COVID-19 IN HUMANITARIAN CRISES: A DOUBLE EMERGENCY

The International Rescue Committee's (IRC) analysis and approach to COVID-19 draws on decades of experience as a humanitarian and health responder in the world's most complex crises, including as one of the largest responders to the Ebola outbreaks in West Africa and the DRC and Cholera in Yemen – the largest outbreaks of the diseases in modern history. IRC's experience finds conflict-affected and fragile countries face a double emergency:

1. **The direct impact of COVID-19** and its lethal and destructive direct impact on unprepared health care systems and populations with pre-existing vulnerabilities;

2. The **secondary havoc** the disease will cause to these states' already fragile humanitarian, economic, security and political environments.

COVID-19 is in the early stages of spreading to less developed and fragile countries, which means there is still time to mount a coordinated response that can ease suffering today and guard against dangerous secondary impacts tomorrow. But the time to act is now. Protracted economic, political and security crises have rendered many countries ill-equipped to respond to the disease. The four countries discussed in this report – South Sudan, Syria, Venezuela and Yemen – as well as camps for displaced populations around the world have weakened health systems unable to meet existing needs. Nearly half (46%) of the people in those four countries already lack access to basic health services. While the United States and Europe face shortages of ventilators, intensive care units, and protective equipment, many conflict-affected and fragile countries have virtually none to begin with:

- In **South Sudan**, there are just 24 ICU beds and four ventilators. With existing life-saving humanitarian programs globally facing unprecedented disruption and suspension, countries like South Sudan with high levels of malnutrition may face famine.

- **Northeast Syria** has only 28 ICU beds and 11 ventilators in the hospitals identified to quarantine and treat suspected COVID-19 cases. In **Northwest Syria**, there are only 105 ICU beds and 30 adult ventilators. Across Northern Syria, there were 85 attacks on health facilities last year alone and the country is likely to see further instability if we see actors like ISIS capitalizing on chaos to gain further ground.

- In **Yemen**, only half of the hospitals are still fully functional and some two-thirds of the population cannot access healthcare. It is one of the most complex operating environments for humanitarians, with bureaucratic delays and impediments already slowing the response. Major donors have also begun to reduce and suspend aid in northern Yemen just as the pandemic began, which could further degrade preparedness and response.

- In **Venezuela**, the existing humanitarian crisis has already forced more than half of doctors to leave the country, 9 out of 10 hospitals to face shortages of medicine and critical supplies, and left only 84 ICU beds nationwide. The country will likely face further economic crisis and reductions in public services, which not only threaten the lives of millions of Venezuelans, but are likely to heighten political tensions.

- Meanwhile, **camps in Syria, Greece and Bangladesh** represent some of the most densely populated areas in the world – up to 8.5 times more densely populated than the Diamond Princes cruise ship, where transmission of the virus was four times faster than in Wuhan, China. In parts of Moria camp, Greece, over 1,300 people share one tap and over 200 share a latrine. Rohingya refugees in one site in Cox's Bazar, Bangladesh could face 590,000 infections and over 2,100 deaths in a year if high transmission occurs, according to new research from Johns Hopkins.

THE IRC'S KEY RECOMMENDATIONS FOR THE INTERNATIONAL COMMUNITY

1. Provide new, fast, sustainable, and flexible financing to COVID-19 frontline responders to quickly reach those most vulnerable. At least 30% of the immediate Global Humanitarian Response Plan financing should be directed to frontline NGOs, already positioned to scale up COVID responses, and donors need to ready significant additional resources to reach the scale of need. The time to act is now to avert dire humanitarian, economic and political stability consequences.

2. Remove constraints to humanitarian action and service delivery – both conflict driven and bureaucratic. New travel and movement restrictions related to COVID-19 must include humanitarian exceptions to ensure flow of humanitarian goods and personnel to those in need.

3. Develop an inclusive and integrated response, built on lessons learned, to support the specific needs of the most vulnerable populations. Include vulnerable populations like refugees, Internally Displaced Persons (IDPs), migrants and other marginalized populations) in national COVID-19 preparedness plans.

4. Strengthen multilateral coordination and a harmonized global response to enable those in fragile and conflict-affected states to play the role required of them to fight a global pandemic. All states, but particularly the US and European Union (EU), must eliminate restrictions on the export of COVID-19 supplies.

5. Address underlying causes of crisis and maintain support for existing humanitarian responses. Invest in health systems of vulnerable countries to strengthen their capacity to prevent, detect and respond to diseases.

RISKS & IMPACTS IN FRAGILE & CONFLICT-AFFECTED STATES

A slow and insufficient humanitarian response to COVID-19 in fragile and conflict-affected contexts is certain to drive further crises with long-term political, economic, and security implications.

COVID-19 has already overwhelmed even the most advanced and prepared health systems. Yet, the IRC anticipates that the scale, speed, and severity of the outbreak will be even greater in fragile contexts, especially where active conflict and weak health systems meet. Protracted crises have increasingly left humanitarian needs disproportionately borne by a small number of countries – often those least equipped to handle them. These populations will be hit hardest by the disease, while insufficient health systems, scarce clean water and cramped, unhygienic conditions will make simple, effective measures to contain the disease nearly impossible. And at the same time, these states will also likely face secondary and long term impacts – on conflict dynamics, on political stability, on already weak economies – that are more significant, more destabilizing, and more widespread than in wealthier countries with more resilient governance, financial systems and social safety nets.

Without a step change in the speed, scale and nature of the COVID-19 response, the virus will soon overstretch existing humanitarian responses around the world, which 168 million people already rely on to survive. It is tempting for wealthy nations to turn inward to focus on their own domestic response, but it is also self-defeating. The most vulnerable may pay the price today for the inaction of the international community, but the consequences would be felt across the globe for years to come

Within these fragile settings, the most vulnerable members of society will be at particular risk.

