

HUMANITARIAN RESPONSE PLAN

WITH HUMANITARIAN NEEDS

OVERVIEW

VENEZUELA

HUMANITARIAN
PROGRAM CYCLE

2020

JULY 2020



About

This document is consolidated by OCHA on behalf of the Humanitarian Country Team and partners. It provides a shared understanding of the situation, including the main humanitarian needs. It represents a consolidated evidence base for joint strategic response planning.

The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

COVER PHOTO

DELTA DEL ORINOCO, VENEZUELA

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Table of Contents

| | | | |
|----|---|----|--|
| 04 | Response Plan Overview | 44 | Part 3: Sectoral Plans |
| 07 | Humanitarian Needs Overview | | Water, Sanitation and Hygiene |
| | Socioeconomic context | | Shelter, Energy and Non-food items |
| | Impact on the population and services | | Education |
| | • Health | | Nutrition |
| | • Malnutrition and food insecurity | | Protection |
| | • Human mobility and protection risks | | Gender-Based Violence Area of Responsibility |
| | • Provision of essential services | | Child Protection Area of Responsibility |
| | • Coping mechanisms of those affected | | Health |
| 18 | Part 1: Strategic Response Priorities | | Food Security and Livelihoods |
| | Strategic Objectives and Response Approach | 75 | Coordination and Logistics |
| | • Response to critical problems related to physical and mental well-being | | |
| | • Response to critical problems related to living standards | 76 | |
| | • Response to critical protection problems | | |
| | Humanitarian access and operational capacity | 77 | |
| 39 | Part 2: Monitoring and Accountability | | |
| | Monitoring | | |
| | Accountability to Affected Populations and Protection against Sexual Exploitation and Abuse | | |

Response Plan Overview

| PEOPLE IN NEED | PEOPLE TARGETED BY THE 2020 HRP | FINANCIAL REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|----------------|---------------------------------|-------------------------------|----------|----------|
| 7M* | 4.5M | \$762.5M | 129 | 234 |

The humanitarian situation in Venezuela continues to have an impact on the physical and mental well-being, living conditions and protection of the 7 million^[a] people estimated to have humanitarian needs in 2019.¹

With the expansion of humanitarian space and the establishment of the international humanitarian coordination architecture in 2019, the United Nations and its partners scaled up the response, providing humanitarian and protection assistance to 2.4 million people.^[b]

Between January and May 2020, the expanding response reached 2.1 million people. This Humanitarian Response Plan (HRP) targets 4.5 million of the most vulnerable people – 53 per cent of whom are women and 47 per cent are men – requiring US\$762.5 million. This includes US\$87.9 million to respond to the health and socio-economic impact of the global COVID-19 pandemic, initially included in the Intersectoral COVID-19 Preparedness and Response Plan.² As of 14 June, more than US\$116 million has been received³.

Three interlinked strategic objectives guide the humanitarian response: (1) ensuring the survival and well-being of the most vulnerable people; (2) contributing to the sustainability of essential services and strengthening resilience and livelihoods; and (3) strengthening institutional and community mechanisms to prevent, mitigate and respond to protection risks.

Under the first strategic objective, the humanitarian response will focus on providing life-saving assistance with critical interventions in the areas of health, nutrition, food security, protection, and water, sanitation and hygiene contributing to four specific objectives related to people’s physical and mental well-being.

Related to the second strategic objective, the humanitarian response will focus on four specific objectives associated with living standards, including strengthening livelihoods, maintaining safe and effective access to essential goods and services (including health, education, water, sanitation and hygiene, cooking gas, and protection), and ensuring safe and dignified shelters for people on the move, including returnees in the context of the COVID-19 pandemic.

* Estimation in 2019

[a] Due to various positions on the methodology for aggregating multiple needs indicators from various sources of data, including official and non-official data, the 2019 estimate for the number of people in need is used. The most recent data available for multiple sectoral indicators, that provides the most up-to-date overview of needs, is published in a disaggregated manner.

[b] Estimated number of people who have been reached with humanitarian assistance at least once. This does not mean that all their needs have been met.

