COVID-19 ADDENDUM TO THE 2020 MYANMAR HUMANITARIAN RESPONSE PLAN

April - December 2020

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FOREWORD BY THE HUMANITARIAN COORDINATOR

The number of cases of COVID-19 in Myanmar has risen steadily since the first was detected on 23 March 2020. The Government of Myanmar has moved quickly to reduce the risk of transmission of the virus and has managed to slow down the spread at the same time as it prepares for potential outbreaks including in humanitarian settings where the virus poses a particular threat.

To counter this threat, the challenges and risks associated with COVID-19 in humanitarian settings in Myanmar requires the urgent mobilization of prevention and response preparedness measures. People in areas affected by ongoing conflict, internally displaced persons (IDPs) in overcrowded camps and camp-like settings in various parts of the country, non-displaced stateless persons in remote areas of Rakhine and other communities with limited access to healthcare, safe water and sanitation services will be highly vulnerable in the event of local outbreaks. Tens of thousands of migrant workers returning from Thailand and elsewhere require basic forms of assistance during their stay in quarantine facilities.

Under the broader strategic framework of the 2020 Myanmar Humanitarian Response Plan (HRP), the United Nations and its local and international NGO partners have developed this COVID-19 Addendum to the HRP in support of Government-led nationwide prevention and response preparedness efforts, in support of various national frameworks including an Action Plan for the Control of COVID-19 in IDP Camps developed by the Ministry of Social Welfare, Relief and Resettlement.

This COVID-19 Addendum reflects existing humanitarian programming that has been expanded or reoriented in light of the COVID-19 pandemic as well as new health and non-health interventions to be implemented between April and December 2020. The Addendum requests an additional US$58.8 million to provide COVID-19-specific support for some 915,000 people (855,000 targeted in the HRP and 60,000 returning migrants).

In June, with close to three months having passed since the first COVID-19 cases were confirmed in Myanmar, humanitarian organizations have come together to revise planning parameters and funding requirements up until the end of 2020, to ensure that the document sets out the most accurate picture possible of anticipated needs and programming priorities over the remainder of the year.

With countries around the world grappling with unprecedented challenges due to the COVID-19 pandemic, we remain extremely grateful for the continued engagement and generosity of the many donors who support humanitarian action here in Myanmar. Humanitarian organizations are firmly committed to doing all they can to ensure the continuity of existing humanitarian assistance, while further scaling up their COVID-19 response.

Ola Almgren
United Nations Resident and Humanitarian Coordinator

SITUATION OVERVIEW

WHO declared COVID-19 a global pandemic on 11 March 2020 and Myanmar reported its first confirmed cases 12 days later. As of 24 June 2020, a total of 292 cases have been confirmed in Myanmar with six fatalities and 204 recoveries, according to the Ministry of Health and Sports (MoHS). The number of imported cases has continued to rise since mid-May, and now represent 45 per cent of the total confirmed cases in Myanmar. As of 24 June, over 66,000 specimens have been tested and more than 36,000 people remain in quarantine facilities across the country.

On 31 January, a Central Committee to Prevent, Control and Treat the 2019 Novel Coronavirus was formed shortly after WHO declared the coronavirus outbreak as a Public Health Emergency of International Concern (PHEIC). On 13 March, this Central Committee was elevated to a National-level Central Committee for COVID-19 Prevention, Control and Treatment, headed by the State Counsellor. On 30 March, an additional COVID-19 Control and Emergency Response Committee was announced, to oversee quarantine and related control measures across the country.

The Government of Myanmar, led by the Ministry of Health and Sports (MoHS), has developed a Health Sector Contingency Plan for COVID-19 and Other Emerging Respiratory Disease Outbreak Response in Myanmar. The Ministry of Social Welfare, Relief and Resettlement (MoSWRR) has been designated to lead the Government's response in IDP camps, in collaboration with humanitarian organizations. The Ministry of Labour, Immigration and Population (MoLIP) is coordinating efforts to address issues arising from the return of thousands of migrants.

COVID-19 presents particular risks in humanitarian settings in Myanmar that need to be urgently managed through prevention and response preparedness efforts. Internally displaced persons (IDPs) in overcrowded camps and non-displaced stateless persons in rural areas of Rakhine with limited access to healthcare, safe water and sanitation services will be particularly vulnerable, in the event of local-level outbreaks. Women and girls face additional access issues to both health services and WASH facilities due to social norms and safety concerns including gender-based violence (GBV).

Communities in conflict-affected areas are also at higher risk, while the rapid return of tens of thousands of migrant workers from Thailand and elsewhere has generated additional needs for basic forms of assistance in quarantine facilities. Their presence has placed further strain on already fragile health systems and community resources. Schools have been widely used as quarantine facilities, compounding challenges in the education sector due to the suspension of the school year and, as of late June, efforts were underway to disinfect and reconvert schools, to enable the resumption of classes from mid-July.

The monsoon season is expected to be underway by the end of June, bringing with it an increased risk of flooding, landslides and other hazards, potentially generating additional needs and further complicating humanitarian access. The use of cyclone shelters for quarantine purposes represents a further challenge, with large-scale evacuation and temporary displacement typical during the monsoon season.

The confirmation in early June that several persons in a refugee transit centre in Maungdaw, in northern Rakhine, who had recently returned from Bangladesh had tested positive for COVID-19 was a stark reminder of the very serious risks that remain among the most vulnerable communities in Myanmar, even as movement restrictions and other containment measures were eased in some areas.

Public health measures

Commercial flights into the country have been suspended and quarantine measures have been put in place for persons arriving from abroad. The MoHS has expanded surveillance at international border crossings and community surveillance systems have been established across the country. The Government has also designated hospitals to treat patients who are suspected or confirmed to have COVID-19.

Laboratory capacity has been expanded significantly following the establishment of COVID-19 testing at the National Health Laboratory in Yangon in February. The Government has now established testing capacity in Mandalay and is working to do the same in Mawlamyaing (Mon State), Taunggyi and Lashio (Shan State) using polymerase chain reaction (PCR) tests. The Government is also making arrangements to roll out testing using existing GeneXpert machines in 14 other locations. The UN has continued to support the Government's testing strategy including through the provision of tens of thousands of test kits and sets of reagents.

Health and non-health partners are continuing to ensure that risk communication and community engagement (RCCE) are streamlined and that the right messages reach every IDP camp, as well as

other vulnerable communities. There are ongoing efforts to support continuity of essential health services and an appropriate response to possible COVID-19 outbreaks affecting IDPs and host communities.

Socio-economic effects

Just before the pandemic, prospects for overall economic growth were positive, despite ongoing conflict and insecurity, significant challenges in terms of social inclusion and low private sector productivity. However, factors including lower trade and tourism, supply chain disruptions, reduced consumption of goods and retail and transport services, unemployment and reduced foreign remittances have had severe consequences in recent months, even with a relatively low number of confirmed cases of COVID-19 within Myanmar to date. Projections for economic growth in Myanmar for the 2019-20 fiscal year have now been revised downwards to between 1 and 3 per cent, compared to 6.3 per cent for the preceding year.

Volumes of exports for manufactured goods have been significantly impacted, due to disruptions to the supply of raw materials, mainly from China, as well as reduced demand from import markets. In the garment sector alone, some 25,000 workers had been laid off by mid-April, with 300,000 others estimated to be at risk of losing their jobs. The tourism sector, which previously accounted for close to 7 per cent of Myanmar's GDP, has also been severely affected, with the Government anticipating a 50 per cent drop in tourist revenues over the course of 2020. Impacts in these and other sectors are being assessed in greater detail.

Casual laborers have been struggling to obtain jobs while movement restrictions have limited access to livelihoods, increasing food insecurity, including in and around villages and displacement sites. The decline in remittances from Myanmar migrants abroad is also expected to impact the local economy.

Women have been and will continue to be disproportionately affected, as they constitute the majority of healthcare staff, function as caregivers for sick family members, and make up a significant proportion of workers in the garment industry and the informal economy. Women also represent 60 per cent of employees engaged in the food and accommodation services, and between 70 to 90 per cent of street food vendors, while an estimated 789,000 Myanmar women are involved in childcare or domestic work overseas. Over half of the unregistered migrants, who have returned in recent weeks have been observed to be women, whilst close to 35 per cent of migrant workers returning through regular channels have been women. The closure of pre-schools and educational facilities has further increased the care duties of women – those women who continue to work are faced with a double burden of both income generation and care for children.

Older people are also significantly at risk. They are more vulnerable to life-threatening complications from COVID-19 and need to take extra precautionary measures in order not to contract the virus. Moreover, many older people rely on support from others to meet their daily needs. This presents considerable challenges, as people are unable to move freely and to access markets, pharmacies, and other necessities. While there are ongoing efforts to expand some existing safety net programmes, including for elderly persons, social protection schemes remain relatively limited, further increasing the risks for older people.

With the risk of higher unemployment, poor households already living without safety nets may turn to negative coping mechanisms. Children including adolescents will be more vulnerable and may be at greater risk of economic and sexual exploitation, and in greater need of psychosocial support.