Refugees, internally displaced persons, and especially women and girls will be particularly affected given the le-

gal and social barriers they already face to accessing healthcare and decent work opportunities. Research from the IRC and CARE highlights early evidence of increased gender-based violence (GBV) in China during the COVID-19 outbreak this year. This reflects wider trends that see women and adolescent girls facing heightened risks of GBV during other emergencies and outbreaks. At the same time, curfews and restrictions on movement aimed at controlling COVID-19 are restricting humanitarian programming that supports women and children to manage such risks. Meanwhile, school closures have already disrupted education for 80% of students globally. The closure of medical facilities is a particular concern during a disease outbreak. In IRC's experience, excess mortality and morbidity from decreased availability and use of essential services during outbreaks is as significant as mortality and morbidity directly caused by an outbreak.

In the midst of a crisis, displaced populations are often overlooked by national preparedness and response plans and they face movement and access restrictions that keep them from much needed aid and services. In addition to supporting states, the response to COVID-19 must therefore support populations failed by states that are unwilling or unable to meet these needs.

Outbreaks – and the responses to them – are likely to drive significant economic crises at the global, national, and local level, compromising the ability of the most vulnerable to meet their basic needs.

COVID-19 is expected to cause global GDP to fall by 1.9% this year, but the impact of this recession will be uneven across the world with fragile and conflict affected states at risk of both immediate and lasting impacts. In wealthier countries, many governments have responded with economic packages aimed at stabilizing their economies and supporting people whose livelihoods have been impacted. But fragile and conflict-affected states with limited financial resources and weaker social protection systems do not have the means to implement similar policies. And at the same time, humanitarian programming aimed at supporting the most vulnerable to meet their basic needs, which includes life-saving cash distributions, has suffered delays and obstacles due to movement restrictions, market disruption and bank closures.

Epidemics are a well-established driver of insecurity and localized violence, which can disrupt efforts to contain an epidemic.

During the West Africa Ebola outbreak, each new Ebola infection confirmed per 100,000 people increased the risk of conflict over the following two weeks in a given area by 10%. A major driver of such violence is that political and armed actors often try to exploit disease outbreaks for gain. Outbreak responses bring vast resources that influential actors want to control. Massive influxes of money to relatively small and economically under-developed areas, such as the hundreds of millions that flowed to eastern DRC in 2018-2019, can drive violent competition for resources.

Disease outbreaks – and the strain they can place on limited resources – also increase tensions between local populations and those displaced, who may be falsely accused of spreading the disease. Stigmatization of refugees can lead to restrictions on their access to services or even violence and pressure from host communities for refugees to be forcibly returned. This in turn can make refugees too afraid to seek medical care or report when they are ill.

The COVID-19 pandemic therefore brings a new urgency to tackle long-standing threats to humanitarian work – and lays bare the cost of continued politicization of aid and international inaction.

Warring parties simply do not prioritize humanitarian need and civilian protection while key international actors have long failed either to enforce laws and norms or hold violators to account. In the absence of strong and consistent humanitarian diplomacy and accountability, warring parties have far too often treated humanitarian responses to previous crises as a bargaining chip to achieve their own objectives. All the while, the UN Security Council has remained deadlocked. An unprecedented pandemic will require bold diplomacy and sustained engagement from

the international community to ensure the response to COVID-19 does not face the same bureaucratic barriers, politicization, and violations of humanitarian law.

The international community's support for conflict-affected and fragile countries experiencing an outbreak will need to come not only in funding and supplies, but also in diplomatic engagement with governments and non-state actors to enact ceasefires in active conflict zones and pressure them to halt attacks on health facilities and other infrastructure critical to the response. So far the signs are worrying. Humanitarian organizations are racing to supply clinics in conflict zones with personal protective equipment – masks, gowns and gloves – despite the all too real risk of these facilities being bombed or shelled; there have already been 56 attacks on health care so far in 2020. While the UN Secretary General has called for ceasefires globally to facilitate the COVID-19 response, the UN Security Council has failed to unite around this call to action. Moreover, the Council deadlock has precluded any coordinated action related to the pandemic – leaving the General Assembly to fill the void with a non-binding resolution.

The need for a timely, unfettered response has never been more urgent as we face a fast-moving disease outbreak.

The ability of humanitarian organizations to prepare for COVID-19 is already being undermined by access constraints – not just due to active conflict, but due to longstanding bureaucratic constraints and newly implemented restrictions enacted to halt the virus' spread. Well-intentioned measures to halt the disease, such as border closures or restrictions on movement, will be counter-productive if they also disrupt the very supplies and humanitarian staff critical to the response.

At the same time, some government and non-state actors have begun to seize the panic and distraction created by the pandemic as an opportunity to expand their influence and control. Some of these efforts are readily identifiable – crackdowns on opposition groups or new military operations. Less obvious will be the political measures enacted under the pretext of controlling the outbreak which – in IRC's experience – cause citizens to doubt the seriousness or even reality of outbreaks. There is then a greater risk of communities dismissing the outbreak as a political trick, feeding into resentment or even violence against aid workers. For example, President Kabila was accused of disenfranchising large parts of eastern DRC by delaying voting in those areas in the country's December 2018 presidential elections, citing the Ebola outbreak. This was a key factor highlighted by members of local communities to explain their mistrust of the response and actors involved in it. As in any humanitarian crisis, efforts to contain a disease outbreak must remain independent and neutral – free of the political and security objectives of both state and non-state actors.

Ending an outbreak in fragile contexts requires a coordinated response that draws on the experience of frontline NGOs to reach the most vulnerable.

While COVID-19 is a public health emergency, in fragile and conflict settings it will be just one more layer on top of existing complex humanitarian crises. In these settings, states are weak at best and in some cases can be an actively malign force.

While ministries of health and the World Health Organization (WHO) are vital parts of the puzzle, where states are weak, their worthy efforts must be buttressed from the start by experienced NGOs. As was ultimately seen in West Africa in 2014-2015, humanitarians, with practiced methods of coordination, needs assessment, communication and logistics, brought speed and scale that were much needed to identify and respond to both first order and second order effects of the Ebola outbreak. Frontline NGOs, like the IRC, bring a strong understanding of pre-existing vulnerabilities and needs, existing service provision, community engagement, cultural and context sensitivity, and an understanding of how the disease may interact with secondary impacts such as increases in gender-based violence, violence against children, food insecurity or loss of livelihoods.

