated action in response to the pandemic fell far short of the required amount ($9.5 billion) set out in the GHRP. As of 15 February, funding for the GHRP, including the financial needs for 63 countries, was $3.73 billion, or 39 per cent of requirements.

This is only slightly more than was recorded at the beginning of November, indicating that only limited new funding specifically for COVID-19 towards the end of the year. In comparison, coverage for the Global Humanitarian Overview (GHO) 2020, which included the GHRP, was 48 per cent. GHRP-specific funding is 20 per cent of all recorded 2020 GHO funding.

Despite the large amount of funding provided by donors at the beginning of the pandemic and throughout the crisis, the amount of unmet requirements - $5.77 billion – is enormous. Additional funding could have helped fill the gaps in primary health services, provided more remote learning opportunities for vulnerable children, and expanded GBV mitigation, prevention and response activities. It could also have meant more livelihoods support to mitigate some of the secondary economic impacts of the crisis, particularly as lockdowns became more severe and widespread.

As noted in previous GHRP Progress Reports, funding coverage varies widely by country, with 15 of the 51 COVID plans/situations funded above 50 per cent (compared to 13 in November and only four in September). Thirty-six of the country / situation COVID response plans are funded less than the 48 per cent GHRP average.

An analysis of COVID-19 and non-COVID requirements in 25 Humanitarian Response Plan (HRP) countries reveals that some plans received similar levels of support for their COVID and overall (GHO) humanitarian requirements, while significant disparities exist for others (see chart on page 6). For example, in nine countries, the COVID-19 plans were better funded than the overall HRPs (Cameroon, Chad, DRC, Mali, Niger, oPt, Ukraine, Venezuela and Yemen). Conversely, the most striking examples of underfunding of the COVID response in comparison to the overall HRP are Burundi, Ethiopia, Haiti, Iraq, Nigeria, Somalia, and South Sudan.

In addition to the $3.73 billion reported for the GHRP, a further $2.86 billion of humanitarian funding for COVID-19 response has been reported for bilateral support directly to Governments, funding to the Red Cross/ Red Crescent Movement, funding to UN agencies and NGOs for non-GHRP countries, and funding for WHO's Strategic Preparedness Response Plan, Contingency Fund for Emergencies, and other activities which cover countries beyond those identified in the GHRP. Some of this funding has been provided flexibly to organizations and may eventually be recorded against the GHRP requirements as final reports are received at the end of the first quarter of 2021.

As seen on next page, there is still disparity among regions in terms of funding for GHRP requirements, as previously reported. The most serious shortfall at the end of the year is in Latin America and the Caribbean, with an average of only 23 per cent covered. Coverage in South and East Africa (27 per cent) is also below the global GHRP average of 39 per cent.

REQUIREMENTS AND FUNDING BY REGION (FOR GHRP COUNTRIES)

REGION	GHRP REQUIREMENTS	FUNDING	COVERAGE
Asia and Pacific	**1.15 B**	471.3 M	**41%**
Eastern Europe	**46.9 M**	38.9 M	**83%**
Latin America and Caribbean	**1.00 B**	225.8 M	**23%**
Middle East and North Africa	**2.25 B**	1.00 B	**44%**
South and East Africa	**2.41 B**	649.1 M	**27%**
West and Central Africa	**1.46 B**	587.0 M	**40%**

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

FUNDING PER APPEAL

INTER-AGENCY APPEAL		GHRP REQUIREMENTS	FUNDING	COVERAGE	GHO REQUIREMENTS	FUNDING	COVERAGE
Afghanistan	HRP	**395.7 M**	181.4 M	**46%**	**1.13 B**	558.8 M	**49%**
Burkina Faso	HRP	**105.9 M**	50.9 M	**48%**	**424.4 M**	250.6 M	**59%**
Burundi	HRP	**71.4 M**	12.2 M	**17%**	**197.9 M**	87.3 M	**44%**
Cameroon	HRP	**81.7 M**	54.1 M	**66%**	**390.9 M**	170.2 M	**44%**
CAR	HRP	**152.8 M**	77.9 M	**51%**	**553.6 M**	364.1 M	**66%**
Chad	HRP	**124.2 M**	58.6 M	**47%**	**664.6 M**	283.8 M	**43%**
DRC	HRP	**274.5 M**	115.9 M	**42%**	**2.07 B**	809.6 M	**39%**
Ethiopia	HRP	**332.7 M**	94.0 M	**28%**	**1.25 B**	722.7 M	**58%**
Haiti	HRP	**144.4 M**	27.7 M	**19%**	**472.0 M**	155.7 M	**33%**
Iraq	HRP	**264.8 M**	105.6 M	**40%**	**662.2 M**	654.2 M	**99%**
Libya	HRP	**46.7 M**	39.2 M	**84%**	**129.8 M**	117.2 M	**90%**
Mali	HRP	**75.4 M**	45.7 M	**61%**	**474.3 M**	226.0 M	**48%**
Myanmar	HRP	**58.8 M**	40.9 M	**70%**	**275.3 M**	186.8 M	**68%**
Niger	HRP	**82.3 M**	68.1 M	**83%**	**516.1 M**	311.7 M	**60%**
Nigeria	HRP	**242.4 M**	66.1 M	**27%**	**1.07 B**	555.4 M	**51%**
oPt	HRP	**72.4 M**	63.6 M	**87%**	**420.4 M**	261.8 M	**62%**
Somalia	HRP	**225.6 M**	86.6 M	**38%**	**1.01 B**	827.0 M	**82%**
South Sudan	HRP	**383.0 M**	103.3 M	**27%**	**1.90 B**	1.09 B	**57%**
Sudan	HRP	**283.5 M**	106.1 M	**37%**	**1.63 B**	874.5 M	**54%**
Syria	HRP	**384.2 M**	191.9 M	**50%**	**3.82 B**	2.13 B	**56%**
Ukraine	HRP	**46.9 M**	38.9 M	**83%**	**204.7 M**	123.9 M	**61%**
Venezuela	HRP	**87.9 M**	44.7 M	**51%**	**762.5 M**	162.9 M	**21%**
Yemen	HRP	**385.7 M**	262.3 M	**68%**	**3.38 B**	1.89 B	**56%**
Zimbabwe	HRP	**85.0 M**	33.3 M	**39%**	**800.8 M**	212.1 M	**27%**
Burundi Regional	RRP	**65.4 M**	7.5 M	**12%**	**267.6 M**	46.7 M	**18%**
DRC Regional	RRP	**155.7 M**	12.1 M	**8%**	**587.4 M**	40.7 M	**7%**
Nigeria Regional	RRP	**–**	–	**–**	**–**	–	**–**
South Sudan Regional	RRP	**128.8 M**	21.9 M	**17%**	**1.02 B**	103.4 M	**10%**
Syria Regional	3RP	**758.3 M**	137.4 M	**18%**	**5.99 B**	2.23 B	**37%**
Horn of Africa and Yemen	MRP	**31.5 M**	0.3 M	**1%**	**43.3 M**	14.9 M	**34%**
Venezuela Regional	RMRP	**438.8 M**	98.0 M	**22%**	**1.41 B**	661.9 M	**47%**
Rohingya Crisis	JRP	**181.4 M**	83.7 M	**46%**	**1.06 B**	618.0 M	**58%**