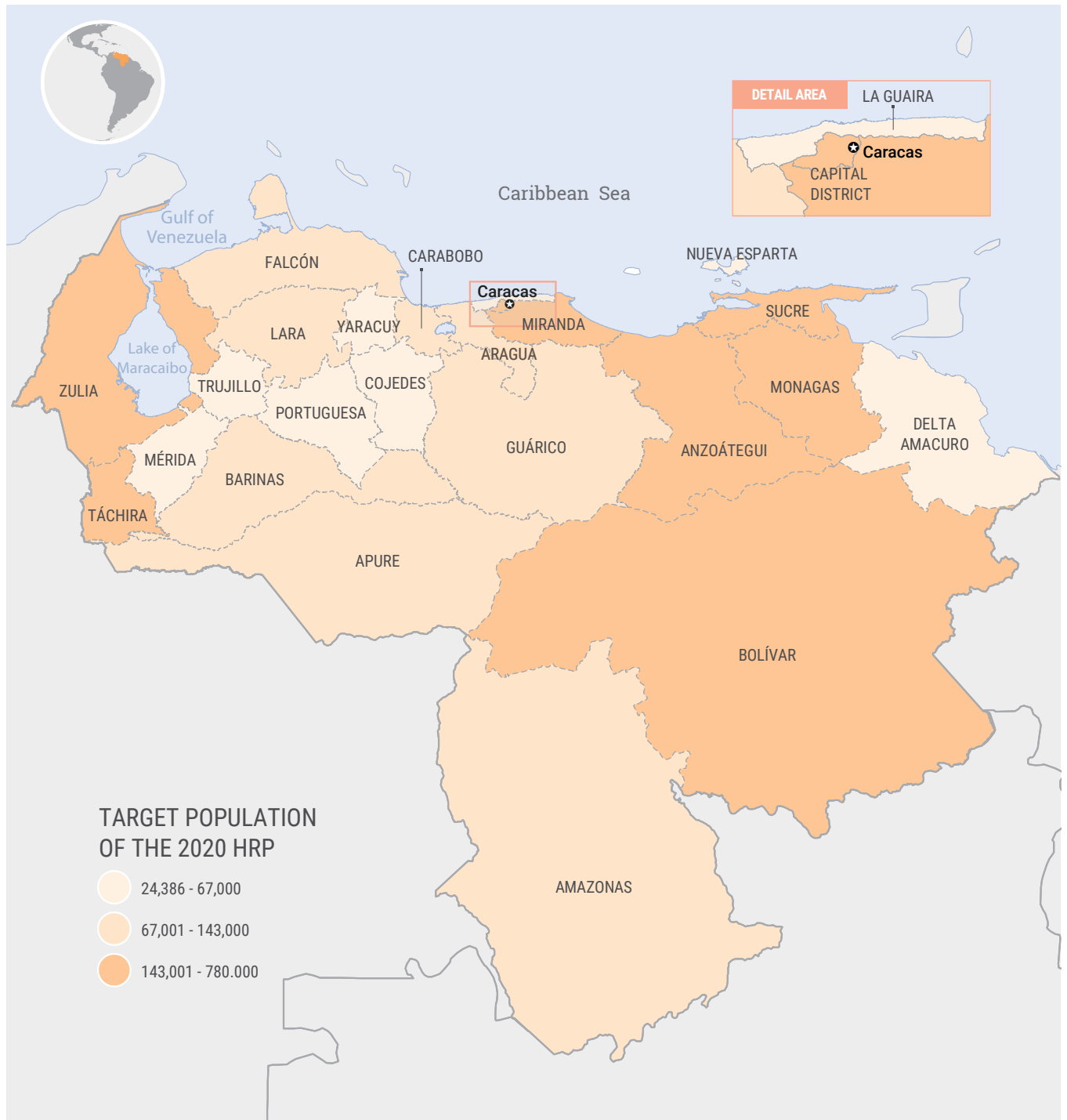
Under the third strategic objective, the humanitarian response will contribute to three specific objectives focused on prevention, mitigation and response to protection risks associated with human mobility, gender-based violence, as well as the abuse, exploitation and neglect of children and adolescents.

