Strongest Together

An NGO Consortia View on Structural Issues in the Humanitarian Response to COVID-19

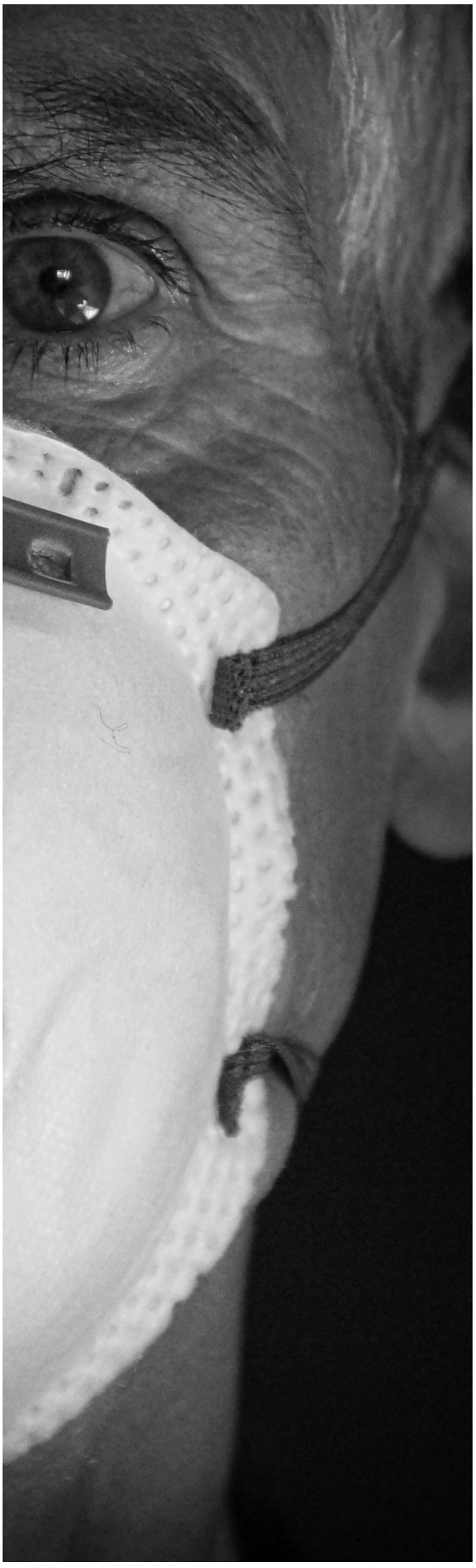
InterAction

Introduction

As nongovernmental organization (NGO) consortia in 13 countries globally, we collectively represent approximately 1000 NGO country offices implementing life-saving activities every day. Through three multi-consortium Zoom consultations, a continuous, long-running, Skype group, and the sharing of country-level resources, we conceptualized and drafted this Working Paper with the intent of communicating our shared challenges—chronic and exacerbated by the current pandemic—and asks articulating the help we require to best support people in need due to COVID-19.

We are joined by our colleagues at InterAction, who represent nearly 200 humanitarian and development NGO members and hold leadership seats on the Inter-Agency Standing Committee (IASC), giving them a unique vantage point on the operational and policy-driven impediments hampering the COVID-19 humanitarian response, as well as opportunities related to it. Based on input from our collective membership, and our own experience representing and coordinating collective humanitarian NGO interests at the field and capital level, we identified numerous time-sensitive humanitarian operational impediments that frontline responders are currently experiencing. The NGO community will be able to save and support more lives if we take collective action now.

We will revise and update this White Paper in the coming months as the situation evolves.



Background and Context

In 2018, over 70 million people worldwide were displaced by conflict, violence, and disasters, either within their own countries or as refugees.[1] And yet, in 2019, global humanitarian funding against need was less than 62%.[2] Through February of 2020, humanitarians struggled to keep up with the global pace and scale of displacement and need while navigating increasingly dangerous, politicized, and complex operational environments.[3] [4] [5]

This is the reality that humanitarian responders are operating within as the COVID-19 pandemic spreads.

COVID-19 has aggravated previously deteriorating humanitarian conditions and increasingly complex operational environments for frontline responders, prompting new operational challenges to emerge. Specifically, the pandemic presents short-, medium-, and long-term threats to health, socioeconomic equality, political stability, conflict reduction, food security, human rights, and livelihoods.[6] [7] [8] There is growing concern over increasingly hostile attitudes toward foreigners or those associated with foreign organizations, including international humanitarian NGOs and their staff, a pervasive spread of mis- and disinformation, internet censorship and blockages, and a new onslaught of access challenges for humanitarian workers due to insecurity and increasingly complex bureaucratic and administrative restrictions and processes established by various authorities worldwide.[9] [10] [11] [12] [13]

Against this backdrop, the humanitarian NGO community has urgently mobilized to support both ongoing humanitarian operations around the world as well as the health response to COVID-19. Pulling lessons and experiences from 13 country contexts across approximately 1000 NGO country-based head offices, NGO consortia are collectively issuing an invitation to join our agenda in support of better preventing and responding to human suffering around the world during COVID-19.