The Government has taken a number of concrete measures to ease the impact of COVID-19 on industries as well as households, including by reducing tax and interest rates, rolling out an electricity subsidy scheme across the country and distributing basic food items to people without regular income during the Thingyan Holiday (Myanmar New Year) in April. Basic online education support for three-to-six months has also been provided in feasible locations.

On 27 April, the Government of Myanmar released a COVID-19 Economic Relief Plan (CERP), in an effort to mitigate the economic impact posed by COVID-19 and to facilitate Myanmar's economy recovery. The UN has developed a framework for the immediate socio-economic response to COVID-19 in Myanmar (UN-SERF), which seeks to support and contribute to the CERP.

Impact on vulnerability and basic services

Internally displaced people, stateless people in Rakhine and other vulnerable crisis-affected people in Chin, Kachin, Kayin, Rakhine and Shan states included in the 2020 Myanmar Humanitarian Response Plan (HRP) as well as returning migrants, who were not included in the HRP, are among the groups most at risk due to COVID-19. Already limited access to adequate health care among these groups

is likely to be further constrained if the disease spreads to these areas.

More than 100,000 migrants are estimated to have returned to Myanmar as of mid-June, according to Government estimates. A majority of returning migrants have come from Thailand, mainly through the Myawaddy border crossing. Some 30 per cent have come from China, through Kachin and northern Shan, while others returned via relief flights from Thailand, Singapore, Malaysia, Japan, India and United Arab Emirates. Many migrants were stranded in Thailand due to internal travel restrictions. Returning migrants are now required to undertake a 28-day quarantine, generally in areas of return.

The establishment of community-level quarantine facilities has created significant additional needs for basic assistance, including in areas not regularly served by humanitarian organizations. As noted above, a large number of schools have been converted to quarantine facilities and now need to be disinfected and rehabilitated ahead of the resumption of the academic year in mid-July.

The COVID-19 pandemic has both direct and indirect impacts on nutrition, especially in areas in which the nutritional status of the vulnerable population, including pregnant and lactating women and children, is already of concern. Women and children may face additional risks impacting diets, nutrition practices, and access to nutrition services. The situation may affect the severity of the symptoms developed due to weak immune systems, and a reduced ability to prevent and fight diseases. The broader socio-economic impacts of the COVID-19 pandemic include disruption of food systems which may limit the availability of and access to nutritious food, and increased reliance on cheap staples (e.g. cereals) and nutrient-poor ultra-processed foods. The potential scarcity of water, combined with ongoing conflict, is also expected to exacerbate the under-nutrition, especially children and women.

Experience from other countries shows that the secondary impacts for pregnant and lactating women and children, especially newborns, may worsen their nutritional status in high risk areas due to disruption of availability and utilization of health and nutrition services associated with mobility restrictions and overburdened healthcare systems. Appropriate infant and young child feeding, especially protection and promotion of breastfeeding, have been undermined by fear and uncertainty around mother-to-child transmission, thus reducing breastfeeding rates in hospitals and communities. In addition, the lack of quality food and fear of infections preventing women from seeking care may alter caregiving practices, undermining responsive feeding especially of sick children. The long-term impact on nutrition will depend on how long the COVID-19 pandemic lasts and could be severe.

RETURNING MIGRANTS

The revision of this Addendum has provided an opportunity to further analyse emergency needs of returning migrants, building on experience since the first iteration of the document was issued. Given unpredictable migration flows and disparities in levels of vulnerability and response capacity in different locations, as well as the large number of quarantine facilities that have been established, partners have agreed that a flexible, decentralized and context-specific approach is critical. Based on available data, a contingency figure of up to 60,000 returning migrants will be targeted with some form of humanitarian support in quarantine facilities, primarily in areas covered by the HRP in which humanitarian response capacities are already in place, as well as at key border crossing points. Humanitarian support for returning migrants mobilized through this Addendum is intended to cover the most urgent needs of individuals and also to contribute to efforts to mitigate the risk of introduction of the disease into the most vulnerable communities covered by the HRP. Broader support for returning migrants, including in states and regions not covered by the HRP, will be taken up through other frameworks and workstreams.

The MoHS has resumed routine immunization since 18 May 2020. This process was carefully planned and prepared, taking into consideration the essential infection-preventive measures along with the standard operational guidelines for health workers and instructions for care-takers.

Educational facilities and child-friendly spaces within displaced communities were suspended in March 2020. Schools, including temporary learning classrooms (TLCs), and other education facilities are not reopening until at least six weeks after the traditional start of the academic year. The closure of education facilities and child-friendly spaces, especially without continued engagement of children in alternative modalities for learning, increases child protection risks, learning loss and school dropout rates. Children in displaced and vulnerable communities already face higher barriers to education and will find it more difficult to both learn at home and then to return to school after a disruption. Closure of schools can also expose adolescent girls

to heightened protection risks, which can lead to gender-based violence.

In times of crisis generally, rates of gender-based violence tend to increase, putting women at particular risk at a time when populations are required to stay at home to reduce the risk of viral transmission. Evidence from other countries affected by COVID-19 also point towards specific risks of increased intimate partner violence. These dynamics may be further exacerbated by the introduction of lockdown measures. Services for survivors of gender-based violence are also negatively impacted by movement restrictions and potentially by response workers having to self-isolate or otherwise reduce direct contact with affected people, resulting in fewer opportunities to report abuse or seek support.

Women are particularly affected by a lack of sufficient and safe sex-segregated WASH facilities, particularly where they are not in close proximity to their shelter. Similarly, overcrowding of any health facilities that might not be able to provide adequate privacy, hinders women's access to health services. Secondary impacts of COVID-19 on the ability of women and girls to manage their menstruation and their health needs to be recognized, and relevant hygiene materials and environment should be made available to meet those needs.

Health workers have faced stigmatization and discrimination. There also continue to be high risks of stigmatization and discrimination of persons with COVID-19, particularly amongst marginalized groups and stateless persons. Restrictions on freedom of movement for some vulnerable groups in Rakhine State already severely limit access to healthcare and other basic services, as well as information.

Pregnant women requiring antenatal, intrapartum and postpartum care are expected to continue to be affected by disruptions to services and may be apprehensive about seeking important care or delivering in a facility. Lockdowns and movement restrictions may also increase demand for family planning. However, pressure on the health system and prevalent access issues are expected to result in an increase in unmet need and unwanted pregnancy.

Natural hazards including storms, cyclones, flooding and landslides, present an immediate risk to people living in precarious conditions, making COVID-19 preventive measures such as social distancing and improved hygiene practices more difficult. Natural disaster events may also cause additional economic losses in an already weakened economy, possibly worsening supply capacity to meet the demand.

Disaster risk reduction considerations and measures are an important complement to ensure effectiveness in the humanitarian response.

Key operational challenges

The operating environment is highly constrained and is likely to become more challenging. Existing access restrictions – notably in non-government-controlled areas and parts of Rakhine and Chin subject to active fighting – will likely persist. Sporadic fighting has also continued in parts of Shan and Kayin states.

Furthermore, in non-government-controlled areas, some ethnic armed organizations' health services, responsible for large IDP populations and actively addressing the pandemic, are severely under-resourced. They require significant support in order to respond effectively and in line with interventions elsewhere.

The limited access of displaced and non-displaced Rohingya to health care and other basic services outside camps due to restrictions on freedom of movement is a longstanding concern of the humanitarian community and will compound the vulnerability of these communities in the event of local-level outbreaks. For IDPs in camps, overcrowding, poor sanitary conditions and lack of space for self-monitoring and quarantine will exacerbate the risk of COVID-19 spreading quickly and make the response extremely challenging. Humanitarian organizations have developed Myanmar-specific guidance on isolation and quarantine considerations in and around IDP camps.

Access constraints and a ban on mobile internet services in most conflict-affected townships in Rakhine severely hamper not only the delivery of humanitarian assistance but also the communication of risk messages and referral instructions. The safe and secure collection and transportation of specimen samples from conflict areas and non-government-controlled areas also remain a key challenge, particularly in conflict-affected areas.

International supply chain disruptions have led to challenges in procuring life-saving commodities including medical and other supplies. This is expected to continue to complicate and this will continue to efforts to purchase and deliver key items.

Given that COVID-19 treatment services are only available at designated hospitals at this stage, disease surveillance and a clear understanding of patient referral pathway for camps, especially in non-government-controlled areas and areas of active armed-conflict, are critical.

SCOPE OF THE RESPONSE

This COVID-19 Addendum to the 2020 Myanmar HRP outlines priority preparedness and response actions to address the particular impacts of COVID-19 in humanitarian settings, in particular in Chin, Kachin, Kayin, Rakhine and Shan states. It reflects existing activities (within the 2020 Myanmar HRP) which have been expanded or reoriented, as well as new health and non-health activities, primarily in areas covered by the 2020 Myanmar HRP.