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

INTER-AGENCY APPEAL		GHRP/GHO REQUIREMENTS	FUNDING	COVERAGE
Benin	COVID	**17.9 M**	3.3 M	**19%**
Colombia	COVID	**283.9 M**	35.6 M	**13%**
DPR Korea	COVID	**39.7 M**	3.5 M	**9%**
Iran	COVID	**117.3 M**	73.5 M	**63%**
Lebanon	COVID	**136.5 M**	103.7 M	**76%**
Liberia	COVID	**57.0 M**	7.5 M	**13%**
Mozambique	COVID	**68.1 M**	54.5 M	**80%**
Pakistan	COVID	**145.8 M**	86.4 M	**59%**
Philippines	COVID	**121.8 M**	20.6 M	**17%**
Sierra Leone	COVID	**62.9 M**	20.1 M	**32%**
Togo	COVID	**19.8 M**	5.2 M	**26%**
Bangladesh Intersectoral	COVID	**205.9 M**	54.7 M	**27%**
Djibouti Intersectoral	COVID	**30.0 M**	5.0 M	**17%**
Ecuador Intersectoral	COVID	**46.4 M**	19.9 M	**43%**
Jordan Intersectoral	COVID	**52.8 M**	18.6 M	**35%**
Kenya Intersectoral	COVID	**254.9 M**	61.8 M	**24%**
Rep. Of Congo Intersectoral	COVID	**12.0 M**	1.5 M	**13%**
Tanzania Intersectoral	COVID	**158.9 M**	18.8 M	**12%**
Uganda Intersectoral	COVID	**200.2 M**	27.6 M	**14%**
Zambia Intersectoral	COVID	**125.6 M**	13.0 M	**10%**
Famine prevention Global	COVID	**500.0 M**	37.0 M	**7%**
NGO envelope Global	COVID	**300.0 M**	5.9 M	**2%**
Support services Global	COVID	**376.0 M**	289.0 M	**77%**
TOTAL		**9.50 B**	**3.73 B**	**39%**

Note: More than $430 million has been reported as GHRP funding, but is not yet recorded against a specific country response plan.
Intersectoral plans cover countries already included in the GHRP through a Regional Refugee Response Plan, a Regional Migrant Plan or a Joint Response Plan.

Flexible and Unearmarked Funding

Flexible and unearmarked funding was central to ensuring that humanitarian organizations could respond swiftly and nimbly to the COVID-19 pandemic that rapidly evolved and began to spread across the globe in 2020. Equally important was the urgent push to work even more closely with front-line responders as borders closed, people were required to physically distance and stay home, and vulnerable people were no longer able to access the aid and services they needed.

UN Agencies and NGOs worked closely at all levels to respond to the difficult funding and operating contexts, and they developed the IASC Proposal for a Harmonized Approach to Funding Flexibility in the Context of COVID-19 (30 June) and the IASC Proposals to Address the Inconsistency in Unlocking and Disbursing Funds to NGOs in COVID-19 Response (20 July). This guidance built on years of experience with some of the main tenets outlined in the Grand Bargain, namely the commitments to reduce the humanitarian funding gap through improving the effectiveness and efficiency of humanitarian aid and action, including through flexible funding and the cascading of funding to humanitarian actors on the front lines of humanitarian response.

Surveys to seven UN agencies in June, August, September and November 2020, and again in February 2021 paint a varied picture of how much flexible funding was received between 1 March and 31 December. The first survey results in June indicated that on average, 42 per cent of the total funding received for COVID could be considered flexible.[1] This average decreased to 37 per cent in August, 32 per cent in September and 29 per cent in November. As of February 2021, the average had decreased further to 25 per cent. Because averages can be misleading, it is important to note that the range each month was quite large, with the lowest percentage between 9 and 12 per cent and the highest varying between 35 and 65 per cent. This quantitative data is consistent with anecdotal information collected in the surveys: more flexible funding was provided at the beginning of the pandemic than in later months.

In terms of how flexible funding supported countries included in the GHRP, the evidence is clear – most agencies used the vast majority of their flexible funding to support the GHRP (percentages ranged from 65 to 100 per cent, with an average of 80 per cent and three agencies reporting 100, 96 and 95 per cent).[2]

As described in previous GHRP Progress Reports, the flexible funding received at the onset of the rapidly evolving global pandemic allowed agencies to adapt, reprogramme, scale up and expand activities related to COVID-19, while continuing to provide life-saving assistance in on-going emergencies. For IOM, flexible funding contributed to scaling up and delivering a comprehensive response package in high-risk areas with gaps. It also supported remote areas with limited, if any, health services, and partners were able to extend their activities through mobile clinics and the development of ground-breaking community surveillance, referrals and outreach. UNFPA used flexible funding to create innovative ways to deliver programmes, such as virtual platforms that democratize access to services and expand the skill sets of staff who use them. These platforms were used in Chad, Libya and Venezuela. In places where flexibility was allowed, UNFPA expanded its activities to different target groups, notably youth, who are often neglected in humanitarian settings. UNICEF also used online / phone communication with aid recipients to deliver services. WHO created the COVID-19 Solidarity Response Fund in March 2020 to enable corporations, individuals, foundations and other organizations

SHAKHAHATI, BANGLADESH
This woman used to live with her husband and son next to the embankment near the Brahmaputra River, but their house was immersed due to river erosion. They received a water-tight drum to transport themselves from one place to another whenever the water level gets high. The drum also helps them to fetch water. The coronavirus pandemic eroded their livelihoods, but they refused to remain idle and starve. "I have to do something to survive," she remarked. *FAO/Fahad Kaizer*

around the world to directly support global efforts to help prevent, detect and respond to COVID-19. The fund was a first-of-its-kind platform for the private sector and the general public to actively accelerate and support global efforts to contain and mitigate a pandemic by pooling flexible financial resources. Over $240 million were raised from more than 660,000 individuals, companies and philanthropic organizations.[3]

Despite these positive actions, additional flexible funding would have provided more opportunities to improve COVID-19 response. For example, additional flexible funding would have allowed FAO to adapt / adjust programmes more rapidly and consistently according to the evolution of needs within and across countries. IOM would have been able to assist a larger number of stranded migrants in several countries with life-saving and return assistance at both points of origin and return. Although prioritization exercises took place to identify the most vulnerable stranded migrants, earmarked funding limited the countries where assistance could be provided. More flexible funding would have allowed UNFPA to address unexpected crises in locations or countries that were not originally planned for as the pandemic evolved. More flexibility regarding the carry-over of 2020 funds to 2021 would have allowed UNHCR to make faster progress in developing and deploying a self-service digital platform for persons of concern to access their personal data, facilitate remote registration, and request UNHCR services. For UNICEF, if more flexible funds had been received prior to the onset of COVID-19, UNICEF teams could have extended current programme and project durations or amended on-going programme activities and geographical coverage of programmes based on the evolving needs on the ground immediately when the pandemic hit. This would have reduced sometimes heavy processes of reviewing and amending partnerships (including with implementing partners and donors) on a case-by-case basis. Flexible funds would also have been beneficial for investment in preparedness (including pre-positioning of essential supplies) which helps to deliver a more timely and cost-effective response and save more lives. With additional flexible funds, UNICEF's response to COVID-19 could have addressed GBV and gender priorities more quickly and widely during the first few months of the response. The funding that WFP received for its Global Common Services was not earmarked to specific countries and thus allowed operations to address the most urgent needs based on the evolving context, priorities and partners' demands. More timely flexible funding would have allowed a more agile and rapid expansion of operations. More flexible funding for WHO would have ensured that all countries with high needs and limited or no financial capacities could receive the resources they needed. Despite the widespread provision of essential laboratory and PPE equipment, deployment of experts, and training of national staff in these resouce-constrained countries, some regions still have very uneven funding patterns and significant programmatic gaps.