While, like all humanitarian crises, COVID-19 presents unique challenges, this is not the first humanitarian crisis we have helped affected communities face—Ebola in west Africa, famine in Somalia, the increased intensity and longevity of armed conflict, and resulting protracted displacement—to name a few. Collectively, the NGO community embodies an enormous community of expertise spanning decades and continents.

We are working tirelessly to save lives and alleviate suffering in this crisis. Together, we can reinvigorate the future: Will you join us?

We are working tirelessly to save lives and alleviate suffering in this crisis. Together, we can reinvigorate the future:

Will you join us?

Humanitarian Operational Response to COVID-19

7 Problematic Trends & Key Recommendations

There are seven major problematic trends—and opportunities for collective action—impacting all country contexts around the world where humanitarian NGOs are responding to protracted or emerging humanitarian needs. These include:

1 Restrictions on the international movement of medical and humanitarian personnel and goods into the affected countries

2 Restrictions on the in-country movement of medical and humanitarian personnel and goods within the affected countries

3 Restrictions on affected populations accessing services and assistance

4 The central role of affected communities in pandemic response

5 Funding constraints and limitations

6 Safety and security of frontline humanitarian and medical workers

7 Response coordination and leadership

1 Restrictions on the international movement of medical and humanitarian personnel and goods into the affected countries

The Problem

Movements of personnel and goods within countries—and into affected countries—was a chronic problem pre-COVID-19 in locations such as Libya, central Iraq, Syria, and Yemen. These movement constraints are exacerbated everywhere during the pandemic. The pandemic is profoundly affecting the international supply of medical products through disrupted air freight and maritime transport, as well as restrictions on the export of equipment and medicines. Closure of borders also means that other emergency activities will face severe delays due to lack of personnel and lack of supplies—including critical water, sanitation, and hygiene (WASH), food security, and shelter interventions. In some areas, government bureaucracy has prevented newly hired NGO staff from receiving visas, or long-term expatriate aid workers from renewing their visas—impacting their ability to reach affected communities as well as to provide technical support for programs.

While measures to limit the spread of the virus are necessary, restrictions must be proportional. We are not asking governments to lift all movement restrictions as we understand that states are balancing competing tensions and objectives. NGOs remain committed to modifying in-field operations wherever possible to reduce the circulation of non-essential staff in support of public health measures, as well as adopting the highest standards of preventative sanitation and public safety. However, we call for governments to assess the net effect of restrictions on humanitarian action and ensure that they accommodate the unfettered movement of people and goods essential for life-saving humanitarian services.

Select Examples

Syria

In Northeast Syria (NES), the partial closure of the Fishkhabour-Semalka border between Syria and Iraq has delayed the delivery of critical activities such as the provision of food baskets, hygiene kits, tent, the rehabilitation of water infrastructure, and a broad range of health activities. Health actors supporting more than 90 health facilities in NES are heavily reliant on the cross-border movement of medical supplies and equipment, as local procurement of the majority of medicines and equipment is not an option. Although essential humanitarian supplies are now permitted to cross the border on one day per week, NGOs still face delays in approvals for medical and non-medical essential supplies to cross. Many organizations that procure medical supplies from outside the Kurdistan Region of Iraq are also facing difficulties navigating the complex approvals process for flying in cargo shipments. These constraints will continue to severely delay the provision of medical supplies to NES health facilities.

Select Examples (continued)

Libya

Access in and out of Libya has always been a challenge for humanitarian actors.[14] Many international NGOs have had to set up offices in Tunisia to work remotely due to visa issues, insecurity, or other constraints. The pandemic further exacerbated these difficulties, as the country's authorities have severely restricted—if not almost completely halted—the possibility of access for international staff. Despite strong advocacy by the humanitarian community to make exceptions for key personnel, access solutions remain very limited to date.

Democratic Republic of the Congo

Likewise, in the Democratic Republic of the Congo (DRC), emergency workers looking to enter the country have been met with a wait of more than a month to obtain visas.

Cameroon

In Cameroon, new expatriate staff will only be granted an entry visa when they present a "Certificate of Non-COVID-19," something that is currently impossible to obtain in most countries.

Myanmar

In Myanmar, humanitarian workers cannot enter the country due to the temporary suspension of visas and commercial flights until May 31, 2020. They are also required to present a "Certificate of NON-COVID-19" upon arrival and go into "facility-based" quarantine rather than home-based quarantine. These measures make it virtually impossible to bring in experienced emergency workers at this time.

What Humanitarian NGOs Need to Succeed

- [ ] Humanitarian agencies must be able to circulate staff, specifically to bring new expatriate staff into a country to continue implementing ongoing or new activities and expand their response as needed. All actors, be they the United Nations Humanitarian Air Service (UNHAS), logistics clusters, donors, or governments, must work together to facilitate staff entry and exit.

