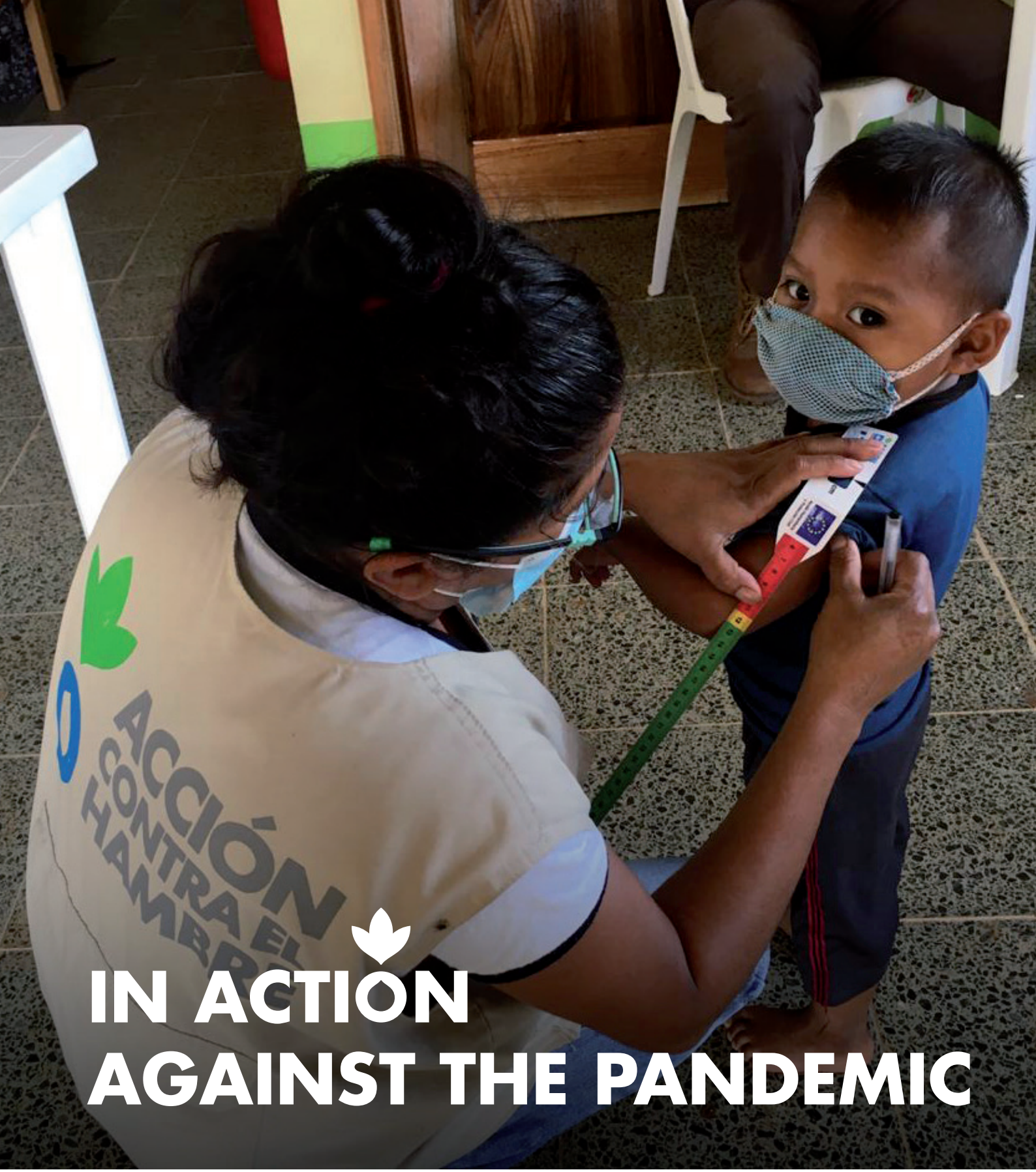

IN ACTION AGAINST THE PANDEMIC

DESCRIPTION AND SCOPE OF THE RESPONSE OF ACTION AGAINST HUNGER 2020 WORLDWIDE

ACTION AGAINST HUNGER

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COVID-19: Scope of the response of Action Against Hunger to the pandemic

1. INTRODUCTION

The COVID-19 pandemic had claimed nearly two million lives worldwide by the end of 2020, with more than 88 million confirmed cases worldwide. Beyond the health emergency, COVID-19 has generated an unprecedented socio-economic crisis that has doubled the number of people going hungry in just one year. According to official estimates, the number of people in a state of food crisis rose from 135 million to 260 million between January and December 2020.