In addition to advocating for more flexible funding, including through the aforementioned IASC guidance, several efforts were made to increase the timely cascading of funding (and contract / reporting conditions) to actors closest to the front lines of humanitarian need and action. On the positive side, the flexible funding that IOM cascaded to NGOs and front-line partners made a significant difference in the provision of critical health care and the decentralization of COVID-19 response in. Partners built isolation and treatment facilities, procured and dispatched PPE and health supplies, hired and trained personnel, and strengthened the capacities of health providers and community networks in several countries, including CAR and DRC. UNICEF continued to advocate for lighter and more flexible internal processes to expedite partnership timelines, including simplified templates with adjustable sample activities and results, lightened internal review and approval processes for COVID-related partnerships, and the launch of digital signatures. UNHCR was the first UN Agency to issue guidelines on increased flexibility for NGO partners in April 2020. It has provided partners greater flexibility to make discretionary budget allocations, issued guidance that permits its Country Offices to accelerate the release of financial installments, reduced reporting requirements, and moved towards the acceptance of digital documents.

Despite these achievements, important questions remain regarding the actual amount of funding cascading to partners with the same (or similar) flexible conditions provided by donors to UN agencies. UN agencies reported that on average, 11 per cent of their COVID funding was passed on to implementing partners. In some cases, the amount of COVID funding cascaded was less than overall annual averages, due to the substantial global procurement of supplies in the early days of the pandemic. In other cases, calculating cascading COVID funding versus cascading regular humanitarian funding was not possible. What remains clear for the GHRP, as well as for other inter-agency coordinated humanitarian plans, is that there is a continued need to improve transparency and tracking of the funding – flexible and other – that is cascading through the system and reaching those front-line partners who are so critical to saving lives in pandemic, conflict and natural disaster contexts.

[1] Humanitarian organizations often have slightly different definitions of flexible funding. For the purposes of this exercise, the working definition of "funding not earmarked to a specific country or project" was used.

[2] WFP is not included because a large amount of its flexible funding was used for global logistics services to transport humanitarian workers and cargo. The average would have been even higher if UNICEF's global procurement of supplies and PPE at the onset of the crisis were taken into account.

[3] The Solidarity Response Fund supported vulnerable communities, including at-risk IDPs and refugees, in GHRP countries and others.

CERF and CBPFs
At the forefront of the COVID-19 response

TOTAL ALLOCATIONS (US$)	CERF ALLOCATIONS (US$)	CBPF ALLOCATIONS (US$)	COUNTRIES
493M	241M	252M	48

PEOPLE TARGETED: CERF [1]

69.2M

OF WHICH :
Men 19.3 M
Women 20.1 M
Boys 15.1 M
Girls 14.8 M

PEOPLE TARGETED: CBPF [2]

44.8M

OF WHICH :
Men 12.1 M
Women 13.5 M
Boys 9.4 M
Girls 9.8 M

OCHA's pooled funds allocated $493 million in 2020 in 48 countries/contexts to support humanitarian partners in their response to the COVID-19 pandemic.

INNOVATING TO RESPOND TO COVID-19

In 2020, CERF and CBPF introduced important innovations to be more flexible and agile in response to COVID-19. Substantial resources were provided to hundreds of humanitarian partners to ensure a timely response to the impacts of the pandemic in contexts already affected by conflict, natural disasters and other public health emergencies.

CBPFs introduced flexibility measures in the use of budgets and adapted monitoring arrangements, allowing partners the flexibility required to adapt to shifting contexts and needs while maintaining sound accountability and oversight. UN agencies were granted maximum flexibility on where to use CERF funding, to allow agencies to prioritize the most urgent needs.

CERF also introduced innovative allocation approaches to channel funding to where it was needed most, and to remain in step with the evolving nature of the pandemic. Early multi-country block grants to jump-start UN agency responses were followed by the first-ever direct CERF support for front-line NGOs in June. CERF also responded to both the immediate and secondary impacts of the pandemic – strengthening the healthcare and water and sanitation response, scaling up cash and voucher assistance to tackle the socio-economic impact of the crisis, and supporting gender-based violence response through allocations supporting local women-led organisations. These innovative allocations were made possible, in large part, by the exceptionally high level of CERF funding – close to the $1 billion target - available in 2020.

RESPONDING TO THE PRIMARY AND SECONDARY IMPACTS

With close to $500 million allocated, CBPFs and CERF played a major role in the delivery of emergency aid to respond to the primary and secondary humanitarian impacts of the pandemic when and where it was needed most, as well as to sustaining the humanitarian response.[3]

Primary impacts: Together, the pooled funds allocated $163 million to health partners to scale up response, including the bulk procurement of medical and protective equipment, mainly through UN agencies. Through their core work with front-line responders, including local NGOs, CBPFs served remote, vulnerable communities with protective equipment, hygiene items and modern technologies. The funds also provided partners with $53 million to increase access to clean water, proper sanitation and good hygiene.

Secondary impacts: Over $113.4 million went to improving food security in contexts where COVID-19 compounded pre-existing vulnerabilities and eroded livelihoods. In response to increasing risk and exposure to GBV, the pooled funds made targeted allocations to strengthen prevention and response. About half of the $65 million allocated in 2020 by CERF in response to GBV was linked to the pandemic. CBPFs provided $6.6 million to scale up GBV prevention and response. An additional $24 million was provided by the funds for other protection services benefiting the most vulnerable people impacted by the pandemic.

Sustaining humanitarian response: The pandemic severely disrupted international supply chains. CBPF and CERF allocated $46 million to ensure critical supplies could reach those in need. This funding enabled WFP and partners to expand logistics services, including the transportation of supplies and emergency workers.

CHANNELING RESOURCES TO NGOS FOR FRONT-LINE RESPONSE

CBPFs and CERF supported a localized front-line response to the pandemic, providing $226 million[4] to international and national NGOs, Red Cross/Red Crescent National Societies and other local partners.

CBPFs continued to be the largest source of funding for local and national partners – in the pandemic response and more broadly ($317 million overall in 2020), leveraging their proximity to affected people and harnessing their local knowledge and social networks. In response to COVID-19, 32 per cent ($80 million) of CBPF funding benefited local and national actors.

In total, CERF disbursed $58 million to NGOs and partners, including by way of sub-grants from UN agencies. This includes an innovative allocation of $25 million specifically to international and national NGOs in six countries at a critical time of need. One third of all NGOs supported under this allocation were national or local NGOs. In Bangladesh, for example, half of CERF funds went to national NGOs providing healthcare, and water, sanitation and hygiene assistance. CERF also provided some $15 million to NGO partners – mostly women-led organizations – as part of its $25 million allocation to respond to increased gender-based violence.

THE POOLED FUNDS' REACH AND IMPACT

Access to **safe drinking water** and clean water for 4 million people. 3.7 million people received **hygiene and sanitation kits**.

Support to over 2,000 **medical facilities** (Intensive care units, isolation rooms, mobile clinics). 3.5 million people benefited from **health care services**.

22 million people reached through **health awareness campaigns** and hygiene promotion activities.

Over 23 million units of **personal protective equipment**, health kits and medical supplies delivered.