This document has been developed in conjunction with the UNCT Country-level Preparedness and Response Plan (CPRP), which focuses on support for the health system in Myanmar in line with the MoHS contingency plan referred to above. The CPRP is linked to the nine strategic pillars in WHO's COVID-19 Strategic Preparedness and Response Plan (SPRP) at the global level. Among the key priorities in the CPRP are large scale procurement of critical PPE supplies and the rapid expansion of intensive care unit (ICU) capacity; improvements in these areas should benefit persons in humanitarian settings as well as the general population. In addition, the UNCT has prepared a UN framework for the immediate socio-economic response to COVID-19 in Myanmar (UN-SERF), to support the Government's efforts to socio-economic challenges linked to COVID-19 and prevent more vulnerable people from sliding into humanitarian need. Together with the HRP Addendum, these three plans provide for comprehensive international support for the whole-of-country and whole-of-system response to COVID-19 that is being led by the Government of Myanmar.

The Addendum estimates that US$58.8 million is needed to mobilize priority activities linked to COVID-19 in affected and at-risk locations, as well as to minimize the humanitarian consequences and interruptions to existing humanitarian assistance. An estimated 915,000 people (855,000 people targeted in the HRP and 60,000 returning migrants) will be reached through multi-sectoral activities outlined in the sector response plan below.

PLANNING SCENARIOS

In the absence of definitive projections on the number of cases across the country, the following "transmission scenarios" were used as per the *IASC Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness and Response in Low Capacity and Humanitarian Settings* as well as the *WHO's Operational considerations for case management of COVID-19 in health facility and community*. Sector response activities have been developed against these scenarios.

1. No cases.
2. Sporadic cases - one or more cases, imported or locally acquired.
3. Clusters of cases - experiencing cases clusters in time, geographic location, or common exposure.
4. Community transmission - experiencing larger outbreaks of local transmission.

COORDINATION

The Government of the Republic of the Union of Myanmar is leading the response to COVID-19. The UN and its local and international partners have been actively engaging with the MoHS, the MoSWRR and other ministries on COVID-19 prevention, preparedness and response activities since January 2020. Technical, materials, operational and financial support has been provided, including medical supplies and equipment, Information, Education and Communication (IEC) materials, and widespread Risk Communication and Community Engagement (RCCE) efforts in humanitarian settings. An allocation of close to $4 million has been made from the Myanmar Humanitarian Fund (MHF) supported by a grant from the Access to Health Fund to kick-start preparedness and response efforts.

The humanitarian community's overall preparedness and response efforts are coordinated through the Humanitarian Country Team (HCT), with support from the Inter-Cluster Coordination Group. At national level, the Resident Coordinator/ Humanitarian Coordinator (RC/HC) has established an HCT COVID-19 Core Group to enable real-time information-sharing and analysis across key humanitarian constituencies, between regular HCT meetings. At sub-national level, COVID-19 Task Teams are in place in Sittwe, Myitkyina and Lashio to rapidly and collectively advance key deliverables for preparedness and readiness in each operating area (Rakhine and southern Chin, Kachin, northern Shan). The Task Teams are aligned with and report back to established HCT COVID-19 sub-national/national coordination bodies in each location.

KEY ACHIEVEMENTS TO DATE (COVID-19 RELATED RESPONSE)

Education: Development of an Education in Emergencies (EiE) Sector COVID-19 response strategy inclusive of system-level support and aligned with the Ministry of Education (MoE)'s plan. Provision of technical inputs to MoE COVID-19 Response and Recovery Plan. RCCE activities conducted by EiE Sector partners, with some partners assisting MoE to distribute IEC materials from MoHS. Multi-partner technical review of learning materials resulting in EiE Sector recommendations for home-based learning packages, with accompanying guides for teachers and caregivers. Increased frequency of co-chaired meetings between MoE and EiE Sector, resulting in greater information sharing.

Food Security: Food Security Sector's global guidelines adapted to the local context. Sensitization messages shared with beneficiaries ahead of various food security interventions in line with national and WHO guidelines. Quick and efficient distribution of food rations, non-food items and agriculture inputs in compliance with social distancing. Distributions being organized through local committees, in smaller groups as alternate collectors to help transport rations to vulnerable groups. Provision of hygiene kits to mitigate the possible spread of COVID-19. Provision of double rations covering two months where appropriate with context specific decisions for the possibility of increased use of cash assistance where markets, security and logistics would allow. Food assistance to returning migrants in quarantine centres in main border states and regions including Kachin, Kayin, Mon and Shan states, and Tanintharyi Region. Cash provision in villages and displacements sites to stabilize income losses, access to food and agriculture inputs.

Health: Close coordination and complementarity established between Health Cluster partners with development health actors on COVID-19 preparedness and response activities. Comprehensive support provided across the nine pillars[1] of public health preparedness and response. Within the states and regions with pre-existing humanitarian operations, 43 partners with township-level field presence in 84 townships in Chin, Kachin, Kayin, Rakhine, and northern Shan States have been providing various forms of COVID-19 support. Activities supporting Pillars 2, 3, 6, and 8 are supported by at least 22 out of the 43 partners. Highest level of support is observed for Pillar 2. More appropriately delivered through the national level coordination platform among health actors, overall support is likewise provided for Pillars 1, 4, 5, and 7. Pillars 3 and 9 are considered regular part of the main HRP 2020 activities and remain key priorities in the context of COVID-19 across all transmission scenarios.

Nutrition: A technical guidance package for nutrition programming adapted to the COVID-19 pandemic in Myanmar was developed to ensure continuity of essential nutrition services during the pandemic while mitigating secondary impacts on nutrition. Online orientation sessions and training provided to over 300 staff from 30 implementing agencies across HRP targeted areas to support implementation of the adapted COVID-19 nutrition programme guidance package. Support to the nutrition supply chain including re-positioning of available nutrition supplies currently in the country to state and regional hubs to cover key interventions for the next six months. Reforecasting and quantification of needs of life saving nutrition essential supplies and commodities completed. Integration of nutrition into the RCCE strategy for the COVID-19 focusing on infant and young child feeding (IYCF) especially protection and promotion of breastfeeding and broader healthy and safe eating tips for families. Infection prevention and control measures taken during provision of nutrition services at the service point.

Protection: Joint CCCM and Protection guidelines for camp management committees shared in Kachin and northern Shan states on COVID-19 prevention, preparedness, and response measures. Mapping of essential protection services and assistance continuity in Kachin and northern Shan states to understand the implications of COVID-19. Continuing protection monitoring, individual assistance and referrals for vulnerable IDPs, and provision of gender-based violence, child protection case management and psychosocial support services. Establishment of a tracking system for temporary IDP returns to villages of origin in Kachin and northern Shan states to avoid COVID-19 risk in camps. Development of child-friendly messages as well as key guidance for women and girls on the continued service provision during COVID-19 and gender-based violence (GBV) referral process. Development and dissemination of messages for communities, through the Communication with

[1] Pillar 1: Country-level Coordination, Planning, and Monitoring; Pillar 2: Risk Communication and Community Engagement; Pillar 3: Surveillance, Rapid Response Teams, and Case Investigation; Pillar 4: Points of Entry; Pillar 5: National Laboratories; Pillar 6: Infection Prevention and Control; Pillar 7: Case Management; Pillar 8: Operational Support and Logistics; Pillar 9: Essential Health Services Maintained

Communities Working Group on COVID-19. Training conducted for CPWG members in responding to Child Protection needs in light of COVID-19 as well as for GBV partners on remote service provision and for non-GBV partners on GBV basic concepts and referrals. Community awareness-raising on COVID-19 safe practices and a strategy to reach children. Development and review of guidance on Child Protection Case Management and alternative care during COVID-19 and training for case management frontline workers and managers. Contextualisation of the global IASC COVID-19 gender alert and dissemination across sectors to encourage gender mainstreaming of COVID-19 programming. Development and adaptation of mental health and psychosocial support (MHPSS) guidelines and tools to address and respond to MHPSS needs of affected people as well as frontline workers during COVID-19.

Shelter/Non-Food-Items (NFIs)/CCCM: Development and dissemination of information package (based on MoHS guidance on COVID-19) in displacement sites in Kachin and northern Shan. Development of guidance for prevention, preparedness and response for COVID-19 including messages on awareness raising, social distancing and referrals. Community surveillance trainings delivered in some sites to continue monitoring the situation. RCCE scaled up in all camps and displacement sites in central Rakhine, based on MoHS' approved messages available in local languages. COVID-19 Task Team (Rakhine) established to track and address negative and harmful rumours in communities, among other tasks. Mapping of all available infrastructure/buildings in protracted camps for potential use as quarantine or isolation facilities, clinics and medical storage facilities. Designs for emergency shelters, isolation facilities or hospitals prepared. Stockpiling to cover at least 4,000 households with emergency NFI distributions. Development of practical guidance on self-isolation and home quarantine in camp settings supported as a preparedness measure for this as a potential eventuality.

WASH: Global WASH Cluster COVID-19 guidelines adapted to the local context and specific government regulations for COVID response, which includes: all on-going hygiene promotion and RCCE activities scaled up in all sites; increased supply of hand washing stations (local manufacturing is being supported to increase the current market capacity); increased distribution of hand washing materials such as soap; and distribution of disinfection materials at household, community and institution levels (bleach/chlorine-based solutions).