Action Against Hunger, present in around 50 countries, mobilised from the very start of the emergency to help stop infections worldwide and mitigate the socio-economic consequences of the crisis.

THE OBJECTIVE of this document is to communicate the results of this intervention to our main stakeholders. The data included in this report reflects the virulence with which the pandemic has hit the different regions around the world in which we work. This is why this report reflects to a greater extent the work carried out in the Latin America and Eurasia[1] regions. Fortunately, the virulence has been lower in West Africa.

This report has been drawn up based on data compiled up to November 2020. In June 2021, we will draw up a full report on the scope and results achieved by the people, communities and institutions that have participated in our response to the COVID-19 emergency in 2020.

[1] Middle East, South Caucasus and Spain

2. DESCRIPTION OF THE RESPONSE TO COVID-19

The COVID-19 pandemic is a global health emergency that is having immediate consequences in all countries, particularly in countries with humanitarian crises that existed before the start of the pandemic. During 2020, 42% of Action Against Hunger's interventions, representing approximately 25% of the year's total volume, have been focused on preventing the causes and alleviating the immediate consequences of this crisis.

The populations that are suffering the most from this situation are people who:

- Have very limited or no access to a social protection system.
- Have very limited or no access to healthcare systems, water and sanitation systems
- Have livelihoods that are highly dependent on the informal economy.
- Have limited capacities to cope with economic change.
- Have limited or no access to technology.
- Work caring for the family increases to the detriment of their independence.

Before the pandemic, the beneficiaries of our work already had zero or very limited access to basic goods and services. The health emergency and measures to restrict movement and lockdowns aggravated this situation of vulnerability.

Action Against Hunger developed a technical response following the recommendations of the World Health Organization, based on the pillars[2], with the main emphasis put on the following five pillars:

PILLAR 1: coordination, planning and monitoring at the country level

PILLAR 2: communication of risks and community participation

PILLAR 3: tracking, rapid response teams and investigation of cases

PILLAR 6: infection prevention and control. Development of risk plans and training for their implementation (community and health centre structures)

PILLAR 8: operational and logistical support

Our response has been structured in two major lines of action:

1. CONTAIN AND PREVENT transmission of the virus by working at three levels: people, communities and structures.

2. MITIGATE the socio-economic and psychosocial consequences caused by the pandemic and measures restricting movement.

[2] https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020_es.pdf

3. SCOPE OF THE RESPONSE TO COVID-19: PEOPLE, COMMUNITIES AND STRUCTURES

In order to provide a response that is more sustainable over time, in addition to providing people access to the basic services most affected by COVID - healthcare, food, and sanitation and hygiene services - we have also worked with communities and institutions to increase their response capacity and resilience in the event of future outbreaks.

The main achievements up to December 2020 are described below: €31 661 086 achieved and 4 006 211 people have been beneficiaries of Action Against Hunger's response.

[3] Sector	People	Volume €
WATER, SANITATION AND HYGIENE	2 149 425	9 828 471 €
NUTRITION AND HEALTH	1 574 804	9 058 845€
FOOD SECURITY AND LIVELIHOODS	281 982	12 773 770 €

PEOPLE

56.4% of the people have received personalised services through the following actions that have been divided into three categories:

1. PEOPLE WITH ACCESS TO BASIC WATER, FOOD AND HEALTHCARE SERVICES

2. PEOPLE EQUIPPED WITH PROTECTIVE EQUIPMENT AND INFORMATION

3. PEOPLE WITH ACCESS TO SOCIAL PROTECTION SERVICES

[3] DRR (Disaster Risk Reduction) actions in the emergency response are not reflected in this table since the volume of activities in this sector has been relatively very low in the immediate response. Only training activities on preventive measures at the community level have been recorded in this sector. However, the volume of activity in the DRR sector will increase considerably in the COVID 21-23 programmatic response by strengthening community response and contingency mechanisms.

1. PEOPLE WITH ACCESS TO BASIC WATER, FOOD AND HEALTHCARE SERVICES.

Globally, 1.43 million people received personalised basic water, food and healthcare services, of which 51.4% were women.