Frontline NGOs also have long-standing experience in engaging communities and an understanding of local-level

Two community health volunteers working for IRC speak with refugees about COVID-19 prevention measures, share information about screenings at IRC health facilities, and put up community awareness raising posters.

Credit: M. Hasan/IRC

dynamics. This expertise allows them to operate in fragile and conflict-affected states without resorting to the over-securitized approaches adopted by some Ebola response actors that antagonized and alienated many communities in eastern DRC. The lack of early and strong community engagement undermined trust in that response, discouraged people from seeking testing and treatment – including treatment for other conditions – and contributed to attacks on response actors.

Rapid and agile funding is therefore needed in the early stages of an outbreak for NGOs, who are already on the ground in fragile contexts and can mobilize quickly, while leveraging their partnerships with the community and understanding of local needs and challenges. This is critical because the work to prepare facilities and communities has to happen now. In 2019, channeling most of the resourcing for the Ebola response in the DRC through the UN and the government introduced delays in getting funds to frontline responders. This inefficient approach risks being replayed in response to COVID-19. The UN's current global appeal for COVID-19 only sets aside 5% of funding ($100 million out of the $1.99 billion appeal) for direct funding to non-UN actors, making it nearly impossible for the response to leverage vital NGO experience and community connections.

At the same time, international bodies, including the UN Security Council and G-20, have a key role to play in pressing for a harmonized response across states, while also ensuring that resources are directed to countries and populations most in need.

Early and flexible funding is vital, but must not be diverted from ongoing humanitarian responses.

Across the board, humanitarian crises remain unfunded by 40%, on average, and humanitarian funding often falls the longer crises persist. Diverting funding from one life-saving response to another will harm both. The response to COVID-19 will require not just treatment for individuals infected with the virus, but also work to strengthen health systems and deliver primary healthcare, protection, and cash programs that are equally life saving.

Funding for frontline NGOs can help ensure that response activities are closely coordinated with existing health – including mental health – and other programming, and that both existing needs and outbreak-related needs are met. Existing needs, particularly malnutrition and other disease outbreaks, put populations at elevated risk for COVID-19 and require prioritization as part of a comprehensive response. The failure to do so in the DRC contributed to the fact that more people died of measles (6,000) than Ebola (2,240) during the Ebola outbreak in eastern DRC from 2018 to 2020.

CASE STUDIES

The IRC has identified the five case studies in this report – South Sudan, Syria, Venezuela, Yemen and camps for displaced populations – as situations at particular risk of severe impact from the pandemic. While countries like the United States, United Kingdom, and South Korea make the top 10 in the Global Health Security Index for their ability to handle an epidemic, these four countries rank 184, on average, out of 195 states and territories in the world and have an average score of less than 21 out of 100. These four states already host 30% of the world's population in need of humanitarian assistance with just 0.6% of global GDP – and are ill equipped to handle an unprecedented pandemic on their own.

SOUTH SUDAN

- **South Sudan already faces widespread and complex humanitarian needs, including some of the largest food insecurity and protection crises in the world, which have left around 64% of the population in need of assistance**

- **The country has just 24 beds in intensive care units and four ventilators**

- **Travel restrictions due to COVID-19 risk disrupting efforts to contain the locust swarms that threaten to massively worsen food insecurity in South Sudan in the coming months**

South Sudan reported its first case of COVID-19 on 5 April and the disease is also present in all neighboring states. The government has reported that there are just 24 ICU beds in the country and there are reportedly only four ventilators. While the government put in place strict restrictions early on to prevent the arrival of the disease, weak government capacity could undermine its ability to monitor border closures or enforce a nationwide lockdown.

South Sudan has only an estimated 0.15 doctors per 10,000 people – one of the lowest rates in the world. Just 44% of the population lives within 5km of the nearest health facility. More than half of the population has no access to primary health services, which, alongside limited access to clean water, poor sanitation services and extremely low immunization rates, has left the population highly susceptible to disease. Before COVID-19, 44% of the population was already at risk from other diseases and 75% of all child deaths were due to preventable diseases. South Sudan already relies on NGOs to provide 80% of its health services.

In South Sudan, more than half of the population has no access to primary health services.

SOUTH SUDAN
Population: 11.7 million

ICU BEDS: **24**

VENTILATORS: **4**
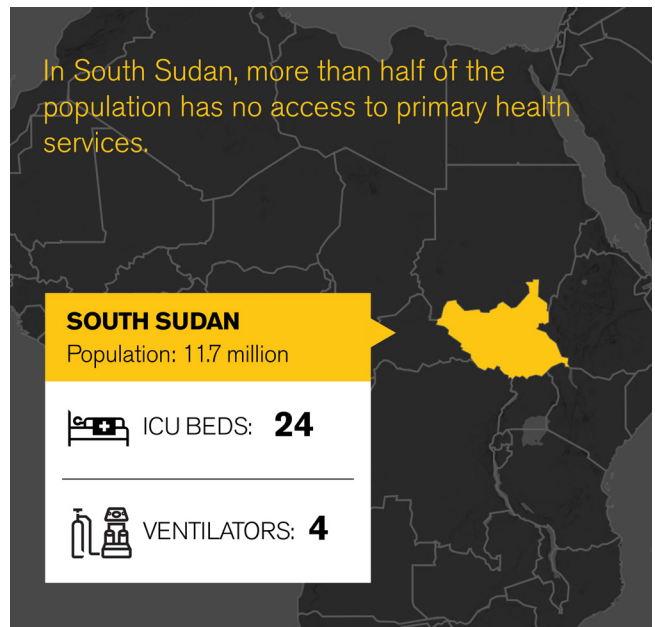
SIMILAR CONTEXTS: Somalia, DRC, Sudan, Central African Republic, northeast Nigeria and the wider Lake Chad Basin region.

Conflict has left one third of South Sudanese displaced – 1.5 million internally and 2.2 million regionally - many of whom live in overcrowded camps, will face higher risks from the disease and even more limited access to health services.