Livelihood support, including agricultural and livestock inputs and skills-development training for 130,000 people. 615,000 people received **shelter** and other items for **early recovery**.

500,000 people received **cash assistance** for household essentials, including food, water, medicines, utilities and rent.

Essential **protection services** for 692,000 people, including psycho-social support, legal assistance and protection awareness campaigns.

Among them, around 343,000 people benefited from **GBV prevention and response** activities.

5 million children supported with **distance or home-based learning**.

54 humanitarian hubs established to facilitate **cargo movement**. 4,834 cargo flights operated.

[1] Includes people indirectly targeted, e.g. via information campaigns.

[2] Number of people targeted may include people indirectly targeted (e.g. through awareness and hygiene campaigns), as well as double counting because some people may receive assistance from more than one project.

[3] Despite the significant sums invested in the COVID-19 response, these accounted for around a quarter of all allocations from both funds in 2020. In addition to the $493 million disbursed in response to COVID-19, CERF and CBPFs also provided $1.3 billion to respond to other humanitarian needs in crises around the world ($658 million came from eighteen CBPFs and CERF allocated $607 million in 2020).

[4] Directly or as sub-grantee of other organizations.

CBPFs

The challenges of clinical work during a pandemic

PORT SUDAN, SUDAN
Credit: NGO Emergency

Prevention protocols, personal protective equipment, isolation curtains for shared rooms, constant disinfection of rooms, and sufficient stocks of medicine are essential to contain the risk of COVID-19 and continue treating patients in health facilities, such as the Paediatric Centre in Port Sudan. According to Nurse Hawa, "We're always very careful and do everything we can to protect ourselves and our patients. It's our responsibility to make sure the Centre remains a safe place for everyone." Training and refresher courses are also crucial to ensure that staff can safely continue clinical work, even during the pandemic.

The Paediatric Centre is the only hospital in one of the city's poorest districts. It provides free, high-quality treatment to children under 14 years old. These children live in extremely difficult conditions, due in part to poor infrastructure and services, and in overcrowded homes that increase the risk of infection. The current pandemic is affecting a population that was already hit by cholera in recent years, and children are exposed to endemic diseases like malaria and malnutrition.

The doctors, nurses, logisticians and administrators at the Paediatric Centre have been able to continue their work and save people's lives thanks to the support received from the Sudan Humanitarian Fund.

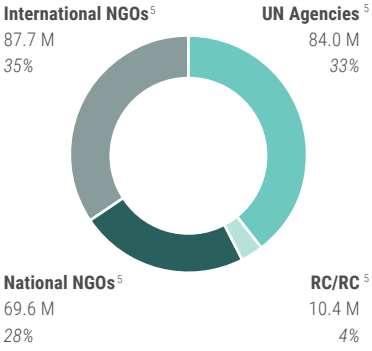
CBPFs ALLOCATIONS PER PARTNER

NO. PARTNERS
283

NO. PROJECTS
765

TOTAL ALLOCATIONS (US$)
252M

OF WHICH: TO NGOs
63%



CERF ALLOCATIONS PER UN AGENCY

NO. UN AGENCIES
10

UN AGENCY	ALLOCATIONS TOTAL
WFP	40.0 M
UNFPA	20.2 M
WHO	20.0 M
UNICEF	16.0 M
FAO	9.0 M
UN Women	8.0 M
UNHCR	6.9 M
UNDP	3.2 M
IOM	2.7 M
UN-Habitat	0.05 M
NGOs *via IOM*	25.0 M
Reprogrammed funds from various agencies	15.6 M

TOTAL CONTRIBUTIONS TO CERF AND CBPFs

TOTAL CONTRIBUTIONS (US$)[6]
1.50B

DONORS
60

TOP 10 DONORS	CONTRIBUTIONS TOTAL	CERF	CBPFs
Germany	**349.7 M**	125.3 M	224.3 M
United Kingdom	**269.5 M**	87.4 M	182.2 M
Netherlands	**169.2 M**	98.8 M	70.4 M
Sweden	**163.9 M**	88.8 M	75.1 M
Norway	**99.3 M**	56.9 M	42.4 M
Belgium	**76.5 M**	24.3 M	52.3 M
Denmark	**65.5 M**	30.9 M	34.5 M
Canada	**59.1 M**	22.5 M	36.5 M
Switzerland	**52.4 M**	24.0 M	28.3 M
Ireland	**46.4 M**	11.4 M	35.0 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 originally planned for later in the year.

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

[6] Donors' contributions as of 31 December 2020.

CERF

Supporting health promoters in Sudan

EL-FASHER, SUDAN
Shehzad Noorani/ UNICEF

"My name is Zahra and I'm a health promoter from Sudari. I have now attended the COVID-19 prevention and control refresher training. I did not know much about the disease prior to attending, but the training provided me with a lot of information about health education for communities and the COVID-19 disease itself, such as transmission, symptoms, and how to protect ourselves, our families and neighbours from the disease."

"I will work to communicate this awareness about transmission, symptoms, and prevention methods, such as hand washing with soap and water, social distancing, and how to avoid spreading infections when sneezing. I will also encourage my family, relatives and neighbours to spread this information to the other members of our community. Finally, I would like to thank Plan International Sudan and their donors (CERF via IOM) for their generous support."