WE HAVE GUARANTEED WATER, FOOD AND HEALTHCARE SERVICES DIRECTLY TO **1,4 MILLION PEOPLE**

1.1.

As the main preventive measure, 84.24% of the people who received basic **services had water access services.** Of these people, 76% received water distribution services through *water trucking* - (3.2K m3), and 9.85% actions to rehabilitate water supply infrastructure in households to improve the quality of their access to water.

WE HAVE DISTRIBUTED **3200 CUBIC METRES OF WATER** THROUGH WATER TRUCKING

Water trucking has allowed us to offer high coverage of access to water during the most immediate response to COVID-19. However, if we consider the fact that the forecast for the duration of the crisis is that it will be long term, we recommend increasing the proportion of water point rehabilitation activities at the household and/or community level. This second type of rehabilitation action for families entails continuous access to the more efficient service, reduces their dependence on informal suppliers, reduces the average cost of access to water per family and strengthens the responsibility holders that guarantee the provision of the service to cope with outbreaks in cases and other public health crises.

1.2.

14.52% of the people who received basic services, 208 213 people, received **food aid services.** They mostly received food distribution services (82%), with an average of 20.75 kg of food per person. The remaining 18% received conditional cash for food products (€1.4 million), with an average of €32.48 per person.

WE HAVE DELIVERED **21 KILOS OF FOOD PER PERSON** (3,6 TONNES)

One of the main reasons why such a high volume of food distribution was implemented during the emergency (3.6 tonnes of food) was due to supply problems in local markets due to restrictions on supplier movements. In the case of the West Africa region, 100% of the basic food services have been food aid services to compensate for supply problems in local markets.

In the Middle East and Africa, gender inequality has been observed among beneficiaries who have received this type of assistance, 44.6% and 10.6% of women beneficiaries respectively. Consequently, we recommend reinforcing actions aimed at equal resource management at the family level in both regions.

1.3.

Finally, as respects **basic nutrition and psycho-social support services,** 1.23% of the people, 17 690 people, received basic nutritional and psycho-social health services. In this case, 72.2% of beneficiaries have been women, on whom family care work has been accentuated during the pandemic. The main services in the field of health have been related to psycho-social support actions (75%), as well as actions aimed at the diagnosis and treatment of child malnutrition (17%) and sexual and reproductive health (8%). The reason why the proportion of basic nutritional healthcare services has been low at the global level has been because Africa is the region where we have the highest volume of operations in the field of nutrition. In this region, given the fact that the COVID-19 crisis has been less virulent, the nutrition and healthcare services that were being provided before the crisis have been maintained, allowing continuity of service.

2. PEOPLE EQUIPPED WITH PROTECTIVE EQUIPMENT AND INFORMATION.

Globally, 753 248 people were equipped with protective equipment (9 in 10 of them received hygiene kits and personal protective equipment - PPE) and participated in information sessions on basic preventive measures. These sessions provided detailed information on transmission mechanisms and preventive measures to be put in place to curb the evolution of the epidemic.

WE HAVE PROVIDED HYGIENE KITS AND PERSONAL PROTECTIVE EQUIPMENT TO MORE THAN **753 000 PEOPLE.**

In Latin America and Eurasia, the proportion of women and men who received this protection is balanced. However, the percentage of women who benefited is slightly lower (32%) in Africa.

3. PEOPLE WITH ACCESS TO SOCIAL PROTECTION SERVICES.

2% of the total number of people served, 73 645, received social protection services, of which only 35% were women. Almost all of these people (76%) received multi-purpose financial aid (not conditioned on a predetermined type of consumption). The average amount received per person was €43.40. The total amount of multi-purpose cash distributed to December 2020 was €4 million. In addition, 24% have received financial aid conditional on spending it on their livelihoods. In the case of Latin America, 100% was cash distributions, while only 64% was cash in Eurasia. However, it is interesting to highlight the change in trend in the case of Africa, since all the actions carried out in the field of social protection are conditioned on livelihoods. One of the reasons is that only in countries with a social protection system already in place, even if weak, the tendency is to supplement the existing social protection system with financial aid that is not conditioned on a specific type of spending. In countries with practically non-existent protection systems, it costs more to fund multi-purpose monetary aid actions and the tendency is still to condition the aid.