All humanitarian organizations that are part of the 2020 Plan are committed to implementing their activities based on the humanitarian principles of humanity, impartiality, independence and neutrality and the Joint Operating Principles for Venezuela, which outline common standards including the centrality of protection, accountability to affected populations (AAP), and protection from sexual exploitation and abuse (PSEA). The humanitarian response places affected people at the centre and takes into account the differentiated needs based on age, gender and diversity considerations.

The Plan was developed by the Inter-Cluster Coordination Group (ICCG), under the supervision of the Humanitarian Country Team (HCT) and was updated during 2020 based on consultations with the Government of Venezuela and other stakeholders including the National Assembly’s Special Commission for the Monitoring of Humanitarian Aid, factoring in important changes to the context due to the global COVID-19 pandemic. The objectives and focus set out in this Plan will be the basis for the response in 2020 and 2021. The Plan will be revised at the end of 2020 to take into account further contextual changes and to review the projects and financial requirements. Efforts will continue with all relevant stakeholders to improve humanitarian access for organizations that are part of the 2020 Plan, including United Nations agencies and international and national non-governmental organizations (NGOs).

Target population of the 2020 HRP

| PEOPLE TARGETED BY THE 2020 HRP | WOMEN | MEN | CHILDREN AND ADOLESCENTS | PEOPLE WITH DISABILITIES |
|---------------------------------|------------|------------|--------------------------|--------------------------|
| 4.5M | 53% | 47% | 47% | 13.9% |



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HRP Key Figures

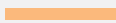







Humanitarian Response by Age

| AGE GROUP | TARGET OF THE 2020 HRP | % TARGET |
|-------------------------|------------------------|----------|
| Children (0 - 18 years) | 2.1 M | 47% |
| Adults (19 - 60 years) | 2.3 M | 51% |
| Elders (60+) | 100 k | 2% |

Humanitarian Response by Gender

| GENDER | TARGET OF THE 2020 HRP | % TARGET |
|--------|------------------------|----------|
| Boys | 1.0 M | 22% |
| Girls | 1.1 M | 24% |
| Men | 1.1 M | 25% |
| Women | 1.3 M | 29% |

Financial requirement by cluster

| CLUSTERS | REQUIREMENTS (US\$) |
|-------------------------------|---|
| Health | \$251.9 M  |
| Food Security and Livelihoods | \$158.1 M  |
| Education | \$106.1 M  |
| Water, Sanitation and Hygiene | \$105.3 M  |
| Protection* | \$69.3 M  |
| Shelter, Energy and NFIs | \$42.5 M  |
| Nutrition | \$19.0 M  |
| Coordination and Logistics | \$10.5 M  |

* The Protection funding requirement includes all the Areas of Responsibility (AoR) requirements which form part of the Protection Cluster [Child protection and Gender-based violence]

Humanitarian Needs Overview

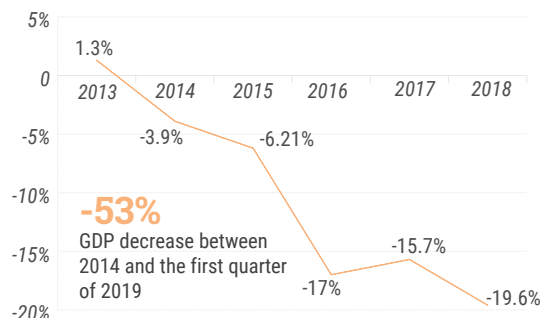
The humanitarian situation in Venezuela continues following six consecutive years of economic contraction and other trends and events such as inflation coupled with episodes of hyperinflation, political, social and institutional tensions, and the recent impact of the global COVID-19 pandemic. Household income, savings and consumption have all declined. Public spending, including significant investment in social programmes, which have been prioritized, and the ability to import and market goods and ensure essential services, have also been affected. While the Government has made significant efforts to maintain social protection programmes, the situation has negatively impacted the living conditions of the most vulnerable people, particularly in terms of their access to food, medicines and medical treatment. The functionality of infrastructure and essential services including water, electricity, domestic gas, fuel and transport have also been affected. In addition, and as a coping mechanism, the situation has led to considerable human mobility as people search for better living conditions and access to basic services and/or protection. People are moving both internally towards border, mining and urban areas, as well as to other countries. However, with the COVID-19 pandemic, there have been an increasing number of returnees, a trend that began several months before. In undertaking these movements, the most vulnerable people face protection risks and face multiple humanitarian needs.