PEOPLE IN NEED

State	HRP Caseload				HRP Caseload Total	Non-HRP caseload	Grand Total
	IDPs*	IDP returnees/ resettled/locally integrated	Non-displaced stateless people in Rakhine	Other vulnerable crisis-affected people		Returning Migrants	
Chin	7,543			3,192	**10,735**		
Kachin	95,912	6,485		15,255	**117,652**		
Kayin	10,621				**10,621**	**60,000**	
Rakhine	202,539		470,000	43,054	**715,593**		
Shan	9,610	3,117		33,533	**46,260**		
Grand Total	**326,225**	**9,602**	**470,000**	**95,034**	**900,861**	**60,000**	**960,861**

* The IDP figures are taken from the CCCM Cluster update as of December 2019 for Rakhine and April 2020 for Kachin and Shan. The AA-Tatmataw displacement figures for Rakhine State (71,653 as of 19 May) and Chin State (7,543 as of 24 April) are from the displacement list shared by the Rakhine State Government and partners.

PEOPLE TARGETED

Chin	4,374			3,192	**7,566**		
Kachin	95,912	6,485		15,255	**117,652**		
Kayin	10,621				**10,621**	**60,000**	
Rakhine	159,834		470,000	43,054	**672,888**		
Shan	9,610	3,117		33,533	**46,260**		
Grand Total	**280,351**	**9,602**	**470,000**	**95,034**	**854,987**	**60,000**	**914,987**

FUNDING REQUIREMENT

Cluster	Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
Education	206,100	204,600	1,500	26.1M	4.8M	30.9M
Food Security	622,643	562,643	60,000	61.4M	6.2M	67.6M
Health	592,258	532,258	60,000	20.1M	21.6M	41.7M
Logistics					2.8M	2.8M
Nutrition	144,895	142,795	2,100	15.8M	1.6M	17.4M
Protection	881,187	854,987	26,200	34.6M	6.6M	41.2M
Shelter/NFIs/CCCM	250,096	250,096	TBC	21M	6.9M	27.9M
Water, Sanitation and Hygiene	587,991	527,991	60,000	33.2M	8.3M	41.5M
Coordination and Common Services				4.3M		4.3M
Grand Total	**914,987**	**854,987**	**60,000**	**216.5M**	**58.8M**	**275.3M**

CLUSTER/SECTOR PLANS

Education

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
206,100	204,600	1,500	26.1M	4.8M	30.9M

Priority Actions

When there are no or sporadic cases, it is expected that schools will be open with safety measures in place. This may mean that students are likely to attend in shifts or on rotating days, necessitating learning both at home and in classrooms. In these scenarios, the following activities are prioritized, in line with the Ministry of Education (MoE) Response and Recovery Plan.

- Implement back-to-school campaigns for both formal and non-formal education with an emphasis on girls' education; The campaigns will include awareness raising and providing material support (in-kind or cash/ school supplies plus masks, soap, and other disease prevention items).
- Continue support to children, teachers, and parents and caregivers for learning to take place at home where classroom hours are reduced;
- Support remedial/catch-up learning before and after education facilities re-open;
- In coordination with the WASH Cluster and in line with the CPRP, assist schools to operate safely including by:
  - Training teachers, school staff, and community members on adhering to sanitary guidelines related to the COVID-19, with specific attention to focal points for health within schools;
  - Upgrading WASH equipment and supplies, and their management, so that adequate water supply, handwashing stations, and latrines are consistently available in educational facilities;
  - Provide WASH kits to teachers, children, and their families;
  - Providing health and hygiene education to children.
- In coordination with the Protection Sector, provide tools for psychosocial support to girls and boys, youth, teachers and caregivers within education activities;
- Raise awareness among girls and boys, youth, teachers, and education staff about how to prevent and control the COVID-19 in community and educational settings, including informing communities about how schools and temporary learning classrooms (TLCs) are being operated safely and how they can support the safe continuation of education in classrooms.

In scenarios where there are clusters of cases or larger outbreaks of local transmission, it is likely that schools will be closed and children will need to continue to learn at home or through distance options. Teacher trainings should be conducted through remote options or in small groups only. The priority activities will therefore be:

- Provide continued access to quality and inclusive learning opportunities for boys and girls by:
  - Expanding the collection of home-based learning materials which supplement the curriculum and integrate psychosocial support and COVID-19 prevention messages;
  - Providing home-based learning material kits to all girls and boys in target groups;
  - Building the capacity of caregivers to assist their children in home-based learning;
  - Informing communities about home-based learning and raising awareness about the importance of continued learning.
- Enhance formal and non-formal teachers' capacity to provide quality education, particularly in regard to alternative education modalities such as home-based learning;

- Support the MoE in planning for girls' and boys' continued learning and teachers' capacity building during the COVID-19 response;
- In coordination with the Protection Sector, provide tools for psychosocial support, as well as counselling and referral services, to girls and boys, youth, teachers and caregivers within education activities;
- Liaise with Water, Sanitation and Hygiene (WASH) partners to ensure schools, TLCs, and other education institutions have adequate WASH facilities and supplies for the prevention and control of the COVID-19;
- Continue to raise awareness among girls and boys, youth, teachers, and education staff about how to prevent and control COVID-19 in community and educational settings;
- Support to returning migrants will include providing continued learning opportunities to children, through learning materials, in areas where they cannot access classrooms and extending the reach of back-to-school campaigns, including provision of school kits.

Changes to Operational Modalities

- All EiE Sector partners are adapting their activities to support prevention and control of the COVID-19. In March 2020, EiE partners temporarily suspended all activities that gather people – including integral education interventions such as classes, exams, and trainings – following instructions from MoE and EiE Sector guidance. Communication, including COVID-19 prevention and other key messaging, for teachers and caregivers has been maintained through mobile phones and Internet (e.g. Viber).
- EiE Sector partners are responding to the need to continue learning by providing remote support to children, teachers, and parents and caregivers. A number of EiE partners were providing remote support to volunteer teachers as of May 2020, and partners are implementing recommendations for newly-developed home-based learning packages so children can continue learning as schools remain closed for at least the first six weeks of the academic year.
- At the same time, the EiE Sector is adapting education provision and support, in alignment with MoE guidelines, so that children and communities remain safe from COVID-19 outbreaks. In classrooms that are already overcrowded, there will be staggered and rotational attendance. Limited capacity to increase the number of volunteer teachers will affect the ability to provide a greater number of classes that would reduce class size. Reduced classroom teaching time will necessitate home-based learning, even as schools, TLCs, and other education institutions re-open.
- Throughout the COVID-19 response, EiE partners are placing additional emphasis on provision of WASH awareness and supplies for COVID-19 prevention, as well as psychosocial support for children, teachers, and caregivers.
- The EiE Sector continues to coordinate with MoE to ensure its response to the COVID-19 is well-suited to the needs of children who are displaced and conflict-affected, and that response activities reach them. Further, given a possibility that some or all schools, TLCs, and other education centers in Myanmar are closed or may need to close after being re-opened, the EiE Sector may provide support for countrywide interventions. However, the focus for the EiE Sector remains on displaced and conflict-affected communities in the HRP's five target states and regions.
- Access constraints may limit partners' ability to reach IDP camps and other conflict-affected communities throughout 2020. With occasional reductions in staff capacity, EiE partners are carrying out program criticality exercises. Increased mobility and access restraints on international actors elevate the importance of local actors and the need to build their capacities to a new level. Additionally, EiE partners will adopt approaches to distribution of supplies and staff interaction with communities in line with guidelines from health experts.

Food Security

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
622,643	562,643	60,000	61.4M	6.2M	67.6M

Priority Actions

- Ensure provision of food and/or cash assistance to cover food and nutrition needs of returning migrants in quarantine centers, as necessary and requested by government;
- Provide specialized nutritious food ration to IDPs having to undergo quarantine in designated facilities;
- Ensure the continuation of food assistance through procurement of key Personal Protection Equipment (PPE) for staff and partners, and distribution sites arrangement for social distancing, hand washing and awareness raising on COVID-19, etc;
- Maintain critical agriculture and livelihood assistance especially in conflict affected areas, including returning migrants;
- Provide and scale up social protection measures, financial support and agricultural inputs for most vulnerable farmers, particularly to those who are landless as well as vulnerable migrants;
- Monitor food security and livelihood impacts of COVID-19; assess impact on food production and agriculture inputs flow and prices of food items/commodities in high risk areas (Yangon Region and Chin, Kachin, Kayin, Mon, Rakhine and Shan states) through phone interviews;
- Conduct community-level survey to assess a short- and medium-term community-level impact of COVID-19 on livelihood of local community and food security situation in Myanmar and support seed security through feasible interventions to ensure sufficient seeds for the next season.