- [ ] Medical equipment, drugs, and other necessary items must be regularly allowed into target countries, and governments must fast-track their entry. Financial transfers must also resume.

- [ ] Governments should prioritize constructive engagement with humanitarian NGOs to resolve administrative and bureaucratic obstacles that hamper their ability to respond, such as simplifying and facilitating the processes for receiving and renewing expatriate visas.

- [ ] Sanctions for relevant countries, including Venezuela, Syria, and Yemen, must include exceptions to support the import and export of critical, life-saving humanitarian supplies such as chlorine. States should facilitate dialogue with the banking sector to ensure that transfers are not affected.

- [ ] Donors must waive existing purchasing policies, giving implementing partners the authorization to buy pharmaceutical products and medical equipment locally. These partners must put in place measures to ensure minimum quality standards and meet their duty of care obligations.

- [ ] Humanitarian staff must have access to Personal Protective Equipment (PPE) to engage with affected people and communities. Healthcare professionals must have gloves, N95 respirators, surgical masks, and gowns, while non-medical humanitarian workers need access to masks. Given that PPE is likely to be a scarce commodity that humanitarian organizations cannot procure themselves, the World Health Organization (WHO) and United Nations World Food Program (WFP) should ensure an adequate supply chain and work with NGOs to ensure accessibility to PPE. In line with duty of care obligations and WHO guidelines on the rational use of PPE during severe shortages, donors must ensure they fund and support partners' ability to secure the necessary PPE to keep their frontline staff and beneficiaries safe.[15]

2 Restrictions on in-country movement of medical/ humanitarian personnel and goods within the affected countries

The Problem

As of April 16, 2020, authorities in at least 188 countries have taken actions that restrict movement domestically.[16] Though some restrictions that are proportionate and timely are necessary as a containment measure, in many contexts, these restrictions impact implementing NGOs' ability to move personnel and goods within countries.

These restrictions are wide-ranging, but all deny people in need access to critical, life-saving services. In 2019—before the onset of the COVID-19 pandemic—nearly 132 million across the globe needed humanitarian aid.[17] Now, as their needs are even higher, humanitarians have even more barriers to navigate before they can access the most vulnerable.

Select Examples

Democratic Republic of the Congo

In the DRC, Kinshasa City Center is shut down, and humanitarians are unable to move within. Unfortunately, this restriction includes the country's main soap factory—which has created a significant need for soap, a staple to the COVID-19 response. Moreover, activities have been suspended or prohibited in certain provinces, including vaccinations against measles. Measles causes the deaths of thousands of Congolese children every year, even when the vaccination programs are operating. In many locations, the distribution of aid to displaced populations has also been halted.

Select Examples (continued)

Nigeria

In Borno state, the state government implemented a lockdown for three weeks in April, during which the state declined to issue movement passes to the majority of essential NGO workers. This left tens of thousands of people unable to access basic and emergency healthcare, which will likely lead to worsening health outcomes and increased mortality rate.

Many locations within Borno, such as garrison towns, are already isolated due to insecurity. Humanitarian workers are the only providers of healthcare, WASH, and basic services for survivors of gender-based violence (GBV). Humanitarian cargo movements were suspended, which led to the stoppage of food distributions and fuel shortages. The suspension of treatment services for malnutrition—with over 100 treatment centers closed[18]—severely endangered the lives of children under five. Insufficient passes disrupted camp management, WASH, and health actors for weeks, at a time when there was a crucial need to implement urgent prevention and preparedness measures to reduce the spread of the epidemic and avoid potential deaths. Almost 400 vendors who support food distribution, cash, desludging, and WASH provision did not receive movement passes during this three-week lockdown.[19] Though several relaxation days during the lockdown allowed actors to restart some activities, implementation varied by area, and interstate travel was very limited. Similar restrictions occurred in Adamawa state.

Jordan

In Jordan, critical NGO staff attempting to secure movement approvals to the refugee camps have found the process difficult and time-consuming. This, coupled with very severe movement restrictions outside of camps, limits NGO provision of essential services, further endangering people already at risk.

Iraq

In Iraq, pre-existing access constraints were further exacerbated by COVID-19 related movement restrictions, where exceptions for NGOs to continue life-saving work were sporadic, suspending numerous humanitarian activities. NGOs working in the health sector also faced issues as they were either unable to—or faced major bureaucratic hurdles while trying to—move health staff, medicines, and medical supplies—including PPE—compromising the quality of care. Over 400,000 vulnerable Iraqis are affected by the suspension or limitation of medical services.[20]

Select Examples (continued)

Myanmar

In Myanmar, access restrictions in conflict-affected areas represent a long-term and ongoing challenge that has worsened amid COVID-19-related movement restrictions. Close to 1 million people are affected by humanitarian crises and internal displacement in Chin, Kachin, Kayin, Rakhine, and Shan states.[21] These people are some of the most vulnerable to COVID-19. Overcrowded shelters and limited hygiene facilities in camps, restrictions on freedom of movement, lack of livelihoods—coupled with often chronic malnutrition and limited access to essential services, including healthcare—have increased people's exposure to risk. Should an outbreak occur in camps for internally displaced people, and those otherwise affected by conflict, the consequences for their health and well-being are set to be devastating.