The humanitarian response in Venezuela takes place in an atypical context. The country is classified as upper-middle income and the humanitarian needs are the result of economic challenges and high levels of political polarization, both at the national and international levels, as well as of situations of localized violence. In 2019, with the expansion of the humanitarian space and the establishment of the international humanitarian coordination architecture, the United Nations and its partners have been able to strengthen their presence throughout the country to provide humanitarian and protection assistance to the most vulnerable people.

Socioeconomic context

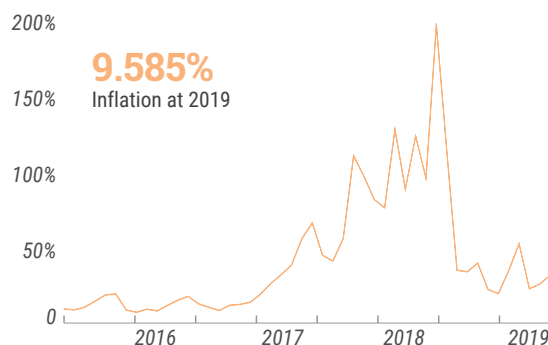
The underlying context of the humanitarian situation in the country is characterized by political and institutional tensions and by an economic contraction of the Gross Domestic Product (GDP) of more than 53 per cent between 2014 and the first quarter of 2019, according to official figures from the Central Bank of Venezuela. Hyperinflation registered its highest peak in 2018 with an annual inflation of 130,060 per cent, closing 2019 with an annual rate of 9,585 per cent. After rates stabilized in February and March 2020, inflation has been rising again since the outbreak of the COVID-19 pandemic, with a cumulative increase of 296 per cent in May 2020.

GROSS DOMESTIC PRODUCT (GDP) 2013 - 2018



Source: Central Bank of Venezuela, 2019

INFLATION 2016 - 2019



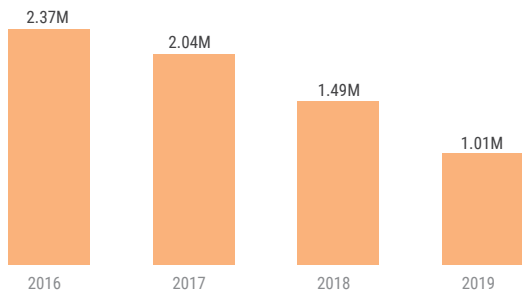
Source: Central Bank of Venezuela, 2019

The oil industry continues to face difficulties with production as well as severe international market restrictions. According to official figures, the oil sector continued to contract during 2019, closing the year producing 1,013,000 barrels per day. This represents a fall of 50.3 per cent compared to the average of 2.04 million barrels produced per day in 2017 and 64 per cent compared to the 2.8 million barrels per day produced on average before 2014.⁴ In addition, collapsing global oil prices since March 2020 due to COVID-19 are impacting the country's fiscal revenues as oil exports represent more than 70 per cent of the total.

The economic contraction has also had a negative effect on other sectors of the economy, as well as on investments in infrastructure and public services - especially public transportation, education, electricity, domestic gas, water and health services - affecting the population's access to them.

OIL PRODUCTION

NUMBER OF BARRELS PRODUCED PER DAY
2016 - 2019



Source: Organization of the Petroleum Exporting Countries, 2019

The economic situation has also affected household income. The purchasing power of pensions and the minimum wage set by the Government fell by more than 50 per cent in real terms over the past six years. Expressed in dollars, pensions and the minimum wage fell from US\$150 per month in 2013 to US\$6 per month in January 2020, including food stamps. Even with massive cash and asset transfers and subsidies for basic services and goods, including free education and food distributions, and minimal tax burdens on individuals, the reduction in real wages has made it difficult for households to access essential goods. In the focus groups organized by the United Nations System (UNS), and in other studies, many households indicate that their income is insufficient to purchase food and other basic goods.⁵

In recent years, the Government has implemented diverse social protection programmes and initiatives to address needs related to access to food, housing, health and education, among other areas. It has also provided subsidies on essential services and goods as well as cash transfer modalities and programmes for food assistance through the Local Committees for Supply and Production (CLAP, *Comités Locales de Abastecimiento y Producción*). The Government reported that the CLAP programme reached 6.2 million families in 2019 and a World Food Programme (WFP) food security assessment showed that 92 per cent of the families surveyed were receiving support from one or more social programmes. However, the scale, quality and regularity of these programmes has been affected.