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 [7]	UN AGENCIES	INT'L NGOs	NAT'L NGOs	RC/ RC [8]
Global operations	42.6 M	**42.6 M**	42.6 M	–	–	**–**	–	–	–	–
Afghanistan	59.5 M	**17.6 M**	17.6 M	–	–	**41.9 M**	17.4 M	21.5 M	2.6 M	0.4 M
Bangladesh	6.0 M	**6.0 M**	3.0 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	10.2 M	**10.2 M**	10.2 M	–	–	**–**	–	–	–	–
Burundi	1.9 M	**1.9 M**	1.9 M	–	–	**–**	–	–	–	–
Cameroon	4.3 M	**4.3 M**	4.3 M	–	–	**–**	–	–	–	–
CAR	15.4 M	**6.8 M**	1.8 M	5.0 M	–	**8.6 M**	2.1 M	5.6 M	1.0 M	–
Chad	2.9 M	**2.9 M**	2.9 M	–	–	**–**	–	–	–	–
Colombia	3.0 M	**3.0 M**	3.0 M	–	–	**–**	–	–	–	–
Djibouti	1.4 M	**1.4 M**	1.4 M	–	–	**–**	–	–	–	–
DPR Korea	0.9 M	**0.9 M**	0.9 M	–	–	**–**	–	–	–	–
DRC	17.2 M	**7.0 M**	7.0 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	9.4 M	**3.9 M**	3.9 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	23.8 M	**2.3 M**	2.3 M	–	–	**21.5 M**	1.9 M	18.7 M	0.8 M	–
Jordan	10.4 M	**2.6 M**	2.6 M	–	–	**7.8 M**	0.6 M	4.3 M	2.6 M	0.3 M
Lebanon	15.7 M	**6.6 M**	6.6 M	–	–	**9.0 M**	0.1 M	3.5 M	5.5 M	–
Lesotho [9]	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	3.7 M	**3.7 M**	3.7 M	–	–	**–**	–	–	–	–
Mauritania [9]	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Myanmar	8.3 M	**4.1 M**	4.1 M	–	–	**4.1 M**	1.6 M	1.5 M	1.0 M	–
Namibia [9]	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Niger	1.7 M	**1.7 M**	1.7 M	–	–	**–**	–	–	–	–
Nigeria	23.7 M	**16.9 M**	16.9 M	–	–	**6.7 M**	5.4 M	0.8 M	0.5 M	–
oPt	20.7 M	**3.7 M**	3.7 M	–	–	**17.0 M**	8.4 M	6.7 M	1.9 M	–
Pakistan	11.0 M	**1.3 M**	1.3 M	–	–	**9.7 M**	0.9 M	1.7 M	7.1 M	–
Peru	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Philippines	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Rep. of Congo	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Samoa	0.5 M	**0.5 M**	0.5 M	–	–	**–**	–	–	–	–
Somalia	8.6 M	**4.1 M**	4.1 M	–	–	**4.5 M**	3.6 M	0.5 M	0.4 M	–
South Sudan	24.3 M	**13.9 M**	9.0 M	3.8 M	1.1 M	**10.4 M**	5.5 M	3.3 M	1.6 M	–
Sudan	25.2 M	**12.6 M**	9.6 M	2.6 M	0.4 M	**12.6 M**	4.6 M	6.8 M	1.2 M	–
Syria	25.0 M	**1.8 M**	1.8 M	–	–	**23.2 M**	14.9 M	5.0 M	2.3 M	1.0 M
Syria Cross Border	38.4 M	**0.4 M**	0.4 M	–	–	**38.0 M**	7.1 M	4.7 M	18.0 M	8.2 M
Tanzania	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Uganda	0.1 M	**0.1 M**	0.1 M	–	–	**–**	–	–	–	–
Ukraine	4.7 M	**0.9 M**	0.9 M	–	–	**3.8 M**	0.1 M	2.3 M	1.3 M	–
Uzbekistan [9]	0.2 M	**0.2 M**	0.2 M	–	–	**–**	–	–	–	–
Venezuela	6.0 M	**6.0 M**	6.0 M	–	–	**–**	–	–	–	–
Yemen	47.3 M	**30.0 M**	30.0 M	–	–	**17.3 M**	16.8 M	0.4 M	0.1 M	–
Zambia	0.4 M	**0.4 M**	0.4 M	–	–	**–**	–	–	–	–
Zimbabwe	1.3 M	**1.3 M**	1.3 M	–	–	**–**	–	–	–	–
TOTAL	**492.3 M**	**240.6 M**	**217.7 M**	**18.2 M**	**4.7 M**	**251.7 M**	**96.6 M** [10]	**95.7 M** [11]	**49.1 M** [12]	**10.3 M** [13]

[7] This table includes funds provided to humanitarian partners as primary recipients only. See previous page for global levels inclusive of sub-grants.
[8] Red Cross / Red Crescent / [9] Non-GHRP countries are included when funds were reprogrammed toward COVID response
[10] Funding received by UN agencies as direct recipients; refer to breakdown by partner on the previous page for funding deducting sub-grants to other organizations.
[11] Funding received by INGOs as direct recipients; refer to breakdown by partner on the previous page for funding including sub-grants provided to and received from other organizations.
[12] Funding received by NNGOs as direct recipients; refer to breakdown by partner on the previous page for funding including sub-grants received from other organizations.
[13] Funding received by RC/RC national societies as direct recipients; refer to breakdown by partner on the previous page for funding including sub-grants received from other organizations

Progress and achievements

The narrative below and data presented in the section on monitoring indicators represent the cumulative progress for the duration of the GHRP (March – December 2020), unless otherwise noted. The achievements represent services or goods provided in GHRP countries (63), unless otherwise noted.

Progress of the response
Strategic Priority 1

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

Despite mobility restrictions and supply chain challenges, one of the major successes of the GHRP was the provision of personal protective equipment to reduce the risk of COVID-19 infection. Within four weeks of COVID-19 being declared a 'public health emergency of international concern', WHO projected PPE needs with a nine-month outlook; afterwards, in collaboration with partners, WHO built planning tools to facilitate country coordination and enable effective supply chain. The tools included the COVID-19 Partners Platform, the Supply Portal, and the Essential Supplies Forecasting Tool, which became operational by March 2020. By December 2020, 55 GHRP countries had received nearly 114 million medical masks coordinated through these tools. UNICEF provided 1.5 million health workers with PPE, while 72.8 million people were reached with WASH supplies and services to reduce the risk of disease transmission.

IOM worked with health actors and authorities to facilitate isolation, physical distancing, and where appropriate, quarantine management. This included repurposing existing health facilities to become isolation and treatment facilities in displacement sites, seeking supplies and equipment, and transporting suspected or confirmed COVID-19 cases in 43 GHRP countries. In Cox's Bazar, Bangladesh, three severe acute respiratory infection isolation and treatment centres were established. IOM also established two maternity wards where pregnant women with suspected or confirmed COVID-19 diagnoses could receive pre-natal care and deliver safely. This intervention also supported COVID-19 contact tracing in the Rohingya refugee camps.

KOTIDO, UGANDA
The Government of Uganda and the United Nations World Food Programme (WFP) are distributing take-home food rations to school children in the Karamoja sub-region in north-eastern Uganda to support home-learning while schools remain closed due to the COVID-19 outbreak across the country. School meals for children were halted in Karamoja when all schools countrywide had to close to contain the spread of COVID-19. The total lockdown that followed left many parents without jobs and coincided with livestock being quarantined because of an outbreak of foot-and-mouth disease. *WFP/Hugh Rutherford*

Immunizations and preparing the ground for COVID-19 vaccination

At the end of 2020, 35 GHRP countries (56 per cent) had at least one vaccine-preventable disease mass immunization campaign postponed due to COVID-19. To support the safe resumption of immunization campaigns, WHO and partners developed global and regional guidance materials, promoted innovative measures such as social media, modified service hours and offered immunization services in strategic places such as pharmacies, social or cultural centres, or designated drive-through areas. For example, in Ethiopia, expanded regular vaccination teams also provided COVID-19 screening and promoted handwashing and physical distancing.

Ahead of the expected roll-out of COVID-19 vaccines (see Section 1 'Outlook for 2021'), the IASC has continued its advocacy for the establishment of a 'humanitarian buffer' through the COVAX facility. In support of these efforts, World Vision developed a 'barrier analysis tool' to identify issues that lead to hesitance towards vaccines. Subsequent analysis demonstrated that faith leaders and community health workers can play a key role in COVID-19 vaccine campaigns and decreasing hesitancy.

Progress of the response
Strategic Priority 2

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

Continuation of essential health services and mental health and psychosocial support (MHPSS)

During the early months of the pandemic, many countries experienced a diversion of staff and supplies from essential health services towards the treatment of COVID-19 patients. At the same time, as mobility restrictions took hold and lockdowns began, access to essential health services became more difficult. On top of this, misinformation fuelled mistrust in health services. Humanitarian actors advocated for and directly supported the continuation of essential health services. UNICEF and partners used remote and digital means for programme delivery and monitoring. This included online/phone sessions for GBV and child protection case management; counselling on breastfeeding and young child feeding support for new mothers and caregivers; care and support for malnourished children; mental health and psycho-social support for children and women; education sessions; parenting classes; and delivery of health and hygiene information. This allowed service providers to overcome movement restrictions while cutting down on operational costs. UNICEF and partners reached nearly 57 million people in 60 GHRP countries with essential health care services. UNHCR, in parallel, provided 605,000 people in 44 countries with MHPSS services.