Syria

In some areas, however, authorities have recognized the criticality of the movement of people and goods by humanitarian organizations. For example, in NES, NGO staff are exempt from movement restrictions by local authorities of the Self Administration (S.A.). Although mixed communication between authorities caused some access challenges for NGOs at checkpoints in the first few weeks of new restrictions, recently, there has been a greater universal understanding of NGO exemptions, and NGO workers have reported fewer challenges, enabling them to continue operations.

Afghanistan

In Afghanistan, health workers are already pulled between competing pressures of working for the community in government and Taliban-held areas. Now there is additional complexity with COVID-19, which requires new resources, which are not available in part due to movement restrictions.

What Humanitarian NGOs Need to Succeed

- [ ] Exceptions from national travel restrictions for humanitarian workers, to ensure widespread and unfettered access to sites for health and non-health critical programming, including but not limited to preparedness and response measures to counter the spread of COVID-19.

- [ ] Exceptions from national restrictions regarding the movement of materials, equipment, and items critical for humanitarian operations.

- [ ] Clear and public communication from all states and non-state authorities about these exceptions to communities, humanitarians, and executing authorities, with monitoring of their implementation and a channel for reporting and problem-solving.

3 Restrictions on affected populations accessing services and assistance

The Problem

COVID-19 is more than a health crisis—it is a crisis that will affect all aspects of people's lives. People in need must be able to access the multi-sectoral programming they need to survive.

Many migrants, refugees, internally displaced persons (IDPs), and other vulnerable groups live in crowded spaces (communities, camps, informal settlements, or detention facilities). Humanitarian actors witness the inability of these groups to self-isolate in sanitary conditions. Coupled with movement restrictions set in place by local authorities worldwide, this only further increases affected communities' inability to follow health advice and access life-saving and sustaining services. Without expanded aid provision and access to basic services, vulnerable populations will be unlikely to maintain social distancing for prolonged periods. In some cases, humanitarian staff have been restricted in providing aid to migrants, refugees, and other displaced populations.

In areas that have undergone complete lockdowns, lower or no income families must still leave their homes daily to secure food. With livelihoods severely impacted, families must be able to access basic human needs. Among other measures, food vendors and local markets must be able to remain open safely. To help these families cope, it is also necessary for the humanitarian community to increase cash assistance. In some areas, bank closures, shortage of cash locally, and sanctions have led to insufficient liquidity to pay staff or purchase necessary supplies.

On March 23, 2020, the United Nations (U.N.) Secretary-General António Guterres put out an appeal for a global ceasefire to allow humanitarians to reach populations that are most vulnerable to the spread of COVID-19. Tragically, this ceasefire has not taken hold. At least one aid worker has already been killed while transporting COVID-19 test samples.[22] Violence and the continuous use of explosive weapons in populated areas not only steal lives and impair bodies but create permanent psychological trauma. Chronic conflicts in many areas have also led to damaged public health infrastructure, which prevents the affected populations from accessing life-saving services.

Shifting lines of conflict disrupt essential health service provision, and health infrastructures are being shelled or targeted by parties to the conflicts. Conflicts also create displacement. This makes it much more difficult to trace whether there is an outbreak while putting the displaced populations at further risk of harm as they flee conflict zones and through areas contaminated by remnants of war such as unexploded shells, grenades, or bombs.

Pandemics are often characterized by the stigmatization of certain ethnic, religious, or other groups. Whether exclusion and deprivation are the results of formal policies or societal stigma, the proliferation of hate speech via social media poses a tremendous risk of sparking or escalating violence against marginalized people. Beyond a ceasefire, other types of violence and protection concerns still afflict civilians, such as sexual violence and abuse, kidnappings, forced labor, etcetera. In times of fear and insecurity, protection incidents increase dramatically. Throughout the globe, especially in marginalized communities and for those who find themselves living in communication-vacuums (as per the point above), rumors and anxiety mount, leading to acute discrimination, harassment, and stigmatization. People on the move are prone to face discrimination and harassment based on their nationality and associated misinformation.

Select Examples

Iraq

Across Iraq, mass bank closures, limitations of withdrawals, and restrictions on international transfers are affecting NGO cash flow and their ability to pay salaries and deliver life-saving support. Moreover, interviews conducted by NGOs indicate that the risk of eviction from public buildings and rented private accommodation is one of the most critical and widespread protection concerns among IDPs and returnees, as the ability to pay rent has been severely impacted due to the loss of or reduced access to livelihoods.