In addition to the challenges outlined above, there is the economic and social impact of the COVID-19 pandemic. The first cases in Venezuela were confirmed on 13 March, after which the authorities responded rapidly by implementing rigorous social quarantine measures and suspending commercial, labour and education activities throughout the country. The Economic Commission for Latin America and the Caribbean (ECLAC) has projected serious negative consequences for the economies of the countries in the region due to the interruption of production processes, the decline in economic activity and the fall in commodity prices, especially for countries that export raw materials such as Venezuela. It is expected that the unemployment rate and the number of people in poverty and extreme poverty in the region will rise.⁶

In March, the Government of Venezuela officially requested the support of the UNS to combat the virus and the associated

socio-economic impacts. In April, given the significant number of Venezuelans returning from Colombia, Ecuador, Peru, Brazil and elsewhere due to the impact of the pandemic, the Government requested additional support to respond to the needs of returnees, who require particular attention to ensure compliance with health protocols.

Over the last year, the Government maintained the official exchange rate close to the unofficial market rate and eased legal restrictions on foreign currency transactions. Since 2019, the country has experienced rapid growth of transactional dollarization, with studies indicating that, on average, more than 60 per cent of transactions in the country in February 2020 were in some foreign currency. The share of transactions in foreign currencies was 40 per cent in April 2019.⁷ Although dollarization is a process that has benefited parts of the economy, the population's varying levels of access to foreign currency are possibly leading to growing inequality between those who have access to foreign currency and those who do not.

With the departure of millions of Venezuelans over the past several years, remittances have become an important source of income for those that remained in the country and a way to access foreign currency. However, given the partial paralysis of the economies in the regional countries hosting a high number of Venezuelan migrants and refugees, there has been a reduction in remittances in the context of COVID-19.

There are multiple causes for the economic contraction in Venezuela. Some point to inadequate and inappropriate economic policies, inefficient management and the lack of transparency. Others highlight the impact of the economic sanctions especially on international financial transactions and the oil industry, which is the country's main source of income. The sanctions were extended to third parties such as buyers, suppliers and transporters, making it difficult for both the Government and the private sector to export oil and import gasoline, basic goods, spare parts for industry and to maintain basic service provision, among others. According to the United Nations High Commissioner for Human Rights, while the economic downturn predates the imposition of sanctions, there are concerns about their impact on the economy and the humanitarian situation.⁸ Whilst there are exceptions that allow for the importation of medicines, food and supplies for humanitarian action, the High Commissioner has indicated that overcompliance in the international financial sector is impacting the availability of State resources for social programmes and public services, and for the population in general. This concern has been restated by the High Commissioner in light of the global COVID-19 pandemic.⁹

Impact on the population and services

The economic and political situation has an impact on people at different levels: on their physical and mental well-being, their living standards and their protection environment. The consequences are felt in health, food security, nutrition, protection, and access to essential goods and services such as education, water, electricity and domestic gas. Faced with these prospects, the population, and especially the most vulnerable people, have adopted coping strategies

that include moving to alternative locations both internally and outside the country. These population movements result in changes to family dynamics that have particular impacts on the lives of women, elderly people, children and adolescents.

Health

The health system in Venezuela is currently under strain as a result of several factors. These include the departure of personnel from the health system due to low salaries among other factors; disruptions to the primary healthcare system and hospital infrastructure; interruptions in water and electricity supplies; and shortages of drugs and medical supplies. In 2020, the humanitarian response seeks to reach 4 million vulnerable people, with a focus on strengthening the capacity of the health system to address priority needs related to communicable and non-communicable diseases, sexual and reproductive health, maternal and child health, and mental health.