Changes to Operational Modalities

- Deliver key communication messages on basic understanding on and mitigation of COVID-19 to households and communities, during the delivery of the assistance;
- Distribution arrangements have been adapted to ensures public health measures to reduce the transmission risk of COVID-19 including through provision for social distancing, hand washing, awareness raising at and around distribution sites.
- The number of distribution points has been expanded using strict hygiene and protection protocols to reduce risk of transmissions. However, it requires additional capacities in terms of logistics and personnel and in some cases additional partners support for social distancing and hygiene practices, and community engagement.
- Joint and bulk procurement of resources/ materials has been pursued to ensure additional coverage. Distribution modalities will be specific to each context. The Sector will continue exploring possibilities for increased use of Cash assistance as markets, security and logistics allow. In northern Rakhine, as a measure to reduce contacts, the distribution modality has been shifted from household to food management committees, which can further distribute items to households in the villages. This approach is currently advocated for across the regions.
- Wherever possible, the Food Security Sector partners for emergency relief considered a double-ration distribution in most camps, and triple rations in the hardest-to-reach areas as much as possible. This is both to mitigate the spread of COVID-19 by limiting contact time with beneficiaries, and to ensure those in need are covered to the extent possible should there be future limitations on movement to receive food and/or cash assistance including mitigating any limitations on humanitarian personnel movement to provide assistance.
- Introduction of mobile Vulnerability Assessment and Mapping (mVAM) to conduct remote mobile-based agriculture, livelihood, market and food security monitoring, will offer a cost-effective and less complex alternative to the traditional face-to-face household and community survey. The mVAM exercise will be done in collaboration with FAO, International Food Policy Research Institute and the Ministry of Agriculture, Livestock and Irrigation.

Health

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
592,258	532,258*	60,000	20.1M	21.6M**	41.7M

* This includes 523,583 people initailly targeted in the 2020 HRP and additional 8,675 newly dispalced people in Rakhine and Chin states.

**This includes $5.1 million for priority activities and $16.5 million (maximum option) for possible contingency activities applicable only in latter transmission scenarios. In terms of hierarchy of priorities, the revised core HRP funding requirement takes overall precedence followed by the additional COVID-19 priority activities, and then lastly by the contingency-related costing

Priority Actions

- Strengthen surveillance support through:
  - Prevent, prepare for, detect and rapidly respond through the Early Warning Alert and Response System (EWARS) for any communicable disease outbreak;
  - Support community surveillance for COVID-19 through various health facilities and community clinics as well as engaging community-based networks;
  - Support contact tracing activities as needed;
- Enhance RCCE, including educating and communications with people of concern on COVID-19 through awareness raising campaigns that reaches all including marginalized population;
- Strengthen infection prevention and control measures in public places with high risk of transmission and quarantine and health facility settings to include adequate supply and promote rational use of personal protective equipment;
- Protect frontline healthcare workers from infection through adequate infection prevention and control measures, and from stigma and discrimination through enhanced community engagement and other relevant support;
- Support continuity of essential and life-saving healthcare services for targeted vulnerable groups (elderly, children, pregnant women, people with disabilities, people with chronic diseases) in collaboration with relevant stakeholders to include but not limited to:
  - Maternal, newborn, child health and sexual and reproductive health care services;
  - Emergency patient referrals;
  - Immunization activity;
  - Antiretroviral therapy needs of people living with HIV; Essential treatment services such as methadone maintenance therapy for people who inject drugs, and HIV risk reduction commodities; Anti-TB treatment;
  - Non-communicable diseases;
  - Mental health and psychosocial support needs.
- Support strengthening case management capacity at health facilities as appropriate (for contingency).

The following are considered as priority activities for the returning migrants during quarantine.

- Support for priority health needs in consonance with maintenance of essential health services;
- Support for surveillance and monitoring;
- Support for emergency health referrals from quarantine location to the nearest, appropriate health facility as needed.

Contingency Activities

COVID-19 affects countries differently depending on several factors such as the extent and speed of public health mitigation measures. This section provides four options of cost estimation for managing three, 50-bed capacity (total 150 patients), severe acute respiratory infections treatment centre with the following assumptions:

- Follows the principle of “no regrets” basis;
- Partners are requested to directly manage mild to moderate cases as government designated COVID-19 treatment hospitals and health staff are at full capacity. Specialists are best placed in government designated

treatment facilities to handle severe cases. Referral support is done by land from the treatment centre to the referral hospital for severe cases.

- Each treatment centre:
  - Has the capacity for 50 beds, running 24 hours with a staff complement for three shifts (medical officers, nurses, health assistants, community health workers with translation capacity as needed by the context, cleaners, and a driver);
  - Can be implemented anywhere in the country where needed regardless of pre-existing humanitarian operations;
  - Is a temporary facility.
- Costed operation is to run for six months including a removal cost which is estimated at 30 per cent of the establishment cost. Costing does not include:
  - IT and communication systems;
  - Initial operations establishment for the health partner if it is deployed in an area where there are no pre-existing humanitarian operations;
  - Organizational management cost.

Description	Estimated cost (USD) for three units:
Option 1: Prefabricated with medical equipment for oxygen therapy (50 confirmed cases, mild to moderate)	16,531,500
Option 2: Low cost materials with medical equipment for oxygen therapy (50 confirmed cases, mild to moderate)	13,401,750
Option 3: Low cost materials without medical equipment for oxygen therapy (50 suspect cases or 50 mild cases)	5,408,850
Option 4: Repurposed *existing* facilities (50 suspect cases)	3,972,375

Changes to Operational Modalities

- Health coordination meeting of partners expanded to include both humanitarian and development organizations at national level. In addition, three thematic sub-groups are also formed (risk communication and community engagement, laboratory diagnostics capacity and case management).
- Resource mapping dashboard and 3W dashboard for COVID-specific activities created.
- There is reduced intensity of mobile clinics and routine services in HRP target areas due to shifting of partners' and government's resource allocation to COVID-19 response while minimizing interruption to the delivery of essential services.
- Implementation of some activities are modified to observe public health infection prevention and control measures such as social distancing.
- Non-essential health services are suspended.
- Coordination meetings and capacity building sessions are organized virtually.

Logistics

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
N/A	N/A	N/A	N/A	2.8M	2.8M*

*This includes an estimated $2 million to set up UNHAS in case of suspension of domestic airlines.

Priority Actions

- Ensure linkages to the global efforts to secure the continuity of supply chain services at local level;
- Ensure linkages to the global efforts to secure the safe and reliable passenger transport related to medical evacuations in general and specific to COVID-19.

Changes to Operational Modalities

- With the aim of linking into the global supply chain efforts and to ultimately feed into the assets propositioned in the regional hubs/staging area, efforts concentrate on providing pipeline visibility on medical and humanitarian supplies requiring transportation into the country.
- Should need arise, a single collection/storage point will be set-up at the Yangon International Airport to provide required handling and temporary storage of inbound cargo before items can be collected by respective humanitarian organizations.
- Existing storage capacity will be upgraded to allow handling of cold chain material across the country allowing, where needed, adequate integration with national systems.
- Set up necessary coordination and logistics arrangements with humanitarian organizations and local authorities to allow for a safe and reliable passenger service related to medical evacuations to designated hub locations for both regular and COVID-19 related cases.

Nutrition

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
144,895	142,795	2,100	15.8M	1.6M	17.4M

Priority Actions

- Ensure continuity of key nutrition services, including treatment of severe and acute malnutrition, blanket and supplementary feeding, micronutrient supplementation, community-based nutrition promotion and infant and young child feeding (IYCF) counselling and support, while reducing potential risks of transmission for beneficiaries and partners;
- Strengthen the nutrition service points for risk communication and community engagement (RCCE) activities including related to the impact of COVID-19 on IYCF; Ensure integration of key nutrition messages into other RCCE activities in relevant sectors, including Education in Emergency, Health, Expanded Program on Immunization, and Water Sanitation and Hygiene;
- Ensure development and dissemination of communication and community engagement materials (print and audio visual) especially on protection and promotion of appropriate IYCF practices that is currently undermined by fear of mother to child transmission, anxiety of the caregivers and weak food systems;
- Ensure adaptation of global nutrition technical guidance to the context of Myanmar to guide partners on provision of nutrition services, while reducing the risk of infection and strengthen preparedness to support the nutritional care of mothers and children with COVID-19;
- Ensure mapping of high risk or hotspots areas and review existing human and financial resources of nutrition sector partners in those areas to identify any gaps that require additional resource mobilization;
- Provide technical and operational support to nutrition partners to continue nutrition services in the HRP and non-HRP areas.
- Coordination and information management to ensure adaptation of the nutrition guidelines in the context of COVID-19 and ensure gaps are identified and addressed.

The following are considered as priority activities for the returning migrants during quarantine.

- Provide technical support to ensure that food support are nutrition sensitive;
- Ensure adherence to the nutrition food basket guidelines developed by the Nutrition Sector;
- Nutrition training for the food handlers, provision of nutrition messages and IEC materials for benefit of pregnant and lactating women and caregivers and young children;
- Where feasible and where food security actors provide dry food rations, implement blanket supplementary feeding programme for the pregnant and lactating and children under-five;

- Where wet feeding is provided, provide technical support in meal planning to ensure that daily calorie and nutrient needs are met;
- Provide multiple micronutrient powder/ supplements as well as multi vitamin tablets to pregnant and lactating women as well as children under-five.
- Where quarantine centres are in proximity to the treatment of acute malnutrition centres, liaise with concerned quarantine centres to actively screen for acute malnutrition and provide the necessary ready use supplementary foods (RUSF) and ready to use therapeutic food (RUTF).