Libya

In Libya, governmental fragmentation adds a layer of administrative impediments due to the uneven application of legislation and policies across the country and the lack of mutual recognition among competing authorities of existing procedures. In March 2020, humanitarian partners reported a total of 851 access constraints on the movement of humanitarian personnel and items within and into Libya.[23] Moreover, medical facilities have been directly targeted during the escalating conflict (including eight facilities in April 2020 alone, bringing the number of conflict-related attacks to 11 this year), reducing the capacity of the health system to respond to the most urgent needs.[24] [25] Conflict, directly and indirectly, led to the closure of a staggering 22% of Libyan medical facilities in 2019.[26] Facilities that have remained open are unable to provide essential services and medicines due to a lack of medical staff, equipment, and drugs. Indiscriminate shelling on heavily populated areas puts civilians at further risks of harm and leads to displacement. Those on the move face even more challenges accessing public health services due to lack of documentation, discrimination, and overstretched health services.

Jordan

In Jordan, virtually all assessments at the time of writing show that loss of livelihoods and household income due to the curfew and as a result of expected economic contraction has been the most severe impact of the pandemic thus far.[27] The movement restrictions on the general population mean that those in remote areas—even those with the means to buy essential supplies—can find it difficult to access open shops. Many small farmers are unable to access their fields when they need to plant and harvest. These economic pressures on individuals and families are further compounded by the strain of living in crowded conditions and by the lack of access to traditional social protections for the most vulnerable. Undocumented refugees, who have no way of accessing subsidized healthcare and must now navigate police checkpoints whenever they move, face additional dangers.

Select Examples (continued)

Bangladesh

In Bangladesh, the final list of critical services approved by the government does not include specific services, including psychosocial care, even though it is known that the psychosocial impact of isolation and other pressures arising from the pandemic can lead to domestic violence.[28]

Syria

In NES, humanitarian activities that the government has dubbed "essential" are also exempt from suspension. Unfortunately, some activities that NGOs consider essential—such as protection and education—have been dubbed "non-essential" by the government and remain suspended.

Nigeria

The conflict continues in north-east Nigeria and, yet, during the initial week of the Borno state three-week lockdown, an estimated 90% of essential life-saving NGO activities in Borno state were suspended.[29]

What Humanitarian NGOs Need to Succeed

- [ ] A global endorsement and support of the U.N. Secretary-General's call for a global ceasefire made on March 23, 2020.

- [ ] Administrative and bureaucratic obstacles that hamper the ability to respond to the urgent needs must be resolved, such as simplifying and facilitating the government-led processes for receiving approvals for new emergency projects.

- [ ] Regulatory mechanisms to prevent soaring prices of food and basic necessities and enable local trade must be strengthened and enforced.

- [ ] In recognition of economic turmoil and mass job loss, funding must increasingly go to cash assistance.

- [ ] Based on lessons learned in other contexts and emergencies, it is known that psychosocial issues from isolation lead to increased domestic violence. There must be awareness-raising and programming to ensure access to mental health and psychosocial services as well as sufficient response for gender-based violence and other forms of violence that target women and children.

- [ ] Increased cash assistance is needed from donors (especially for women's protection and empowerment programming, food, and utilities), met with timely government project approval processes.

- [ ] Measures that governments put in place to halt the spread of the virus must not unduly harm populations or infringe on freedom of rights. People must still be able to access potable water, food, and healthcare.

4 The central role of affected communities in pandemic response

The Problem

Community mobilization is central to stopping the spread of epidemics. We have seen community mobilization work in West Africa during the epidemic of 2014-2015, 2019 in DRC, and throughout the years in response to cholera, measles, and rubella.[30] [31] [32] [33] [34] Life-saving pandemic-response programming will fail without responsible community engagement and clear, consistent, two-way communication between affected communities.

While the WHO declared a public health emergency of international concern in late January (over 100 days ago at the time of writing), knowledge of COVID-19 prevention, testing, and treatment pathways continues to be limited in many marginalized communities. Communication is a critical aspect of aid access and delivery. However, in some areas, government telecom restrictions impact responders' ability to communicate with people in need of assistance. People in need are thus unable to access life-saving information.

Moreover, engagement with local communities from all relevant parties must be funded, consistent, and culturally conscious. Asking communities to dramatically change their behavior—for example, to isolate sick loved ones rather than to surround them with affection and care—without providing proper context and evidence for why they must do so, and without enabling communities to steer the "how" and "what" of these changes, will fail.[35]

How improper engagement will fail depends on the context. It may, simply, mean that evidence-based medical guidance will be ignored, further spreading the disease and multiplying deaths. It may exacerbate existing local tensions, mistrust, xenophobia, and—by extension—contribute to a volatile climate. Rumors have already surfaced in multiple locations—Nigeria, the Central African Republic (CAR), Bangladesh, DRC, among others—that "foreigners," be they humanitarian personnel or refugees, are behind the spread of COVID-19. Clear dialogue can quash these rumors, while unclear actions can exacerbate them. As an example, as an effect of the Ebola response, we understand that different cultures perceive the wearing of masks differently.[36] Culturally appropriate communication with an affected population about PPE can save many lives.