WE HAVE DISTRIBUTED MORE THAN **4 MILLION EUROS.**

It is important to highlight the fact that the intervention modalities carried out under social protection are precisely the actions that give the person greater autonomy and freedom to allocate the aid received to what they need most. In this regard, we recommend continuing to increase the multi-purpose aid approach, reinforcing actions aimed at reducing inequality in access to and management of resources at the family level.

COMMUNITIES

At the COMMUNITY level, our work has been focused on prevention actions:

1. Campaigns to raise awareness in the community on COVID prevention.
2. Training for community representatives
3. Improving the quality of access to water at the community level o

The objective of this approach has been to offer a response that is more sustainable over time in which there is ownership as respects the services by the community and to promote local leadership in IPC initiatives based on awareness of social and cultural dynamics and barriers in order to promote good practices for containing COVID.

Through campaigns to raise awareness and promotion of good practices based on local initiatives, we have managed to increase prevention coverage, training 1.74 million people on how to prevent and contain transmission.

OUR CAMPAIGNS TO RAISE AWARENESS ON AVOIDING INFECTION HAVE REACHED **1,4 MILLION PEOPLE**

It has also been necessary to strengthen capacities at the community level on prevention and treatment of COVID for 1131 nutrition and healthcare volunteers (43% women) to improve the capacity for identification, diagnosis and treatment at the community level.

This approach has been especially necessary due to mobility limitations and lack of access to services in hospitals and health centres. Furthermore, this approach is in line with our community approach and the Action Against Hunger localisation agenda, which favours an increase in direct work with local actors.

To help reduce the gender gap in community representation spaces, it would be recommendable to reinforce actions that encourage the participation of women in performing roles with good recognition at the community level, such as healthcare and nutrition volunteers.

WE HAVE BUILT **478 COMMUNITY WATER POINTS AND COMMUNITY LATRINES** FOR **1,4 MILLION PEOPLE.**

Finally, the third prevention action carried out at the community level has been focused on improving the quality of access to water through the provision of 478 water and handwashing points at strategic places for communities, such as markets, health centres, schools etc.

As well as building latrines from which practically 1.4 million people will be able to benefit.

STRUCTURES AND INSTITUTIONS

The work carried out at the STRUCTURES and INSTITUTIONS level has aimed to guarantee the continuity of service once Action Against Hunger's intervention is no longer necessary.

At the level of health structures, the Middle East and Africa have been the regions in which we have developed the most actions to support health structures. During this period, we have trained an average of nine healthcare professionals per centre on the diagnosis and treatment of COVID-19, as well as on measures to protect the healthcare personnel themselves, of which 40% have been women.

At the institutional level, some of the main achievements to which Action Against Hunger has contributed are detailed below:

• In **Lebanon,** we have managed to include the water and sanitation sector as a priority in the humanitarian response to COVID-19, thus mobilising an additional €60M for this from donors.

• In **Syria,** we have achieved exceptions to the sanctions regime established by donors to facilitate the response to COVID-19 (permission for interventions based on monetary aid).

• In **Niger,** we have managed to resume and increase UNHAS flights during the pandemic to ensure safe access for humanitarian teams throughout the country.

• In **Niger, Mali and Mauritania,** we have managed to include humanitarian teams as essential; consequently, they are exempt from the mobility limitations imposed by the authorities in response to the pandemic.

4. CONCLUSION

This pandemic is not a short-term emergency. The virus will leave a very deep imprint on the healthcare and socio-economic systems of all countries, especially the poorest.

Action Against Hunger has already designed a multiannual programmatic response (2021-2023) to help more than 4.2 million people. Our main objective will be to help mitigate the socio-economic and health effects of COVID on the most vulnerable people and guarantee the continuity of the basic services that most affect the fight against hunger as a preventive measure in the three regions in which we work as a priority: Latin America, Eurasia and the Sahel. In January 2021, our organisation presented to the humanitarian community three regional appeals (I)[4] that described the lines of action and calculated the funding required to make them a reality to be €138 million. Our organisation is looking for partners to be able to make this response effective while we work to advocate for nutrition, health, food and livelihoods to be essential pillars in the global response to the pandemic.