KEY CONCERNS FOR SOUTH SUDAN:

- Travel restrictions in South Sudan and its neighbors due to COVID-19 may impede efforts to control the desert locust swarms threatening to invade and destroy regional agricultural production this year. More than half of South Sudan's population – 6.5 million people – face severe food insecurity. Food insecurity and poverty levels will worsen, as the COVID-19 outbreak and a locust invasion coincide with the lean season (when household food stocks are exhausted and market prices peak).

- Food insecurity and malnutrition will grow possibly to famine levels. A COVID-19 outbreak will reduce the workforce for the highly labor-intensive agricultural sector and, together with reduced production, will have long-lasting effects on food security. Supply chain disruptions will also have far-reaching implications for a country highly dependent on imports, and could affect food distributions for a quarter of the population and increase prices of basic goods. The country has so far excluded all humanitarian aid from recent border restrictions, enabling work to pre-position supplies before the start of the rainy season in April. But children are likely to suffer most given South Sudan already has one of the world's highest rates for wasted children.

- Tensions in the unity government formed in February 2020 could worsen. South Sudan is at a particularly delicate moment; the government and opposition's new unity government comes as the country is in the early stages of recovering from conflict. The threat posed by COVID-19 could provide a new incentive for the two sides to resolve outstanding issues and implement the peace deal. However, budget shortfalls exacerbated by the pandemic may further delay the integration of former fighting forces or disrupt payments for security forces, driving weak command and control and a fragile security situation.

- IRC experience suggests gender-based violence is likely to rise during a COVID-19 outbreak. Women and girls in South Sudan already face some of the highest levels of violence in the world, with 65% experiencing violence. 80% of at-risk women and girls already do not have access to services for gender-based violence. This gap will likely grow as the outbreak persists.

IRC RESPONSE

The IRC has operated in South Sudan for over three decades and is one of the largest providers of aid in the country, serving more than 900,000 people. IRC programming includes health, nutrition, reproduction health and women's protection and empowerment, child protection, and livelihoods. IRC has worked to expand the capacity of state clinics and train local health workers to provide basic health care.

A woman is pictured carrying water from a well at the community water pump in her village Panthou in Aweil South State, South Sudan.
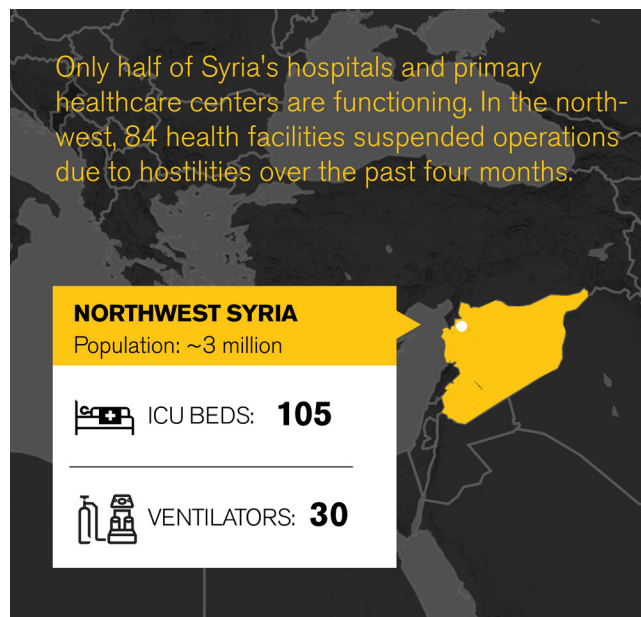
Credit: C. Lomodong/IRC

■ SYRIA

- **Syria ranks at 188 of 195 in the Global Health Security index, indicating a very low level of preparedness for an epidemic.**

- **Syria's ability to cope with COVID-19 is severely diminished after almost a decade of conflict which has significantly weakened the health system, including by the deliberate targeting of healthcare facilities.**

- **COVID-19 may undermine shaky truces in southern Syria and drive tensions between rival opposition factions in the northwest. The Islamic State group could try to exploit any outbreak to carry out more attacks and free its fighters from prison.**

- **The pandemic – and restrictions related to it – will exacerbate the economic crisis, hindering humanitarian actors' ability to secure life-saving supplies and pricing Syrians out of basic goods.**

Syria has reported 19 confirmed cases of COVID-19 and two deaths from the disease in government-controlled parts of the country as of April 6. There have been no reported cases in opposition-held Idlib governorate in northwest Syria or in the northeast which is governed by the Kurdish-led administration. However, testing has not been widely available in these areas.

The country ranks at 188 of 195 in the Global Health Security index, indicating a very low level of preparedness for an epidemic. Syria's health system is severely damaged after almost a decade of war, including the deliberate targeting of healthcare facilities. Only half of its hospitals and primary healthcare centers are functioning. According to WHO, there were 494 attacks on health in Syria between 2016 and 2019 – 68% of them in northwest Syria. Over the last four months, 84 health facilities in northwest Syria have been forced to suspend operations due to hostilities. In the northeast, just one out of 16 hospitals is fully functioning and there are only 28 ICU beds and 11 ventilators in the hospitals identified to quarantine and treat suspected cases.

One third of the country remains internally displaced,

Only half of Syria's hospitals and primary healthcare centers are functioning. In the northwest, 84 health facilities suspended operations due to hostilities over the past four months.

NORTHWEST SYRIA
Population: ~3 million

ICU BEDS: **105**

VENTILATORS: **30**

SIMILAR CONTEXTS: Yemen, Libya, Somalia, Afghanistan, NE Nigeria, NW and SW Cameroon

with most living in overcrowded camps or informal settlements, making social distancing impossible and adequate health or water services out of reach for many. For example, the population in al-Hol camp in the northeast increased seven-fold in 2019 to 68,000 people within just 1.82km² – almost four times more densely populated than New York City. Meanwhile, the displacement of nearly a million people in northwest Syria since December 2019 has left hundreds of thousands of people living in tents, unfinished buildings and reception centers, drastically increasing their vulnerability. In the midst of growing needs, the UN Security Council's failure to renew UN cross-border aid operations through the Yaroubiya border crossing in the northeast has significantly undermined efforts to pre-position medical supplies. Areas under government control also have a shortage of trained medical staff, as many areas outside of Damascus lack sufficient hospital beds and medical equipment.