Changes to Operational Modalities

- Weekly Strategic Advisory Group meetings are organized with participation from key nutrition development and humanitarian partners, including Government, to maximize synergy in response and avoid duplication.
- In line with the technical guidelines, operational modalities are being adjusted to ensure COVID-19 measures are integrated (e.g. handwashing with soap, use of PPE, physical distancing) as well as to ensure a minimum standard of nutrition service delivery in context of differing population mobility restrictions and access to/capacity of local health facilities because of the pandemic.
- All nutritional services in camps will continue with adjustments to ensure physical distancing, appropriate handwashing with soap and avoiding crowds.
- Blanket Supplementary Feeding Program (BSFP) and treatment of severe/moderate acute malnutrition to be reduced to bi-weekly, with the use of simplified protocol of mid-upper arm circumference for admission and discharge criteria.
- Virtual service delivery platforms are being explored and established where feasible, including a hotline for IYCF counselling and support, and virtual learning resource and capacity building platforms for partners in context of nutrition programming and COVID-19.
- Remote monitoring using mobile devices and on a web browser is being developed.
- In an effort to avoid disruption of services, the Nutrition Sector ensured strategic reserves of nutrition supplies for the prevention and treatment of undernutrition and to preposition nutrition commodities and routine drugs in strategic locations.

Protection

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
881,187	854,987	26,200	34.6M	6.6M	41.2M*

*[GBV Sub-Sector: Total requirement: $7.5M (Non-COVID requirement: 6M + COVID requirement: 1.5M), Child Protection Sub-Sector: Total requirement: 11M (Non-COVID requirement: 8.6M + COVID requirement: 2.4M)]

Priority Actions

- Work closely with partners and authorities to ensure the inclusion of those emerging and existing needs of protection into COVID-19 preparedness, prevention and response activities with a focus on child protection, gender-based violence (GBV) and mental health and psychosocial support;
- Support partners to maintain remote protection monitoring activities to identify existing risks to vulnerable groups, including persons with specific needs;
- Ensure that the right to health, including COVID-19 related health and sexual and reproductive health services, are available to all without discrimination. In particular, to advocate for emergency contraception as well as clinical care available and accessible for GBV survivors;
- Provide targeted assistance for persons with specific needs;
- Strengthen mental health and psycho-social support services, including remote delivery, and strengthening of local mechanisms (technology, translation of materials to enable local actors to use them and support to

community-based organizations and the Department of Social Welfare) as a strategy to prevent and respond to children and vulnerable individuals in need, particularly those most affected by COVID-19 quarantine, movement restrictions, or other measures;

- Provide referral support, including through mobile outreach teams in displacement areas and transportation support, to identify and refer vulnerable women, girls, boys, care givers, unaccompanied and separated children, the elderly and persons with disabilities, to life-saving services;
- Provide case management to women, girls and boys who have experienced violence, exploitation, neglect and abuse in a way to ensure health and safety of both clients and service providers;
- Support providing/arranging temporary safe house/shelter for GBV survivors who face safety/security risks;
- Meet the hygiene and dignity needs of women and girls by providing COVID-19 adjusted Child Protection kits and Dignity Kits in camps, villages IDP sites and community quarantine facilities;
- Provide technical support to and strengthen synergies with local structures and other sectors/clusters (including Education, Health, Nutrition) as well as support to the Government/the Department of Social Welfare frontline services and national level structures to identify needs, gaps and barriers to protection services and adopt child protection mechanisms in the overall response to mitigate and respond to violence, neglect, exploitation and abuse as well as increase access to children affected by the response;
- Support generation of analytical data on protection risks, including GBV and sexual exploitation and abuse, and closely monitor such trend/patterns of protection risks, to inform prevention, mitigation and response services;
- Implement remote case management for girls and boys who are at risk of and are experiencing abuse, exploitation, neglect and violence due to COVID-19 including Unaccompanied and Separated Children;
- Ensure family-based alternative options are available for children, older persons, or persons with disabilities whose care givers are being quarantined or hospitalized by strengthening kinship care and resorting to non-family based interim placement as a last resort;
- Continue advocacy on ongoing protection issues and potential rights violations (e.g. freedom of movement, discrimination in access, or restricted access, to services, etc.);
- Advocate for all humanitarian programming to mainstream Protection, Gender and other intersectional considerations including age, sexual orientation, and disability.

Changes to Operational Modalities

- Building community-based protection capacity through focal points outreach volunteer networks and protection partners;
- Ensuring that displaced, stateless and conflict affected people and communities including women are to be included in township-level coordination structures designed to support preparedness and response to the COVID-19 outbreak to ensure that their specific needs are addressed in relevant planning. Ensure women are included in design and implementation of programming and engaged in decision making/leadership roles;
- Increasing remote protection monitoring through focal points and partners, while also using technology/online platform, to disseminate information and risks communication about the preparedness, prevention and response to the COVID-19; Ensure inclusive information campaigns and awareness raising on protection related key messaging - noting impact of COVID-19 on pre-existing barriers for groups such as women, girls, the elderly and people with disabilities;
- Partners adopting practical operating and service delivery modalities (also considering the views of the communities) to cope with increased movement restrictions and social distancing measures, including increased use of cash transfer services to move funds to camps for individual assistance, and audio-messaging for awareness raising in place of mass gatherings and tele communications to reach people in need with mobile protection services.
- Strengthening protection monitoring and provision of services in the areas of origins where temporary returns are taking place due to the COVID-19 (restricted movement and livelihood opportunities in the camps);
- For GBV sub-sector, the number of people targeted has decreased from the original 250K to around 175K. This is because large-scale awareness/outreach sessions and GBV prevention activities have been mostly suspended due to COVID-19 control measures.

Shelter/NFIs/ Camp Coordination and Camp Management (CCCM)

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
250,096	250,096	TBC	21M	6.9M	27.9M

Priority Actions

- Dissemination of RCCE materials and information by camp management agencies and cluster partners in support of the wider inter-sectoral drive on RCCE;
- Prepositioning of ready-to-deploy shelter solutions that support the Government facility quarantine locations as well as other infrastructure to expand/enhance medical facilities (with items including but not limited to rub halls, plastic sheeting, tents and other non-food items (mattress, mosquito nets, blankets etc.)) and supporting the local production of PPE whenever feasible;
- Provide non-food-items (NFIs) assistance (mosquito nets, sleeping mats, blankets, clothing, buckets, jerry cans, tarpaulin, kitchen sets, cooking stoves and solar lanterns) to displaced and host population in need;
- Provide/rehabilitate shelter units to reduce overcrowding, using disinfectants in communal spaces and maintaining drainage for surface water around shelters in camps which contributes to the spread communicable diseases;
- Establish feedback mechanism to facilitate referral to other specialized actors for response if needed (e.g: topping up the communication cost for camp management committees to regularize remote monitoring);
- Support has been requested by the State Governments of Kachin, Kayah, Kayin and northern Shan states for NFI in 33 isolation sites. More sites will be identified as the situation evolves.

Changes to Operational Modalities

- Partners are adjusting their operational modalities to the evolving ground level situation with a combination of remote operational management - with direct communication with focal points in camps - and the continuation of direct programming in camp settings;
- Pre-existing access limitations persist, hampering the delivery of essential messaging and COVID-19 related programming alongside programs within the existing HRP.

Water, Sanitation and Hygiene (WASH)

Total People Targeted	HRP Caseload	Non HRP Returning Migrants	Revised core HRP funding requirement (US$)	Additional funding requirement for new COVID-19-focused activities (US$)	Total Funding Requirements (US$)
587,991	527,991	60,000	33.2M	8.3M	41.5M

Priority Actions

- Increase safe water supply (five liters per person per day) for handwashing purposes;
- Increase water storage capacity to facilitate disinfection and handwashing;
- Increase handwashing stations installed in critical locations;
- Distribute extra hygiene kits (with extra soaps, sanitary pads and laundry detergent) until the outbreak has been contained;
- Ensure continued access to hygiene supplies where restrictions may limit access to markets;
- Distribute community-level cleaning kits for communal WASH facilities (camps, monasteries, schools, Child Friendly Spaces, Youth Centers, Women's Centers, Mosques/churches, etc.);
- Regular disinfection of communal WASH infrastructures in high risk locations;

- In collaboration with the Government, ensure appropriate WASH facilities in all designated isolation or quarantine facilities across Chin, Kachin, Kayin, Rakhine and Shan states, particularly in those used for IDP, migrants and/or returnees, whom are the most vulnerable. This may include responding outside of the five states primarily covered by the 2020 HRP.