Select Examples

Nigeria

The first reported case and death of COVID-19 in north-east Nigeria was, tragically, an NGO health worker.[37] Following this, several incidents of violence against health workers related to the pandemic were recorded. Funded and supported community engagement is necessary to clarify transmission pathways, undertake contact tracing, promote temporary behavior change, and protect health workers from stigma.

Select Examples (continued)

Lebanon

In an example of good practice, in Lebanon, NGOs have applied risk mitigation measures and are continuing to conduct awareness sessions with reduced numbers or via digital platforms. Community-based groups with NGO support are also exploring how to assist community leaders and volunteers in developing an action plan for prevention and handling any cases in their settlement or community.

Bangladesh

In Cox's Bazar, Bangladesh, government internet shutdown and phone restrictions impact responders' ability to communicate with people in need of assistance. This is especially impactful as movement into refugee camps becomes increasingly restrictive, and humanitarian operations, which always relied on the work and community expertise of local volunteers, now are solely reliant on them.

Myanmar

In eight townships in Rakhine and one in Chin State, Myanmar, government internet shutdown is significantly hampering efforts to raise awareness among the population on the risks of COVID-19 and promote preventive measures, such as handwashing and physical distancing.[38] The shutdown is also impacting humanitarian operations' ability to communicate with populations in need of life-saving assistance. The internet shutdown represents a major setback for communication and information sharing, and amidst a global pandemic, this poses a significant public health risk.

What Humanitarian NGOs Need to Succeed

- [ ] Engagement activities with local communities must be robustly funded and proactively designed to mitigate stigmatization and social tensions. Proactive strategies to counter stigma must be implemented, and constant care taken with language and translation.

- [ ] All parties to the response must ensure clear, consistent, continuous, culturally sensitive, two-way communication on the measures taken against the epidemic, known medical and epidemiological elements, and good prevention practices to reduce the spread of rumors and stigmatizing speeches.

- [ ] Governments must lift area-based telecommunication and communications restrictions, especially as more humanitarian activities will be done "remotely," i.e., led by local communities as travel grows increasingly challenging.

- [ ] Official communications must be sent to all local administrations to clarify the need for continuity of humanitarian aid and the importance of facilitating these efforts.

- [ ] All parties to the response must ensure that they include and partner with local civil society organizations and communities to design inclusive responses to the COVID-19 pandemic and deploy awareness-raising actions.

5 Funding constraints and limitations

The Problem

There are now three simultaneous types of programming: ongoing work, integration of COVID-19 into ongoing work, and COVID-19 focused programming. All three are critical. Moreover, it is essential to recognize that COVID-19 is not only a health crisis; it is also a human and socioeconomic crisis that affects livelihoods, food security and nutrition, education, and protection. It disproportionately affects the most vulnerable, including refugees, the internally displaced, and migrants, as well as persons with disabilities, older persons, or those suffering from chronic diseases. Funding must be provided to address the multi-dimensional nature of the crisis and its related effects, not solely for a medical response.

In multiple contexts, the annual humanitarian response plan (HRP) was already severely underfunded. For example, by the end of 2019, Cameroon, DRC, and the Syria region were all funded at well under 50% of need. At the time of writing, no single HRP has been funded as high as 35%. Venezuela is currently funded at 3.8%, the DRC region at 1.2%, and the Syria region at 3.2%.[39] Given budgetary pressures experienced by the donor countries that traditionally contribute to the international humanitarian response and their focus on the impact of the virus on their societies and budgets, there is a risk that resources for COVID-19 response will be diverted from existing humanitarian programs. Repurposing resources from already underfunded humanitarian operations to respond to the COVID-19 virus could result in even more acute shortfalls in addressing current humanitarian needs. Frontline responders require additional funding—not reallocated funds or funds "borrowed" from other critical ongoing work—to ensure the response to COVID-19 does exacerbate its negative effects.

Simultaneously, funding for ongoing programming must be flexible to accommodate any changes in activities, staffing, program delays, increased reliance on local partners, and other shifts in approach. Flexibility in partner agreements must allow for financial and programmatic changes in a fast-changing environment. Streamlined processes, partnering tools, and requirements help to eliminate bureaucratic hassles and hasten an adapted and scaled-up response. This is essential for NGOs to maintain their operations and presence, manage programs in light of rapidly evolving circumstances, and ensure the duty of care for their staff. Every intervention will be unique, and as the context changes quickly, assurances of flexibility will be critical.

While there has been substantial and generous financial support offered by donors to the NGO community, at the time of writing, nearly none of it has made it to the organizations working on the frontlines. InterAction undertook a snapshot survey of our humanitarian NGO membership during the last week of April 2020. Of 36 entrants responding to the COVID-19 crisis, only 19.4% reported seeing new or additional U.N. funding, 8.3% reported seeing new or additional U.S. government funds, and 30.5% reported seeing new or additional funds from bilateral donors.[40] These responses parallel the data on the U.N. Office for the Coordination of Humanitarian Affairs' (OCHA) Financial Tracking Service (FTS). Of the $859 million contributed to the GHRP, 91% has gone to U.N. Agencies, while less than 2% ($10 million) has gone to NGOs.[41] Donors and agencies must prioritize finding ways to channel funding to NGOs and to track funding, using resources such as FTS, as it moves through the system.