KEY CONCERNS FOR SYRIA:

- COVID-19 will further stretch the limited healthcare capacity. There is limited availability of personal protective equipment and medical equipment, such as ventilators. Given the significant increase in global demand for these goods, procurement will become increasingly difficult.

- Humanitarian needs will rise since COVID-19,

and the restrictions related to it, are likely to price Syrians out of basic goods, including those necessary to prevent the spread of the disease. Some families already spend over 50% of their income on purchasing clean water. In Idlib governorate in the northwest, the cost of hand soap ranges between SYP 250 – 1,000, while the average daily wage for unskilled labor there is SYP 1,200.

- The pandemic will exacerbate the economic crisis and could hinder humanitarian actors' ability to secure life-saving supplies. COVID-19's impact on the banking sectors in neighboring Lebanon and Iraq will drive liquidity issues in Syria and put further pressure on the Syrian Pound, which already hit record lows over the past year. It may become even more challenging for NGOs to move funds into Syria to sustain operations and life-saving interventions, including cash assistance to vulnerable populations.

- A mismanaged response to COVID-19 could lead to localized instability, whether by undermining fragile, localized truces in government-controlled areas in the south or by worsening tensions between rival opposition groups in the northwest. The government could also capitalize on the pandemic by launching a fresh offensive to capture more territory if it views the opposition as distracted by COVID-19.

- COVID-19 could lead to greater Islamic State (IS) violence, particularly in northeast Syria. The outbreak could disrupt efforts by the international coalition and local authorities to counter the group, which has shown it will capitalize on crises to further its agenda. For example, during the Turkish offensive in northeast Syria in October 2019, the group claimed responsibility for a bombing outside Hassakeh prison in an attempt to free IS fighters from the facility.

IRC RESPONSE

The IRC has been working in Syria since 2012. IRC's COVID-19 response includes promoting community awareness campaigns and training IRC and partners' healthcare workers on waste management and infection prevention and control. In the Northwest, we are working closely with the Early Warning, Alert and Response Network (EWARN) to ensure an effective reporting mechanism for any suspected cases. The IRC has also designated an ambulance in NW Syria to transport suspected COVID-19 cases to referral hospitals that have quarantine facilities.
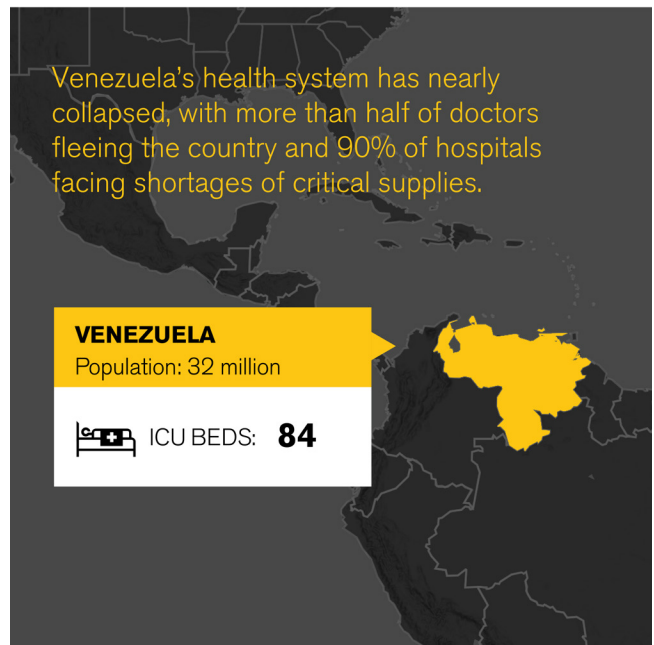
VENEZUELA

- **Ranks 176 out of 195 countries for its ability to manage an epidemic; more than half of doctors have left the country and 90% of hospitals report shortages of medicine and critical supplies**

- **COVID-19 will deepen a severe economic crisis that has left 7 million in need of humanitarian assistance inside Venezuela**

- **The pandemic will hinder vulnerable populations' ability to seek safety in the midst of the largest external displacement in Latin America's modern history**

Venezuela has reported 144 cases of COVID-19 and three deaths as of April 6. The scale of the outbreak is likely worse, as the Venezuelan government has limited the publication of official health data in recent years. Venezuela's capacity for COVID-19 testing is limited, with reports of only one hospital conducting centralized testing. Venezuela ranks 176 out of 195 countries for its ability to manage an epidemic, according to the Global Health Security index.

Before COVID-19 arrived, a quarter of Venezuelans (7 million people) already required humanitarian assistance and at least one third of the country faced food insecurity. The health system had also nearly collapsed. The humanitarian crisis forced more than half of doctors to leave the country. Meanwhile, 90% of hospitals face shortages of medicine and critical supplies and 70% do not have regular access to water. The country has 8 hospital beds per 10,000 people and only 84 ICU beds for a population of 32 million. The increasing lack of access to clean water impacts not only hospitals but Venezuelan households; only 18% of people consistently have access to clean water.

Recent disease outbreaks in Venezuela, and their spillover effects in the region, provide a frightening precedent for COVID-19. Venezuela went from eradicating malaria, measles, and diphtheria to some of the largest outbreaks globally. By 2017, Venezuela saw 406,000 cases of malaria – a 69% increase in a year. In 2019, Venezuela faced 9,300 reported cases of measles. Measles then spread across 14 countries in the Americas, which had initially been the first region in the world to eradicate the disease.

Venezuela's health system has nearly collapsed, with more than half of doctors fleeing the country and 90% of hospitals facing shortages of critical supplies.