Changes to Operational Modalities

- Prepositioning of stocks to ensure continuation of life-saving activities. This includes (as a minimum, but not limited to hygiene kits, hygiene-related materials (soap, bleach) and water treatment products (e.g; chlorine);
- Increasing remote operational capacity: Training/capacity building of local actors to be able to undertake basic technical work via remote supervision. This includes (as a minimum, but not limited to) safe water provision, sanitation facilities (operation and maintenance);
- Distributions with less people, handwashing and physical distancing;
- Increase unconditional cash transfer to support WASH expenditures;
- Facilitating the procurement of hand washing hardware in order to mitigate potential market depletion of materials; This includes (as a minimum, but not limited to) hand washing stations and hand washing materials (locally made soap, hand sanitizer).

Coordination

Priority Actions

- Education in Emergency Sector: As the EiE Sector responds to COVID-19, additional information management capacity will provide much-needed support to designing and managing needs assessments, providing information products tailored to the requirements of the EiE Sector, supporting review and analysis of secondary data, and developing and implementing monitoring tools to assist EiE Sector coordination.

MULTI-SECTOR RAPID RESPONSE MECHANISM (RRM)[2]

The Rapid Response Mechanism (RRM) is an operational, programmatic and partnership model designed to enhance the humanitarian community's capacity to respond in a timely, coordinated and predictable manner to the needs of populations made vulnerable by conflict, displacement, disease and/or natural disasters in humanitarian settings. Since its creation in the Democratic Republic of Congo (DRC) in 2004, the RRM has provided life-saving assistance to more than 25 million people in DRC, South Sudan, Syria, Iraq, Haiti and Yemen. The model could be adapted to support a multi-sector response to communities affected by lockdowns and other movement restrictions in Myanmar imposed as part of efforts to contain the current COVID-19 pandemic. Any RRM consortium would require the endorsement of the Government of Myanmar, specifically the Department of Disaster Management, and will work closely with national and sub-national emergency response systems. Protection, gender and disability sensitivity, and 'do no harm' would be mainstreamed into all RRM operations.

The intent of the RRM is to complement existing programmes in the five states where there is currently little or no humanitarian reach and where there are specific COVID risks matching the geographic and vulnerability criteria. RRM activities will also take place outside of HRP areas where there is verified need matching the criteria.

The RRM Consortium structure envisaged for Myanmar includes UNFPA, UNICEF and WFP as primary partners with the contributions of other agencies. Based on experience from previous RRM collaborations, WFP and UNICEF will act as co-lead agencies, formalized under a Memorandum of Understanding. Other partners include UNHCR, or others who bring additional response capacities. RRM distributions will be through direct implementation principally and through national NGOs or other Cooperating Partners according to the context.

Rapid Response Package

Through the RRM, UN partners will provide **critical multi-sectoral emergency response** in a wide range of sectors with a focus on Food and WASH support. As needed, additional support could include Nutrition, Non-Food Items, Health, Education and Protection components. The RRM also establishes a framework for humanitarian access and includes a strong component related to Inter-Agency and Cluster Coordination.

The precise contents of any rapid response package, and its intended duration, is to be determined, but may include:

- Food assistance (in-kind or cash, depending on context)
- Drinking water/water purification kits
- Hygiene kits and other WASH NFIs
- Dignity kits

After initial agreements are in place, RRM Consortium partners will focus on the following:

Pre-positioning: where possible, the RRM Consortium will pre-position supplies at its own warehouses or Cooperating Partner warehouses in key locations across Myanmar to guarantee an immediate and effective response. Coverage will be dependent on further discussions on geographical prioritization.

Delivery: Following multi-sectoral rapid assessments, delivery and distributions of RRM assistance will be carried out by UN agencies and/or Cooperating Partners staff, in collaboration with relevant local and national authorities.

Follow-up: Post distribution monitoring will allow agencies to determine if additional support is required. This could include assistance linked to existing government safety nets such as the Maternal and Child Cash Transfer Program and old-age pension.

[2] UN agencies are currently finalizing the use of this approach with the Government of Myanmar and this mechanism will be known locally as the Coordination Mechanism to Respond to COVID-19.

INDICATORS FOR THE 2020 MYANMAR HUMANITARIAN RESPONSE PLAN ADDENDUM FOR COVID-19

INDICATORS	HRP CASELOAD		RETURNING MIGRANTS		SECTOR
	IN NEED	TARGETED	IN NEED	TARGETED	
Number of girls and boys (ages 3-17) who continue to have access to safe and functional, quality and inclusive learning opportunities that promote their protection and wellbeing.	**255,754** Chin: 936 Kachin: 43,298 Kayin: 3,593 Rakhine: 195,264 Shan: 12,663	**204,600** Chin: 749 Kachin: 34,637 Kayin: 2,874 Rakhine: 156,212 Shan: 10,128	**2,400**	**1,500**	Education
Number of people who received food and/or cash assistance Number of people who received agriculture and other livelihood support contributing to household food security	**562,643** Chin: 2,600 Kachin: 82,672 Rakhine: 459,377 Shan: 17,994	**562,643** Chin: 2,600 Kachin: 82,672 Rakhine: 459,377 Shan: 17,994	**60,000**	**60,000**	Food Security
Number and proportion of people within the HRP addendum caseload most vulnerable to COVID-19 who received health assistance*	**627,592** Chin: 1,797 Kachin: 98,200 Kayin: 10,621 Rakhine: 481,491 Shan: 35,483	**532,258** Chin: 925 Kachin: 83,896 Kayin: 10,621 Rakhine: 423,160 Shan: 13,656	**60,000**	**60,000**	Health
Number of caregivers of children 0-23 months who received key messages that protect and promote appropriate breastfeeding practices in the context of the COVID-19	**83,462** Chin: 1,321 Kachin: 23,373 Kayin: 3,960 Rakhine: 27,566 Shan: 27,242	**44,327** Chin: 686 Kachin: 8,117 Kayin: 2,345 Rakhine: 25,752 Shan: 7,427	**2,100**	**2,100**	Nutrition
Number of people, vulnerable to the pandemic who received information on risks and available services	**854,987** Chin: 7,566 Kachin: 117,652 Kayin: 10,621 Rakhine: 672,888 Shan: 46,260	**854,987** Chin: 7566 Kachin: 117,652 Kayin: 10,621 Rakhine: 672,888 Shan: 46,260	**25,000**	**5,000**	Protection
Number of people with access to gender-based violence response, including during the COVID-19 crisis	**524,077** Chin: 2,561 Kachin: 81,437 Kayin: 6,213 Rakhine: 403,369 Shan: 30,497	**175,453** Chin: 858 Kachin: 27,264 Kayin: 2,080 Rakhine: 135,041 Shan: 10,210	**21,000**	**10,000**	Gender-Based Violence sub-sector
Number of children and caregivers with access to specialized child protection response to the COVID-19 crisis	**377,893** Chin: 1,750 Kachin: 65,602 Kayin: 4,355 Rakhine: 282,771 Shan: 23,415	**233,271** Chin: 1,198 Kachin: 32,927 Kayin: 1,368 Rakhine: 184,912 Shan: 12,866	**16,400**	**11,200**	Child Protection sub-sector
Number of IDPs, stateless, returning migrants and vulnerable members from host communities who received COVID-19 assistance from Shelter/NFI/CCCM cluster members	**269,925** Chin: 1,087 Kachin: 100,032 Kayin: 4,744 Rakhine: 154,760 Shan: 9,302	**250,096** Chin: 1,087 Kachin: 92,839 Kayin : N/A Rakhine: 148,302 Shan: 7,868	**TBC**	**TBC**	Shelter/ NFIs/ CCCM
Number of people reached with critical WASH supplies (including hygiene items) and services to strengthen COVID-19 prevention.	**869,154** Chin: 4,279 Kachin: 132,614 Kayin: 9,132 Rakhine: 665,869 Shan: 57,260	**527,991** Chin: 1,000 Kachin: 85,938 Kayin: 9,132 Rakhine: 410,888 Shan: 21,033	**50,000**	**50,000**	WASH

*The health assistance can range across the nine pillars. If a partner supported multiple pillars, then the pillar with the most number of beneficiaries will be used for reporting.

ANNEX I: RATIONALE FOR SECTOR-LEVEL PROGRAMME PRIORITIZATION

EDUCATION

The response strategy of the Education in Emergencies (EiE) Sector encompasses a full continuation of regular HRP activities with adaptations for COVID-19, and additional activities to ensure continued and safe learning for girls and boys, and capacity building for teachers. EiE Sector partners agreed to maintain the same targets for the 2020 HRP, given that children cannot have their education put on hold, whether they are learning at home or returning to classrooms.

EiE Sector support in line with the 2020 Myanmar HRP includes enrolment of girls and boys in temporary learning centers, provision of student kits and school kits with teaching and learning supplies, trainings for formal and non-formal teachers, and other forms of assistance to children and teachers. Across all transmission scenarios, these activities will be adapted to reflect guidance on physical distancing and hygiene, and some may be delayed particularly due to schools re-opening later, but none will be cancelled during the nine months covered by the HRP addendum.

Significant additional funding is required to ensure children have continued learning opportunities in a safe environment. As children will need to learn at home during school closures or reductions in classroom hours, EiE partners will provide learning materials to be used at home as well as support to parents and caregivers to assist their children. An increased focus on emotional wellbeing will also require additional resources for children and teachers. Another dimension of the EiE response focuses on strengthening WASH facilities and community engagement on measures for COVID-19 prevention, in collaboration with WASH and Health Clusters.