According to UNFPA's survey of health facilities in December 2020, 21 per cent of GHRP countries reported a decrease of at least 25 per cent in institutional deliveries in over half of reporting health facilities compared to the previous year. Although this number is an improvement in the significant decrease in access to and use of health facilities for sexual and reproductive health that was experienced in the first months of the pandemic, much work remains to ensure vulnerable people continue accessing essential health services. CARE International provided continued sexual and reproductive health services to 1.5 million women and girls in CARE-supported health facilities.

Preventing gender-based violence (GBV)

One of the most insidious side-effects of the pandemic has been the spike in gender-based violence, including in the particularly vulnerable lesbian, gay, bisexual, transgender and intersex community. Humanitarian partners have mobilised to mitigate the risk and address the consequences of GBV through risk information campaigns – with sensitization and/or information campaigns taking place in all GHRP countries – as well as with additional services to support victims. In addition, country-specific programmes were set up to address GBV. In collaboration with WFP, UNFPA-Congo set up a referral mechanism for free, holistic care for victims of GBV that could be accessed during food distributions. In Colombia, UNFPA implemented a remote GBV case management model and psychosocial support services in three departments, providing support and safe referrals through nine case workers and eight helplines. UNFPA Myanmar developed guidance and provided training for GBV programme adaptation for remote service delivery; deployed a mental health and psycho-social support roster team to provide timely technical assistance and provided dignity kits to women and girls at quarantine facilities. UNFPA DRC provided support to equip four integrated centres offering GBV services in Kinshasa.

Education

As schools shut down amidst the pandemic, depriving children of early intervention opportunities for nutrition and protection programmes and important academic and social development, humanitarian partners rallied to provide distance and home-based education and mitigate the effect of school closures. UNICEF supported virtual and home-based education programmes, benefiting 128.9 million children in 60 GHRP countries. UNHCR supported 908,000 refugee children and youth with distance or home-based learning in 37 countries, including through radio broadcasts.

From March until the end of the 2019/2020 school year, UNRWA supported children and students enrolled in its schools and vocational training centres. UNRWA also helped to deliver catch-up programmes to mitigate the impact of learning loss during the 2019/2020 school year, including remote learning, face-to-face instruction, and hybrid/blended learning modalities. UNRWA has continued to apply this flexible approach to ensure continuity of learning for 540,644 students in its schools and more than 8,000 youth in technical and vocational centres for the 2020/2021 school cycle.

Food security and livelihood support

The number of food insecure people has skyrocketed since COVID-19 emerged, partly due to global economic contractions, and partly due to labour shortages, supply chain problems, movement restrictions and market volatility. WFP estimated that by December 2020, over 270 million people would be acutely food insecure due to COVID.[1] In its simplest form, combatting food insecurity requires a combination of food assistance and livelihood support, together with longer-term solutions developed and implemented with development actors. UNHCR reported that over 1.24 million people most vulnerable to/affected by COVID-19 in 50 GHRP countries received livelihood support. This included skills training, inputs and grants for business creation and recovery, wage employment, and agriculture support. IOM helped over 1.2 million individuals in 47 GHRP countries with livelihood support, including cash-based assistance. The Danish Refugee Council provided livelihood support for another 1.2 million people in 36 countries, including basic needs assistance and economic recovery support. FAO delivered livelihoods support (e.g. cash transfers, agricultural inputs and technical assistance) to over four million households (or nearly 24 million people, 46 per cent of whom were women). In addition, 511,756 households benefited from increased or expanded social protection.

FAO – collaborating with WFP, the Global Food Security Cluster and the Global Network Against Food Crises Partnership Programme – set up a data facility covering 29 countries, to support remote data collection and analysis and inform assessments and programming in contexts already experiencing humanitarian crises, producing interactive dashboards for use by all partners to inform their programs and interventions.

Cash-based programming

Cash and voucher assistance increased as a result of the need for flexibility in disbursement and the need to have contactless options to prevent the transmission of the virus. UNRWA provided additional cash and/or food assistance to more than one million Palestine refugees across five fields of operation. In Bangladesh, UNDP provided cash transfers to 88,144 people, 91 per cent of whom were women, while another 8,009 people (32 per cent of whom were women) received cash-for-work support in the last quarter of the year. CARE International provided 764,075 people with food assistance, 559,726 people with cash/voucher assistance, and 596,887 people with cash assistance in 23 GHRP countries.

Risk communication

Risk communication was a critical deliverable under the GHRP to contain and prevent the spread of the virus and safeguard vulnerable people. During the pandemic, affected communities played a critical and active role in risk communication within their own communities. In all refugee, IDP and mixed situations in which UNHCR engages, the agency prioritized community-based approaches to protection, as well as effective mechanisms of accountability to affected people. UNHCR worked in Ukraine and South Africa with refugee and IDP-led organisations to support groups at heightened risk, and in South Sudan with affected youth to inform the community on COVID-19 risks and precautions.

Risk communication and community engagement interventions were rolled out by UNICEF, reaching people with life-saving information and driving people-centred and community-led approaches that promote healthy and safe lifestyles in 59 GHRP countries. In addition, these interventions aimed to build trust and social cohesion which was key to halt the spread of the virus, and reduce the negative impacts of the pandemic.

UNFPA's implementing partners in northwest Syria used social media platforms to engage a high number of persons and groups through interactive GBV awareness-raising sessions. As implementing partners became more proficient with such online platforms, they have been able to increase the number of people reached.

In Somalia, FAO developed a series of radio broadcasts to reach farmers and pastoralists in remote areas, in combination with promoting sustainable agricultural practices. The broadcasts disseminated key messages in local languages to boost community awareness on the risks of COVID-19 transmission and prevention measures.

Progress of the response
Strategic Priority 3

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

The COVID-19 pandemic exacerbated protection concerns in humanitarian crises by exposing refugees, asylum-seekers, IDPs, host communities and stateless persons to new threats. Globally, there has been a steady increase in COVID-19 cases amongst refugees and IDPs. As of 31 January 2021, 103 countries reported 49,200 cases of COVID-19 among forcibly displaced people and over 446 refugees and IDPs have died due to COVID-19.[2] For the duration of the GHRP, 39.4 million refugees, IDPs and migrants particularly vulnerable to the pandemic received COVID-19 assistance in 61 GHRP countries. In that same period, 9.4 million people received essential healthcare services through UNHCR and partners in 39 GHRP countries, which is 3.4 million more than originally envisaged. UNHCR has worked with State authorities to adapt the registration of new asylum applications remotely so that those seeking protection are still able to do so. More than 107 States have adapted registration procedures for new applicants.

[1] As of February 2021, 272 million people are estimated to be acutely food insecure.
[2] The latter figure is likely to be higher but reporting in these contexts is difficult.

In 60 GHRP countries, 15.3 million people accessed protection services. Furthermore, the Danish Refugee Council reached 3.9 million forcibly displaced persons in 34 countries, providing protection, WASH, basic needs assistance and economic recovery support.

With more than 85 per cent of refugees hosted in low- and middle-income countries which often have weak health systems and limited capacity to manage persons with severe diseases susceptible to COVID-19, UNHCR focused its health system support on activities that could be scaled up in low resource settings. This included training of health staff in surveillance, case management, contact tracing, isolation and quarantine, and communicating with communities. Where possible, national health services have been supported to provide case management to refugees and host communities, including through psycho-educational and tele-counselling services for at-risk groups with difficulties accessing services, such as older persons and persons with disabilities.