VENEZUELA
Population: 32 million

ICU BEDS: **84**

SIMILAR CONTEXTS: Sudan, Zimbabwe, Eritrea

KEY CONCERNS FOR VENEZUELA:

- Humanitarian needs within Venezuela will grow since border restrictions imposed due to COVID-19 will prevent many Venezuelans from meeting basic needs or seeking asylum. Two million Venezuelans were expected to move between Venezuela and Colombia this year, relying on an open border for daily access to food, medicine, and other basic goods and services in Colombia. That can no longer happen. Likewise, border closures will undermine the ability of some 1.6 million Venezuelans to flee to safety this year alone. Given shortages of basic goods in Venezuela, there is likely to be a significant impact on health and food insecurity.

- Rather than halt cross-border movements, past travel restrictions and border closures pushed large numbers of Venezuelans to travel through informal crossings where there are greater risks of physical danger and exploitation by criminal groups and human traffickers. Moreover, there large-scale, irregular, untracked movements threaten to spread the virus.

- There is a high risk of xenophobia and stigmatization of Venezuelans displaced to other countries, who may be falsely accused of spreading the

IRC staff provide COVID-19 telemedicine services to members of the Cucuta community.

Credit: IRC

disease. Fears of COVID-19 and the spread of rumors could discourage displaced populations from seeking services and escalate tensions with host communities.

- While the magnitude of the threat from COVID-19 could drive some compromise to resolve the political crisis, all signs to date suggest the disputes over the presidency are likely to worsen. The U.S. has threatened to ramp up pressure for adoption of its new "democratic transition framework." This will likely incentivize both sides to try to secure their political power, perpetuate instability and politicize the COVID-19 outbreak. The odds of a resolution to the political and economic crisis will weaken as both sides dig in and the Venezuelan government fears new attempts at regime change.
- Heightened political tensions and economic strain are a perfect storm for greater social unrest and humanitarian need. As the pandemic and deteriorating economic situation force reductions in public services, there will likely be growing tension and grievances. In February 2020, the country averaged 26 protests daily.

◤ IRC RESPONSE

IRC supports populations on both sides of the border, with support to partners in Venezuela and programming in Colombia. In response to COVID-19, IRC is continuing to provide vital access to quality maternal health care (birthing kits) and is supporting the response inside Venezuela with Personal Protection Equipment for doctors and nurses. In Cúcuta, the IRC has set up a call center run by doctors and nurses to support vulnerable populations, distribution of free medicines, continued sexual/reproductive healthcare and cash to keep Venezuelans safe.
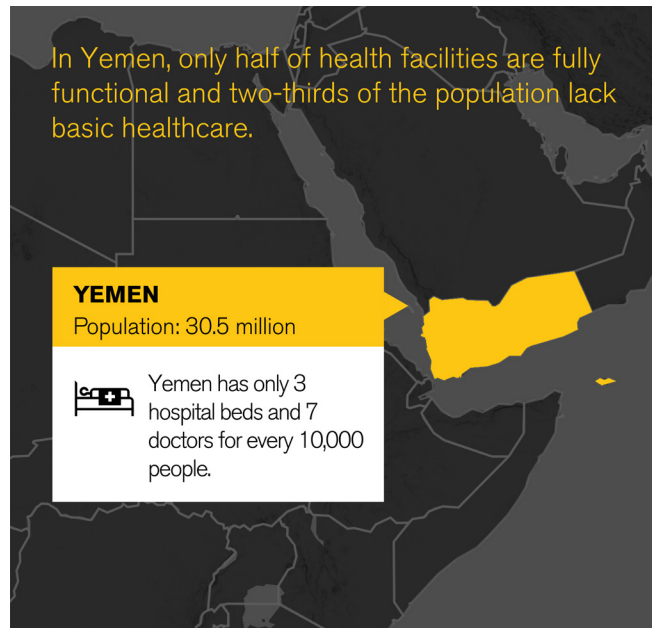
▉ YEMEN

- **Yemen is the largest humanitarian crisis in the world; 80% of the population is already in need of humanitarian assistance.**

- **Ranked 193 out of 195 countries for its ability to manage an epidemic; only 51% of health facilities fully functional**

- **Restrictions due to – or justified on the basis of – COVID-19 could prevent the response from moving at the necessary speed and scale**

In Yemen, only half of health facilities are fully functional and two-thirds of the population lack basic healthcare.

YEMEN
Population: 30.5 million

Yemen has only 3 hospital beds and 7 doctors for every 10,000 people.

SIMILAR CONTEXTS: Syria, Libya, Somalia, Afghanistan, NE Nigeria, NW and SW Cameroon

No cases of COVID-19 have been confirmed in Yemen but, once it arrives, the disease will spread rapidly. Yemen ranks in the bottom five countries in the world for its ability to manage an epidemic, according to the Global Health Security index. Yemen scores just 9 out of 100 for its ability to detect a pandemic. Only two sites in the country, one in Sana'a and one in Aden, reportedly can conduct COVID-19 testing. And out of 244 people identified for self-isolation after entering the country between January and March, a staggering 40% are already unaccounted for.

Yemen's acute vulnerability stems from five years of brutal conflict, which has led to widespread damage and destruction of critical infrastructure. The conflict, and its 142 attacks on health facilities, have left only 51% of health facilities fully functional and two-thirds of the population without basic healthcare. The remaining health infrastructure is woefully insufficient. Yemen has only 3 doctors and 7 hospital beds per 10,000 people, according to WHO.

Many Yemenis already face underlying or unaddressed health conditions that place them at an even greater risk from COVID-19 and will likely drive higher mortality rates in Yemen than in other countries. For instance, over one third of children are malnourished. Key recommendations to counter COVID-19, like handwashing, are not a realistic option for many Yemenis, half of whom lack direct access to safe water, sanitation and hygiene. Similarly, social distancing will be impossible for many of the 3.6 million IDPs in overcrowded camps and informal settlements.

KEY CONCERNS FOR YEMEN:

- COVID-19 will cause needs to rise even further as the humanitarian response is critically weakened by significant funding gaps. The economy has shrunk by 50% since the conflict began and this trend will likely continue. The arrival of COVID-19 may coincide with a new wave of cholera cases, which are likely to spike during the rainy season from April to August. Over 30 UN programs, including health programs, will be reduced or shut down by late April. Major donors have also begun to reduce and suspend humanitarian work in northern Yemen in response to the Ansar Allah (Houthi) authorities' interference in humanitarian assistance. USAID started suspending "non-life-saving" assistance, including some health and hygiene programming, in Ansar Allah-controlled areas in late March.