HEALTH

The revision of the health section for the HRP followed a five-step process:

1. **Reviewed existing activities in the 2020 HRP**: Existing priority activities were reviewed in the context of the COVID-19. Generally speaking, all previous activities remains prioritized primarily as it is directly related to the maintenance of essential health service delivery or Pillar 9. Other pillars[3] that were strongly aligned are 1, 3, and 8. While conduct of such activities remains feasible overall, there are noted variations at field level which are geographical and context-specific. These then are either temporarily suspended with regular review for resumption or implemented through a modified operational modality.

2. **Considered other resource plans**: The MoHS health sector contingency plan outbreak response on COVID-19 and other emerging respiratory disease in Myanmar includes a whole-of society approach. It considers conflict-affected communities, displaced and non-displaced, in collaboration with other relevant actors such as respective state/regional governments and Ministry of Social Welfare, Relief and Resettlement. The UN Country Preparedness and Response was prepared in support of the MoHS plan. It likewise highlights the linkage with humanitarian context. As national level plans, it supports three out of the 9 pillars which is deemed to benefit people targeted in the HRP:

Pillar	Rationale
4: points of entry	PoEs are fixed locations. Support prioritized international points of entry which is appropriate considering the disease is not endemic. Therefore, PoE support benefits HRP targets. As PoE support is already included in both MoHS and UN plans, PoE support is excluded in this addendum throughout the four transmission scenarios.
5: national laboratory	Strengthening of the national laboratory system improves overall capacity for testing in the country by processing collected samples following the standard protocols. Therefore, national laboratory support benefits HRP targets. As national laboratory support is already included in both MoHS and UN plans, national

[3] Pillar 1: Country-level Coordination, Planning, and Monitoring; Pillar 2: Risk Communication and Community Engagement; Pillar 3: Surveillance, Rapid Response Teams, and Case Investigation; Pillar 4: Points of Entry; Pillar 5: National Laboratories; Pillar 6: Infection Prevention and Control; Pillar 7: Case Management; Pillar 8: Operational Support and Logistics.

	laboratory support is excluded in this addendum throughout the four transmission scenarios.
7: case management	Case management is primarily provided by government through the MoHS designated COVID-19 treatment facilities, including capacity strengthening for severe case management. Current policy specifies that all suspect and confirmed cases are to be referred to government treatment centers. Therefore, case management support benefits HRP targets. As case management support is already included in both MoHS and UN plans, case management support is excluded in this addendum throughout the four transmission scenarios. At the same time, a scalable **contingency provision** is proposed for the last two scenarios in the interest of preparedness.

The rest of the pillars are likewise supported by both MoHS and UN plans through broader, national level approach. The proposed health activities in this addendum supports all the remaining pillars which will be specific for the HRP people targeted in consideration of the strong alignment with the existing 2020 HRP priority activities as well as additional COVID-19 priority activities (i.e. non-contingency).

3. **Updated COVID-19 specific activities against four transmission scenarios:** In discussion with health cluster partners, the following table illustrates which pillar is to be supported, and therefore costed, in the revised addendum according to the transmission scenario. The pillars not costed below is covered in the MoHS and UN plans which benefits the targeted caseload in this addendum.

Transmission scenario	Pillar 1	Pillar 2	Pillar 3	Pillar 4	Pillar 5	Pillar 6	Pillar 7	Pillar 8	Pillar 9
No cases	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes
Sporadic cases	Yes	Yes	Yes	No	No	Yes	No	Yes	Yes
Clusters of cases	Yes	Yes	Yes	No	No	Yes	Contingency	Yes	Yes
Community transmission	Yes	Yes	Yes	No	No	Yes	Contingency	Yes	Yes

4. **Reviewed financial requirements:** Same costing methodology as was used for the 2020 HRP which used the five-year average of cost (in USD) per pax per year or 38 USD per person per year. This was adjusted to the nine-month period duration of this addendum yielding 28.5 USD per person for nine months. From here, a qualitative estimation approach is adopted for an additional 20 per cent on top of the existing HRP cost for the target already included in the existing HRP. For the additional caseload, it is estimated at 120 per cent for the nine-month period. Contingency measures as well as financial overview is further detailed in the above section. Using this approach, the total COVID-19 addendum requirement for health is estimated at US$5.1 million excluding the contingency measure. It is important to understand that this estimation is on top of the requested funding in the existing HRP. In other words, if the revised HRP 2020 fund requirement of $20.1 million for Health is not funded at 100 per cent, then the funding requirement for Health in the COVID-19 addendum increases accordingly.

5. **Reviewed sector monitoring framework:** All existing HRP target caseload are included in this addendum plus an additional caseload which were not included in the previous people in need. The number of beneficiaries to be reported will include the COVID-19 activity with the largest reach among the target population. Further details in the monitoring framework section.

NUTRITION

Continuity of essential nutrition services, namely treatment of acute malnutrition, blanket supplementary feeding, micronutrient supplementation and IYCF counselling and support as outlined in the HRP 2020 remain a priority with adjustment in service provision to ensure reduction of potential risks of transmission for beneficiaries and service providers/partners. This is a part of the IASC guidance to maintain essential health and social services for all in low capacity and humanitarian settings for COVID-19 preparedness and response operations and to some extent part of the Pillar 9 of the CPRP. Nutrition sector partners agreed not to change targets and funding for the 2020 HRP, considering (1) 16,273 so far reached with services, (2) the duration of nine months instead of 12 months, (3) the feasibility of providing nutrition services with modified operational modalities, including

distancing, reduced frequency and activities, and 4) lack of enough evidence to estimate the increased burden on malnutrition as impacted by of COVID-19.

The nutrition partners' guidelines for operational modalities are adjusted to ensure a minimum standard of nutrition service deliver in the context of differing population mobility restrictions and access to health facilities while integrating COVID-19 risk reduction measures (e.g handwashing with soap, use of masks, physical) can be adapted against the four transmission scenarios (no cases, sporadic cases, cluster of cases, community transmission).

In discussion with partners, it is estimated that $1.6 million will be needed to ensure (1) technical and operational support including procurement and distribution of adequate supplies (2) capacity building of additional partners and volunteers in case surge support is needed during community transmission including setting up hotline IYCF counselling and support services (3) and coordination and information management to support adaptation of the guidelines at field level, dissemination of nutrition messages during the nine months depending on the situation. The 2020 HRP funding for the Nutrition Sector of $15.8 million is also essential to fulfil the nutrition COVID-19 response plan.

As for the nutrition support in the quarantine centre, an estimated 2,100 people will be assisted. Where possible, the nutrition support will include nutrition messaging and support for pregnant and lactating women and caregivers of young children, blanket supplementary feeding, meal planning (where wet feeding are being practised), micronutrient powder/ multi vitamin tablets and ensuring adherence to the nutrition food basket guidelines (where food baskets are being provided recognising the implementation might be challenging due to mobility in the quarantine centres).

WASH

The revision of the WASH Cluster Response involved the following steps:

1. Reviewed existing activities and priorities in the 2020 HRP that needed to be implemented in view of limitation and challenges affecting partner's response in the context of COVID-19 and what was feasible over 2020. This led to an outcome of needing to continue all activities, and/or expanding some activities and incorporating new ones to respond to the needs for prevention.
2. Reviewed additional request from other sectors and the MOHS in response to COVID-19, and the need to support in newly identified locations, such as quarantine/isolation centres, other communal facilities, and direct support to the MOHS and the Department of Disaster Management.
3. Reviewed contingency stocks and additional needs for key prevention supplies, such as water, hygiene items and handwashing stations (including WASH facilities at quarantine/isolation facilities). The need for additional supplies and materials was identified.
4. Reviewed financial needs for expanding WASH activities, and for the non-HRP returning migrants (60,000 people) added to the overall total people targeted. This resulted in additional funding requirement of $8.3 M or (25 per cent increase of HRP Core funding) for COVID-19-focused activities including expanded activities as well as new activities to assist both HRP caseload and returning migrants.
5. Reviewing the monitoring framework and including an additional key COVID-19 indicator as listed above.

The WASH Cluster established the following response strategy for four transmission scenarios.

1. No cases: Planned WASH activities continue, along with the COVID-19 priority actions/preparedness.
2. Sporadic cases: All planned WASH activities continue with the COVID-19 priority action/preparedness, and targeted responses where needed.
3. Clusters of cases: Increased COVID-19 priority actions/response to address the needs of vulnerable people in affected locations, alongside on-going planned WASH activities. Distribute extra hygiene kits on a monthly basis until the outbreak has been contained. Reduce on-ground staff presence where feasible. Extra training and PPE for implementers as appropriate.
4. Community transmission: Increased COVID-19 priority/response to address affected locations, alongside on-going life-saving WASH activities. Distribute extra hygiene kits on a monthly basis until the outbreak has been contained. Postpone all non-critical construction and maintenance activities. Reduce on-ground staff presence where feasible. Extra training and PPE for implementers as appropriate.