To respond to the increased risk of GBV, UNHCR operations adapted existing programming. Of the 48 GHRP countries which reported, 81 per cent were able to maintain or expand GBV services in response to COVID-19 in 2020. A key part of the adapted programming includes the regular revision of GBV referral pathways to incorporate remote services. Many operations created or expanded the capacity of 24/7 emergency hotlines, e.g. Kenya, South Sudan, Pakistan and Zambia. UNRWA supported 1,150 GBV survivors between August and December 2020. In addition, UNRWA provided legal support services through referral to external specialized partners, and scheduled follow-up calls for refugees with disabilities to aid through home deliveries where possible.

IOM has provided technical support to country-level, cross-border and regional coordination mechanisms to ensure that migrants, displaced persons, returnees and other vulnerable populations are included in regional and national preparedness and public health planning. IOM estimated that there are close to three million stranded migrants whose intended movements were affected due to COVID-19. For the duration of the GHRP, IOM received 201 requests to help 8,115 migrants from 56 nationalities stranded in 48 countries, territories and areas who did not have the means to return home and who are in vulnerable situations. IOM helped over 6,000 migrants to return to their country of origin and provided assistance to meet migrants' needs, including food and shelter, child-care, and health, risk communication and preventive COVID-19 measures.

Monitoring indicators
Situation and needs

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	FEBRUARY REPORT
Spread and severity of the pandemic	Number of confirmed COVID-19 cases in GHRP countries	WHO	Over 25 million
	Total number of deaths among confirmed cases in GHRP countries	WHO	722,509
	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 31 of 38 GHRP countries
		WHO	-
	Proportion of countries where pre-COVID-19 levels of family planning/ contraception services are maintained	UNFPA	-
		WHO	28% no disruption 63% partial disruption 7% complete disruption[1]
	Proportion of countries where pre-COVID-19 levels of institutional births are maintained	UNFPA	For December: maintained in 7 out of 38 countries; 8 countries showed declines in more than 50% of health facilities, 13 countries showed decline in 25-50% of health facilities and 10 in 10-25% of reporting facilities
		WHO	48% no disruption 48% partial disruption[2]
Mobility, travel and import/export restrictions in priority countries	Number of priority countries with international travel restrictions in place	IOM	62[3]
		WHO	54[4]
		WFP	Overview is available here
	Number of priority countries with partial or full border closures in place	IOM, WHO	50

[1] September values.
[2] September values.
[3] As of 29 December 2020
[4] As per October 2020 report.

SITUATION AND NEEDS THEME	INDICATOR	RESPONSIBLE	FEBRUARY REPORT
Food security	Market functionality index	WFP	Available data cannot be aggregated at the global level
	Number and proportion of people with unacceptable food consumption score	WFP	268,435,711 (29.5%)
	Number of people adopting crisis level coping strategies (Reduced Coping Strategy Index)	WFP	268,008,340 (29.01%)
	Number of priority countries with reduced availability of agricultural inputs	FAO	20 out of 21 countries[4]
	Number of people in IPC Phase 3+ in priority countries (in countries where new analyses are available)	FAO/IPC	108,412,000[5, 6]
Education	Number of children and youth out of school due to mandatory school closures in GHRP countries	UNESCO	As at 31/12/20: 85,731,664 affected learners, which is 4.9% of total enrolled learners[7]
		UNHCR	1.68 million refugee children and youth (32 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	57%[8]
Gender-based Violence	Number and proportion of countries where GBV services have been interrupted	UNFPA	As of December, 7 out of 55 countries
Child protection	Number and percentage 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	29
Protection	Number of countries reporting incidents of COVID-19 pandemic-related xenophobia, stigmatization or discrimination against refugees, IDPs or stateless persons	UNHCR	61% (35 of 57 countries reporting incidents)

[4] Of the 21 countries where data is currently, 20 are reporting reduced availability of/access to agricultural inputs for crop and/or livestock production. Only Myanmar reports no change in the accessibility/availability of inputs. Note that this is not nationally representative data; it is based on the perceptions of key informants, including farmers and agro-dealers.

[5] This figure takes into account all IPC and CH numbers (current and projected) that are valid as of end of December 2020 in the countries referenced. This number represents a significant increase compared to the previous reporting period (60.9 Million). However, extreme caution should be exercised when comparing these figures due to the addition of new CH/IPC numbers for 13 countries where no numbers were reported in the previous period (Benin, Burkina, Cameroon, Chad, Liberia, Mali, Niger, Nigeria, Sierra Leone, South Sudan, Togo, Zambia and Zimbabwe). In addition, for a number of countries referenced in both the previous reporting period and this one, the number of people in IPC Phase 3 or above fluctuated due to seasonality and the evolution of other factors contributing to acute food insecurity.

[6] The indicator covers the following countries: Afghanistan (13.15 million), Benin (0.38 million), Burkina Faso (2.02 million), Burundi (1.33 million), Cameroon (2.69 million), Central African Republic (1.93 million), Chad (0.60 million), DRC (21.83 million), Ethiopia (8.61 million), Haiti (3.99 million), Kenya (1.88 million), Liberia (0.45 million), Mali (0.44 million), Mozambique (2.68 million), Niger (1.23 million), Nigeria (9.20 million), Sierra Leone (0.85 million), Somalia (2.11 million), South Sudan (5.77 million), Sudan (7.10 million), Togo (0.10 million), Uganda (2.0 million) and Yemen (13.48 million), Zambia (1.98 million) and Zimbabwe (2.60 million).

[7] https://en.unesco.org/covid19/educationresponse.This represents a tremendous decrease from the peak in April 2020, which was more than 1.48 billion affected learners, or 84,5% of total enrolled learners.

[8] As per October 2020 report.

Monitoring indicators
Strategic Priority 1

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	FEBRUARY REPORT
Ensure essential health service and systems	Number of passenger movement requests fulfilled	WFP	90%	97%
	Number of cargo movement requests fulfilled	WFP	90%	97%
	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%	83%
	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	15,225,034	17,190,093
	Number of 3 plies/medical masks distributed against need (or request)	UNFPA	25,000,000	106,534,083
		UNHCR	20.5 million	20.9 million / 33.0 million, 63% (52 countries reporting)
		WHO	-	113,772,530
	Number and per centage of children and adults that have access to a safe and accessible channel to report sexual exploitation and abuse	UNICEF	20,042,480	15,855,097
	Number of existing or newly established service points continuing to offer specialised services to victims of sexual exploitation and abuse during the COVID-19 crisis	UNFPA	-	1,120 service points in 55 countries
	Number of health workers provided with PPE	UNICEF	1,405,349	1,517,801
		UNRWA	3 months supply of PPE for more than 3,000 UNRWA front-line health workers	100%
		WVI	-	422,719
Learn, innovate and improve	Percentage of countries implementing sero-epidemiological investigations or studies	WHO	20%	16% initiated 46% confirmed interest

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	FEBRUARY REPORT
Prepare and be ready	Number of countries with costed plans in place to promote hygiene and handwashing in response to COVID-19	UNICEF	60	60
	Proportion of GHRP countries that have a national Infection Prevention and Control programme including water, sanitation and hygiene (WASH) standards and WASH basic services operational within all health-care facilities	WHO	100%	29%
Prevent, suppress and interrupt transmission	Proportion of GHRP countries with a functional, multi-sectoral, multi-partner coordination mechanism for COVID-19 preparedness and response	WHO	100%	98,4%
	Number and proportion of countries with COVID-19 Risk Communication and Community Engagement Programming	UNICEF	60	59
	Proportion of GHRP countries with COVID-19 national preparedness and response plan	WHO	100%	98,4%