- An insufficient humanitarian response will increase the risk of famine and force a vulnerable population to adopt negative coping strategies to survive, including reduced food consumption and clean water purchases as well as greater child labor and child marriages. Women and girls will be disproportionately affected. Within just the first three years of conflict, there was already a 63% increase in gender-based violence and tripling of rates of child marriage and early and forced

marriage. 80% of Yemenis already live in poverty and the economy has shrunk by 50% since the conflict began; COVID-19, and the measures to address it, are likely to drive further economic decline.

- New travel restrictions due to COVID-19 have prevented humanitarian staff from moving in and out of the country and are likely to disrupt the movement of critical supplies, adding to existing constraints. Parties to the conflict may also use COVID-19 as an excuse to impose additional measures. Already, Ansar Allah has cited the pandemic as justification to not allow WFP to use a biometric system to prevent aid diversion.

- COVID-19 could drive more conflict activity in the short-term, as all sides seek to blame others for its spread. Ansar Allah is seeking to maximize their position on the ground as the international community's attention has shifted to the pandemic. Already, leaders of Ansar Allah have said

they will hold the Saudi and Emirati-led Coalition responsible for any cases, given its control of air, sea, and land ports, while local forces in the south reportedly held some COVID-19 response equipment in Aden port to prevent it from going to areas under rivals' control. In the long term, the common threat posed by COVID-19 could drive progress in the political process to end the conflict as key parties to the conflict have signaled a willingness to abide by a nationwide ceasefire, but it will depend on continued pressure from the international community.

◤ IRC RESPONSE

The IRC has been working in Yemen since 2012 and rapidly scaled programming in 2015 to address greater humanitarian need caused by the conflict. IRC provides life-saving healthcare, economic empowerment, women's and child protection and empowerment, and education programming.

A displaced woman and her son receive medical and nutrition assistance at an IRC mobile clinic operating on the outskirts of Aden, Yemen. Credit: W. Swanson/IRC

CAMPS FOR DISPLACED POPULATIONS

- **COVID-19 will spread quickly in some of the most densely populated areas in the world, where many residents have limited access to essential hygiene and health-care facilities**

- **Lack of information inhibits understanding of a pandemic, affecting health and well-being and risking further infection spread**

- **National responses to COVID-19 are restricting access to vital services**

The population density of refugee and IDP camps poses a specific challenge for the COVID-19 response. Analysis by ACAPS draws a useful comparison with the Diamond Princess cruise ship, where the transmission rate was four times higher than observed in Wuhan, China, at the peak of the outbreak. This trend is attributed to the high population density (24,400 people per km2) and poor sanitary conditions of the ship – factors that are significantly exaggerated in camp settings. IRC analysis shows that population densities are 37,570 per km2 in Al Hol, Syria, 40,000 per km2 in Cox's Bazar, Bangladesh , and a staggering 203,800 per km2 in Moria, Greece. Social distancing in these contexts will be nearly impossible.

For camp residents, access to health services is often limited to primary level care with inadequate capacity for isolation and intensive care of COVID-19 patients. Underlying health conditions, such as malnutrition and other communicable and non-communicable diseases, also increase displaced populations' vulnerability to the virus. Limited access to water and sanitation limits scope for necessary hygiene activities; in areas of Moria camp, Greece, over 1,300 people share one water tap and over 200 share a latrine. Rohingya refugees in one site in Cox's Bazar, Bangladesh could face 590,000 infections and over 2,100 deaths in a year if high transmission occurs, according to new research from Johns Hopkins.

Limited or constrained access to information contributes to increased risks that displaced populations spread the infection. The Government of Bangladesh's ban on mobile phones and restricted internet

Social distancing isn't an option inside a crowded refugee camp.

Population density on Diamond Princess cruise ship:

24,000 PEOPLE PER SQUARE KILOMETER

Population density in Cox's Bazar Refugee Camp:

40,000 PEOPLE PER SQUARE KILOMETER
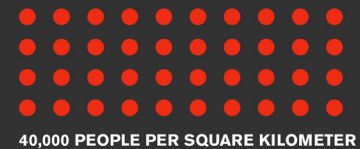
access in Rohingya refugee camps is already hampering efforts to disseminate health information and counter misinformation about the virus and limits service provision.

Finally, the legal status and gender of displaced populations may impact their ability or willingness to access health services. Asylum seekers without legal status are often reticent to trust local authorities, much less reveal themselves once they get sick. Women and girls – already less likely than men to have power in household decision-making during times of crisis – may be even less able to access central health facilities or health information when confined to their homes and shelters. Displaced populations – particularly refugees and migrants – face the risks of exclusion from national preparedness and response plans (e.g. national disease surveillance, health information efforts, and access to health services). There are positive examples, however. In Kenya, the government has included refugees and asylum seekers in its national plan to combat COVID-19. Ninety beds are available inside the Dadaab camp itself to accommodate coronavirus patients and isolation facilities have also been set up in nearby Kenyan host communities for both refugees and residents.

KEY CONCERNS FOR CAMPS FOR DISPLACED POPULATIONS:

- Efforts to limit humanitarian services deemed

non-essential to COVID-19 response may exacerbate humanitarian needs. Some governments have decided to close program centers, including women and girl and child friendly spaces. For instance, isolation has driven a sharp rise in intimate partner violence (IPV), reportedly rising 30% across the country since a lockdown began in France. Displacement and armed conflict are also known to increase IPV; IRC data shows that even before COVID-19, one in four women in Cox's Bazar experienced GBV. Ensuring vulnerable and marginalized populations have continued access to protection networks, information and support will be important to avoid secondary risks.