[4] http://bit.ly/RegionalAppeals2021-2023

ACTION AGAINST HUNGER

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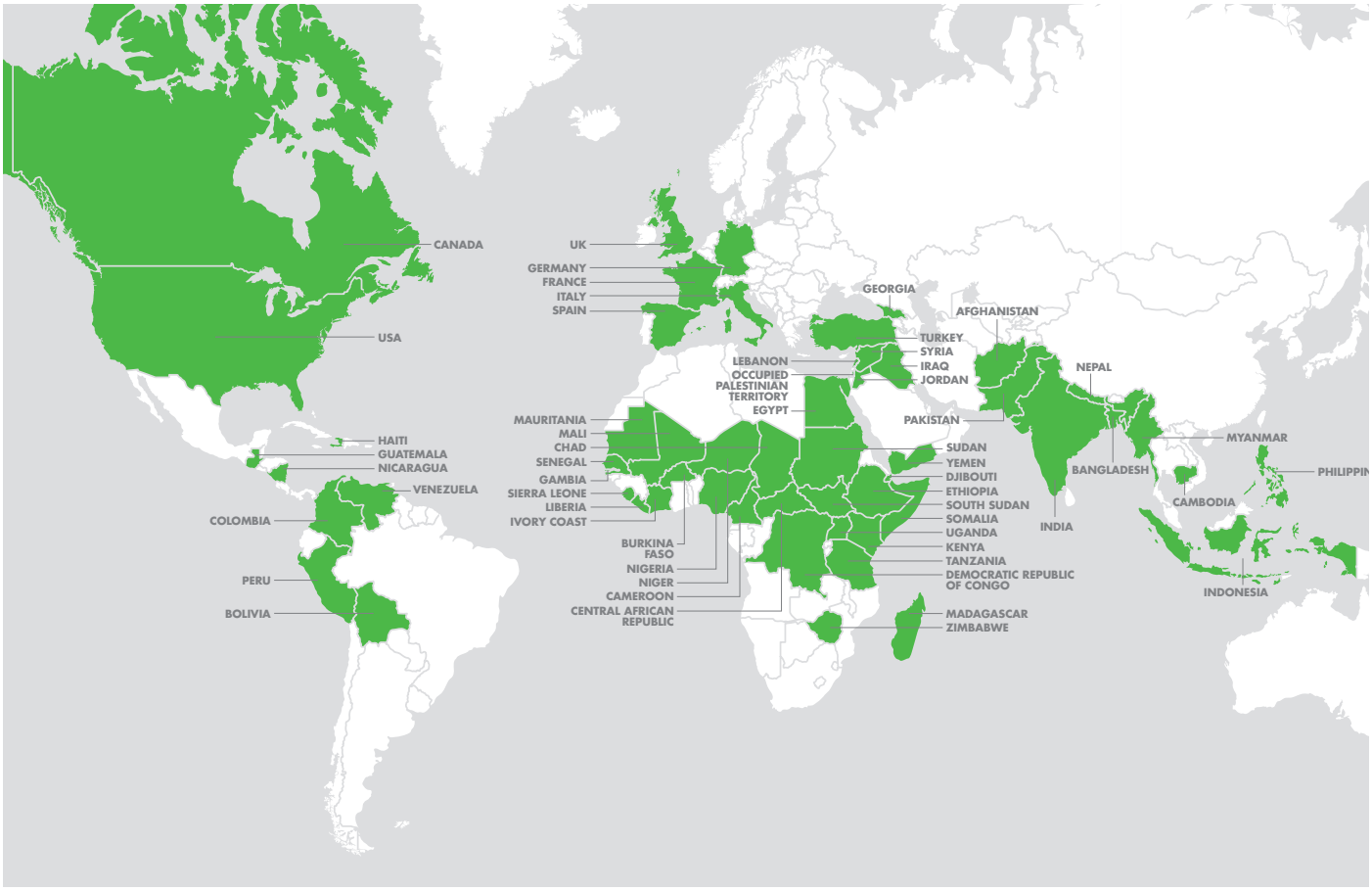
ACTION AGAINST HUNGER INTERVENES IN AROUND 50 COUNTRIES WORLDWIDE



www.accioncontraelhambre.org

Action Against Hunger is an international humanitarian organisation that fights against the causes and effects of hunger. We save the lives of malnourished children. We ensure that families have access to safe water, food, training and basic health care. We also work to free children, women and men from the threat of hunger. In Spain, we work against unemployment and for the social and labour market inclusion of people with difficulties in accessing the labour market.