Select Examples

Libya

Despite several requests for support, funds are currently limited in Libya for preparedness and response activities on the ground. Health actors alone need an approximate additional $15 million on the required $30 million to ensure aid agencies, public hospitals, and medical staff are trained and equipped to respond to the pandemic. At the time of writing, only $4.4 million has been provided.[42]

Afghanistan

Afghanistan already has severely impoverished communities due to a drought in 2018-2019, continued food insecurity in 2020 (12 million are projected to be in the "emergency" and "catastrophe/famine" phases of food insecurity in 2020),[43] and an ongoing armed conflict spanning the past four decades. The Humanitarian Fund has granted three Reserve Allocations for COVID-19 activities in February, March, and April 2020, and one Standard Allocation for regular humanitarian programming in March.

What Humanitarian NGOs Need to Succeed

- [ ] Dedicated funds allocated to respond to the COVID-19 pandemic must not mean a reduction in funding for other ongoing crises in the same target areas. Additional funding—flexible, multi-year, and multi-sectoral—is now needed in all contexts.

- [ ] Funding must go going beyond a purely medical response to integrate aspects of awareness-raising, community work, and activities to ensure the community is engaged with and steering the measures to reduce both the risk of spread and the socioeconomic impact of the disease and the response.

- [ ] Humanitarian agencies need written assurances of flexibility to reprogram existing funding to account for the COVID-19 context—including medical, but also protection, psychosocial, economic, supply, security, and risk reduction actions.

- [ ] Flexible partner agreements must allow for operational changes, including the costs of maintaining staff and all necessary support costs to keep operational capacities during movement restrictions. Humanitarian agencies need to retain, and thus to pay, their key staff even while certain activities are suspended, to ensure the ability to ramp back up as soon as possible.

- [ ] Global level guidance provided by donors and U.N. agencies eases the burden of negotiating changes to programs on a case-by-case basis—a burdensome process for both partner and U.N. agency staff. Providing overarching guidance will allow for a degree of uniformity in approach across countries and programs.

6 Safety and security of frontline humanitarian and medical workers

The Problem

The importance of the principle of "saving lives together" implies a duty of care for all humanitarian and development workers—including the expatriate and national staff of NGOs. In the COVID-19 crisis, this also entails ensuring the continuity and expansion of services while safeguarding staff and ensuring that they are diligently and vigilantly implementing precautionary measures. Moreover, security problems are often exacerbated in periods of contracting economic activity, whether it is pure criminality or engaging with armed groups, which will affect NGO operations.

Medical and security evacuation (medevac and secevac) plans must be in place for all NGO humanitarian workers who are putting their own health and lives on the line to support communities most at risk, regardless of their country of origin. NGO humanitarian workers must also be able to access quality care, either within their duty station country or in a nearby country, should they fall ill.

As detailed above, rumors that aid workers are transmitting the virus have begun to spread in multiple contexts, necessitating clear communication and community engagement.

Select Examples

Central African Republic

In CAR, the French embassy has agreed to evacuate all European Union (and United Kingdom) staff, should security worsen significantly. The U.S. embassy will evacuate Americans. But the vast majority of expats in CAR are from other African countries, and there has been no security evacuation plan that includes them.

Nigeria

In Nigeria, NGO workers have been officially offered four places in the U.N. specialized treatment center, which is a welcome development. However, it is not enough. Evacuation from the deep field for staff with symptoms is currently only possible by road, which can be highly insecure. Discussions are ongoing regarding the U.N. Regional Medical Facility (97 beds) in Accra, Ghana.

Select Examples (continued)

Libya

The lack of medical and security evacuation options inhibits NGOs from sending more staff in Libya. Due to administrative blockages, UNHAS recently stopped flying. This caused many NGOs to refrain from flying their essential staff to Libya, as other NGOs have personnel stuck at the frontline of the COVID-19 response and heavily intensified fighting, with no option to be safely evacuated.

Democratic Republic of the Congo

In DRC, the response to COVID-19 necessitates a massive deployment of experienced humanitarian and medical personnel. However, rather than expanding teams of international experts, NGOs have severely reduced their teams of aid workers in-country due to the rapid closure of borders and airspace and the fear that aid workers would have no safe medevac or secevac options should they be in need.

What Humanitarian NGOs Need to Succeed

- [ ] Humanitarian staff must have exceptions for international travel restrictions for medical and security evacuations and for circulating staff.

- [ ] Evacuation plans must be in place for all expatriate staff regardless of nationality.

- [ ] Within each country, there must be designated healthcare providers for expatriate and national humanitarian staff, particularly as local facilities become overwhelmed. These facilities must have a testing capacity that is up to global standards. Where there are U.N. health facilities, they should be opened up to NGO workers.