- Controls on movement and tensions with host communities may lead to a deterioration in security in and around camps. In contexts where camp residents face restrictions on their freedom of movement, populations may try to leave camps if conditions deteriorate significantly, potentially triggering tensions with national security actors and/or premature return to their home conditions that may not be safe. Reports of Afghans returning to Afghanistan from Iran and rising attacks on foreigners accused of spreading the virus in Ethiopia illustrate the risks.

- Local markets found in and near many refugee and IDP camps are vulnerable to a range of economic impacts associated with the COVID-19 pandemic. These include reductions of imports; increases in prices and inflation rates; and steps taken to limit business activity. In Bangladesh, prices of essential goods such as rice, eggs, onions, and chicken have already increased significantly. Social distancing efforts may include closing markets which supply residents' basic needs or offer livelihoods on which families rely.

◤ IRC RESPONSE

- The IRC has decades of experience in refugee and IDP camps. In Kutupalong, the world's largest refugee camp in Bangladesh, we are training our health teams on COVID-19 infection control and prevention measures and installing handwashing points.

- In Dadaab and Kakuma, Kenya where IRC has worked for nearly three decades, we are working closely with the Ministry of Health (MoH) and UNHCR to identify isolation units at an IRC-run hospital.

- In Thailand, we are working with the MoH to set up triage, screening and isolation rooms at health facilities within refugee camps, and are holding weekly meetings with refugee camp leadership.

Kutupalong Refugee Camp in Cox's Bazar, Bangladesh, is home to over 700,000 Rohingya refugees who have fled Myanmar since 2017. Credit: IRC

KEY RECOMMENDATIONS TO MANAGE THE IMPACTS OF COVID-19 IN FRAGILE AND CONFLICT-AFFECTED STATES

1. **Provide fast, sustainable, and flexible financing to respond to COVID-19 wherever it spreads and to reach those most vulnerable.**

   - Fully fund the UN's Global Humanitarian Response Plan (GHRP) for COVID-19 responses on top of funding for existing Humanitarian Response Plans to ensure that ongoing, life-saving humanitarian programs continue at scale. This is necessary both as a good in itself and to manage where COVID-19 and pre-existing needs will intersect.
   - Ensure immediate COVID-19 financing reaches frontline responders, who are already positioned to scale up COVID-19 responses to serve the most vulnerable and those most likely to fall through the cracks of state responses. At least 30% of immediate GHRP financing should be directed to front-line responders. In addition to supporting the GHRP, donors must direct resources directly to frontline NGOs. The time to act is now to avert dire humanitarian, economic and political stability consequences.
   - Shift towards financing that is long-term and flexible to allow frontline responders to pivot their responses as needs change on the ground and implement strategic and effective programming to address the pandemic's longer-term impacts.
   - Ready significant additional resources to reach the scale of need.

2. **Remove constraints to humanitarian action and service delivery – both conflict-driven and bureaucratic.**

   - Push all authorities for the removal of pre-existing bureaucratic obstacles and delays that impede humanitarian responses. Press local and national-level actors to remove any impediments to humanitarian assistance, including ensuring all air, sea, and land ports are fully functional and open to humanitarians, and to streamline existing bureaucratic processes to allow for timely, effective response.
   - Press for humanitarian exceptions for new restrictions related to COVID-19, including all travel and movement restrictions, to ensure the flow of life-saving humanitarian goods and personnel can continue uninterrupted and reach those in need.
   - Heed the UN Secretary General's call and push for ceasefires in active conflicts to allow humanitarians to respond to needs and do preparedness work. We urge the Secretary General to engage UN member states in an effort to secure a global ceasefire and the UN Security Council to adopt a resolution codifying the request for a halt to fighting and unfettered access and to take concrete steps to apply this global call to specific conflicts.
   - Pressure warring parties to stop attacks on civilian infrastructure, including healthcare and sanitation facilities, and publicly hold perpetrators of such attacks to account.

3. **Develop an inclusive and integrated response, built on lessons learned, to support the specific needs of the most vulnerable groups.**

   - Include vulnerable populations (refugees, IDPs, migrants, and other vulnerable and marginalized populations) in national COVID-19 preparedness plans to address both immediate response needs and longer-term global health security and system strengthening.
   - Ensure community engagement plans are in place, clear roles defined and allocated, and funding is in place for actors contributing to community engagement.
   - Integrate mental health and gender into the response from the outset. Without sufficient attention to these needs, people living in humanitarian settings, particularly women and children, will feel the effects of the COVID-19 crisis far beyond the physical health impacts.

- Mitigate the negative impact of lost livelihoods through emergency humanitarian cash in the immediate term.
- In the long term, this will require support to rebuild markets and job opportunities.

4. Strengthen multilateral coordination and a harmonized global response to enable those in fragile and conflict-affected states to play the role required of them to fight a global pandemic.

- The COVID-19 response requires an international coordinating mechanism to direct resources where they are most needed, promote a harmonized response and coordinate production and distribution of critical COVID-19 supplies. UN Security Council resolution 2177 to address Ebola outbreaks in West Africa provides a model, but barring UNSC action, this coordination could be under the auspices of the G-20.
- All states, but particularly the US and EU, must eliminate restrictions on the export of COVID-19 supplies, including personal protective equipment, tests, masks, and ventilators. Ad hoc policies risk a race to the bottom at the expense of the most vulnerable states – all but ensuring the pandemic will continue to spread and risk returning to developed countries.

5. Prioritize underlying causes of crisis to mitigate secondary and long-term impacts of this outbreak and prepare for future crises.

- Ensure the global economic response meets the needs of the most vulnerable and those who are often excluded, such as refugees. The G20 should define concrete commitments to financial assistance for fragile and conflict-affected states, to which the IMF should also extend debt relief. Social safety nets must also be expanded in collaboration with the World Bank and other multilateral development banks.
- Invest in health systems of vulnerable countries to strengthen their capacity to prevent, detect and respond to diseases. Fragile and conflict-affected states will require support for enhancement of detection capabilities, maintenance of pandemic preparedness capacity after this crisis ends, training of local health workers, and health information dissemination campaigns.

Cover photo: A woman cleans her hands at the Alexandria refugee camp in northern Greece.

Credit: T. Todras-Whitehill / IRC