Monitoring indicators
Strategic Priority 2

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	FEBRUARY 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	-	4,111,310 households / 23,884,718 people
		UNHCR	1 million people	1.24 million people (50 countries reporting)[9]
		UNICEF	1,594,666 households	1,725,541 households
		UNDP	20 million people	23,734,845 people [10]
		IOM	2,040,542 people	1,232,932 people
		DRC	-	2,444,854 people
		CARE	-	764,075 (food) and 596,887 (cash/voucher assistance)
		WVI	-	161,313

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

[10] As per October 2020 report.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	FEBRUARY REPORT
	Number of people/households most vulnerable to/affected by COVID-19 who benefit from increased or expanded social protection	FAO	–	511,756 households
		UNICEF	20.9 million households	9,796,436 households
		UNDP	4 million people	2,480,000 people[11]
		UNRWA	850,000 Palestine refugees	1,118,598
		UNHCR	640,000 people	1.16 million people (35 countries reporting)
Ensure the continuity of and safety from infection of essential services including health, water and sanitation, nutrition, shelter, protection and education for the population groups most exposed and vulnerable to the pandemic	Number of people (girls, boys, women, men) who are receiving essential health-care services	IOM	6,418,315	3,618,675
		UNHCR	6 million	9.38 million (37 countries reporting)
		UNICEF	50,280,946	56,845,664
		UNRWA	–	5.8 million in-person patient visits (not including telemedi-cine consultations)
	Number of people reached with critical WASH supplies (including hygiene items) and services	UNICEF	62,522,653	72,856,959
		IOM	31,150,053	28,702,481
		DRC	-	1,228,123
		CARE	-	3,860,013 people received increased access to safe water; 2,470,308 people received hygiene kits; 68,339 handwashing stations with soap and water were installed
		SCF	-	1,147,905 households supported to access safe water, facilities for hand-washing with soap and environmental practices
		WVI	-	14,662,134
	Number of children and youth supported with distance/home-based learning	UNICEF	178,336,631	128,946,720
		UNHCR	1.2 million	907,764 refugee children and youth (37 countries reporting)
		SCF	-	3,469,524 million children (51% female, 49% male), including 87,830 children with disabilities

[11] As per October 2020 report.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	FEBRUARY REPORT
	Number of children and youth in humanitarian and situations of protracted displacement enrolled in pre-primary, primary and secondary education levels	UNHCR	1.7 million	1.3 million refugee children and youth in 33 countries reporting
		UNRWA	533,000	School year 2019/20: 533,342 School year 2020/21: 540,644
	Number of people (including children, parents and primary caregivers) provided with mental health and psychosocial support services	UNICEF	18,091,461	20,640,615
		UNHCR	390,000	605,691 in 44 countries
		IOM	2,525,283	2,298,198
		SCF	-	246,838 children (46% female, 54% male) and 378,685 adults (55% female, 45% male)
	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	7,280,186	2,995,085
		UNHCR	55,000	52,656 in 23 countries
	Number of children 6-59 months admitted for treatment of moderate acute malnutrition (MAM)	UNHCR	140,000	132,219 in 23 countries
		SCF	-	391,455 children under 5 (51% female, 49% male)
	Number of women and girls who have accessed sexual and reproductive service	UNFPA	-	16,751,831 women in 51 GHRP countries and 7,095,287 adolescents in 47 GHRP countries
		UNHCR	710,000	1.18 million (31 countries reporting)
		CARE	–	1.5 million[12]
	Number and proportion of countries where messages on gender-based violence risk and available gender-based violence services were disseminated in all targeted areas	UNFPA	100%	48 countries out of 56 reporting countries
		UNICEF	30	30 (100%)

[12] 1.5 million women and girls received continued sexual and reproductive health and rights (SRHR) services in CARE-supported health facilities during the COVID-19 crisis. CARE supported 3,756 health facilities/service delivery points (e.g. mobile clinics) to provide health/SRHR COVID-19 related services.

SPECIFIC OBJECTIVE	INDICATOR	RESPONSIBLE	TARGET	FEBRUARY REPORT
	Number and proportion of countries where GBV services are maintained or expanded in response to COVID-19	UNFPA	61 GHRP countries	In December, 48 out of 55 countries
		UNHCR	All GHRP countries (63)	81% (48 of 59 countries reporting)[14]
		CARE	—	25 GHRP countries
	Number of people who have accessed protection services	UNHCR	10.7 million	15.34 million in 60 countries reporting
		IOM	1,675,147 people	1,185,227 people
		DRC	-	2,837,713 people
		CARE	-	1.7 million people[15]
		SCF	-	112,087 children (50% female, 50% male)
		WVI	-	1,439,969
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 pharma-ceuticals, medical devices and supplies to implement life-saving sexual reproduction and health services shipped since 1 March 2020	UNFPA	100%	47 /48 GHRP requesting countries (98%) had consign-ments shipped; 44/47 (94%) had consignments arrive to the country; and all 44/44 (100%) had consignments distributed to implementing partners.[16]

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

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

[16] UNFPA continues to procure, ship and distribute life-saving SRH commodities, contraceptives and other supplies, and conduct pipeline monitoring and stock availability at both central warehouse levels and service delivery points. In coordination with local government authorities and UN partners, UNFPA ensured contraceptives are available at health facilities, prioritizing regions with low stock levels. Furthermore, health facilities were supported with PPE & infection prevention and control supplies, and supplies for continuity of SRH service provision, notably the minimum initial service package.

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	37,465,770	35,925,620
		UNHCR	67 million people	39.4 million people[17]
		SCF	-	553,896 households received cash and/or voucher transfers
		DRC	–	4.86 million people
Prevent, anticipate and address risks of violence, discrimination, marginalization and xenophobia towards refugees, migrants, IDPs and people of concern by enhancing awareness and understanding of the COVID-19 pandemic at community level	Number and proportion of countries where areas inhabited by refugees, IDPs, migrants and host communities are reached by information campaigns about COVID-19 pandemic risks	IOM	60	52 countries
		UNFPA	100%	49 of 54 countries reporting
		UNHCR	100%	40 of 58 countries reporting
		UNICEF	-	6 countries[18]
		DRC	-	COVID-19 messages and risk information has been integrated in sectoral activities in 26 countries reaching 2,718,760 people in 2020
	Proportion of countries inhabited by IDPs, refugees and migrants with feedback and complaints mechanisms functioning	UNHCR	All GHRP countries (100%)	100% (61 of 61 countries reporting)
		UNRWA	Palestine refugees in all 5 fields of operation	Hotlines and other communication mechanisms implemented in all 5 fields of operation

[17] Approximately 39.4 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 7.85 million individuals who received cash assistance.

[18] This figures includes only those countries that report on disaggregated data by refugee/IDPs; however most do not do this disaggregation.

"We have reasons for hope. The speed with which effective vaccines have been developed is a historic achievement for humanity. But we have also seen a dangerous failure to take adequate action to help the world's most vulnerable countries. The next six months will be crucial. Today's decisions will determine our course for years to come."

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

"It is time to change course and take the sustainable path. And, this year, we have a unique opportunity to do so. We can use our recovery from the COVID-19 pandemic to move from fragilities to resilience."

António Guterres
United Nations Secretary-General