- [ ] Countries that have agreed to accept all evacuated staff must be designated, especially if a staff member's country of origin is unable to unwilling to grant them entrance.

7 Response coordination and leadership

The Problem

Strategic and operational collaboration is key at all levels. In-country, strong OCHA and WHO leadership have proven to be essential for the well-being of the most vulnerable, but this must be backed by the strong political will to ensure the COVID-19 response is not short-sighted. The secondary effects this outbreak is expected to have on the world's poorest and most vulnerable are unfathomable. A recent report based on potential response scenarios estimates between 500 million and 1 billion COVID-19 infections, leading to between 1.7 to 3.2 million deaths in 34 conflict-affected and fragile countries.[44] To effectively mitigate these threats, we need a global joint approach that is sustainable, long-term, and addresses the wide range of economic, social, and political risks associated with COVID-19.

We also need to strengthen and streamline coordination between humanitarian actors. As seen in multiple prior responses, including the recent Ebola response, parallel coordination mechanisms led by multiple agencies will lead to a confused response. Existing coordination mechanisms should be strengthened to ensure they are not overwhelmed by the growing crises.

Especially in countries where the government is leading the response, OCHA should be supported to continue to become more flexible and innovative to ensure that humanitarian actors are heard, and humanitarian principles are not compromised.

Select Examples

Democratic Republic of the Congo

Lessons learned during the ongoing Ebola response in DRC show that parallel coordination mechanisms can lead to a confused response and lessened efficiency. Similarly, in Colombia, Libya, and Bangladesh, differing mechanisms established to coordinate an IDP response and a refugee response waste resources, including the time of key frontline humanitarian leaders, and do not contribute to "one" humanitarian response in a country context.

Select Examples (continued)

Colombia & Myanmar

Clear, coordinated response leadership is especially critical for dual mandate countries, such as Colombia and Myanmar, where the United Nations High Commissioner for Refugees and OCHA share management of humanitarian coordination depending on the geographic location.

Nigeria

In Nigeria, multiple plans and strategies have been produced. For example, in addition to the addendum to the HRP, there is a "COVID-19 Multi-sectoral Joint Support Framework for Borno" and a "Strategic integrated conceptual framework for BAY states." Though these papers could be beneficial and worthwhile, the multiplication of policies may result in serious coordination gaps.

Democratic Republic of the Congo, Afghanistan & Others

In DRC, Afghanistan, and other countries where the government is taking the lead on the response as a public health issue, humanitarian coordination must be increasingly agile and innovative to ensure humanitarian principles are not compromised.

What Humanitarian NGOs Need to Succeed

- [ ] Humanitarian leaders should ensure that the coordination of humanitarian activities related to the COVID-19 response is done through existing humanitarian coordination mechanisms, rather than creating new, parallel systems. This is important in all countries but especially in dual mandate countries.

- [ ] The role of OCHA as a secretariat who ensures all actors contribute should continue to be strengthened, taking into account lessons learned recently, including and most relevantly in the Ebola response in North Kivu.

- [ ] Ensure that the coordination of the response includes all relevant stakeholders—national governments, U.N. agencies, national NGOs, international NGOs, and donors.

- [ ] Existing mechanisms should always ensure that national NGOs remain part of the response planning and implementation.

Conclusion

COVID-19 is not only a public health crisis. It is a crisis that touches all aspects of peoples' lives regardless of geography: their health, safety, livelihoods, and futures. For the most vulnerable, it exacerbates pre-existing challenges and presents additional protection risks. For frontline responders, it aggravates previously deteriorating humanitarian conditions and is yielding a new problem set for the entire humanitarian community.

The people most at-risk from COVID-19 deserve and are entitled to quality support, as are people already residing in humanitarian settings living with acute needs. In response, NGO experts on the frontlines offer this shared understanding of the specific challenges to alleviating human suffering during this pandemic and what helpful actions—if taken—would help significantly. The worst impacts of the pandemic can be reduced by securing access to quality services and assistance for affected and vulnerable populations and protecting the safety and well-being of frontline NGO staff and volunteers. Considering the immense risks people around the world are facing, the global community is obligated to redouble our collective efforts to save lives.

Sign-offs

Joined by our colleagues at InterAction, this paper has been drafted by the following NGO consortia:

Agency Coordinating Body for Afghan Relief and Development

Association of International Development Agencies

Coordination of Humanitarian International Non-Governmental Organizations in Cameroon

DRC INGO Forum

Foro ONGI Humanitarias en Colombia

Forum des ONG Internationales au Mali

INGO Forum Myanmar

Jordan INGO Forum

Libya INGO Forum

NGO Coordination Committee for Iraq

Nigeria INGO Forum

Pakistan Humanitarian Forum

Somalia NGO Consortium

This paper was also drafted in consultation with the Syria International NGO Regional Forum (SIRF) and the Lebanon Humanitarian INGO Forum (LHIF). It was made possible through the generous support of the Swiss Agency for Development and Cooperation (SDC).

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