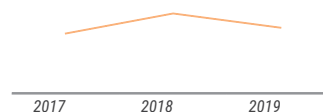
Recent years have seen the reappearance or an increase in the incidence of some communicable diseases. In 2018, 404,924 cases of malaria were reported. Transmission remained high in 2019, with 323,392 cases reported up to October of that year, with a 55 per cent increase in the number of pregnant women with malaria being reported nationwide.¹⁰ Although the malaria outbreak was initially concentrated in the states of Bolívar and Amazonas, since 2010 there has been an increase in the number of cases registered nationally. By 2016, malaria cases had been reported in 16 of the 24 states of the country. The municipality of Domingo Sifontes in the state of Bolívar had the highest number of cases nationally (43 per cent of the total reported). The epidemiological trend is associated with the expansion of gold mining and the arrival of people from other states and countries.¹¹ Internal human mobility stimulated by the allure of mining led to the disease reaching other parts of the country, as miners and their families returned to their home communities. As a result, malaria has reached areas where no cases had been reported for decades.

The diphtheria outbreak that began in July 2016 is ongoing, with a total of 3,060 people suspected of having diphtheria and 292 deaths recorded as of December 2019.¹² In addition, a case of yellow fever was confirmed in November 2019 in the state of Bolívar. It was the first confirmed case in Venezuela since 2005, and the only one up to today.¹³ Estimates by the Ministry of People’s Power for Health (MPPS, Ministerio del Poder Popular para la Salud) and the Pan American Health Organization (PAHO)/World Health Organization (WHO) indicate that 4.5 million people between the ages of 2 and 59 are susceptible to yellow fever because they have not been vaccinated and reside in ten priority states.¹⁴ Similarly, since the beginning of the measles outbreak between July 2017 and 2019, the country reported 7,054 confirmed cases and 84 deaths, with more than 62 per cent of all cases in children under age five. A high number of cases was reported in indigenous communities.¹⁵ However, the outbreak was declared under control in January 2020 through the efforts of the authorities with support from humanitarian partners. The decrease in the number of states affected by measles went from 23 at the end of 2018 to just one in August 2019.¹⁶ As regards to diphtheria, there was a 60 per cent decrease in suspected cases reported in 2019

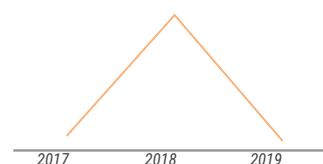
compared to 2018.¹⁷

COMMUNICABLE DISEASES

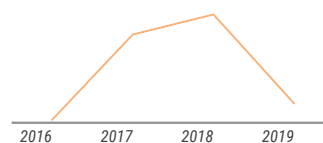
404K
Cases of malaria (2018)



7,054
Cases of measles (July 2017 to December 2019)



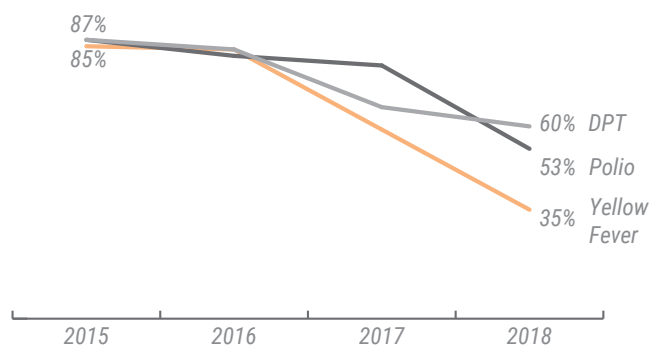
3,060
Suspect diphtheria cases (2016 to 2019)



Source: MPPS, 2019

A challenge to control communicable diseases has been the lack of sufficient vaccines in the country and significant shortcomings in the functioning of the cold chain, aggravated by recurrent power outages. The vaccination coverage of the regular immunization programme for children under one year of age has decreased since 2015. This includes the pentavalent vaccine coverage, whose coverage was 87 per cent in 2015 and dropped to 60 per cent in 2018, with more severe gaps in hard-to-reach areas such in the Delta Amacuro and Amazonas states, where coverage can reach as low as 25 per cent. Measles, mumps and rubella (MMR) vaccine coverage was 92 per cent in 2015 and dropped to 74 per cent in 2018; polio vaccine coverage was 87 per cent in 2015 and dropped to 53 per cent in 2018; and yellow fever vaccine coverage was 85 per cent in 2015 and dropped to 35 per cent in 2018.¹⁸

VACCINATION COVERAGES 2015-2018

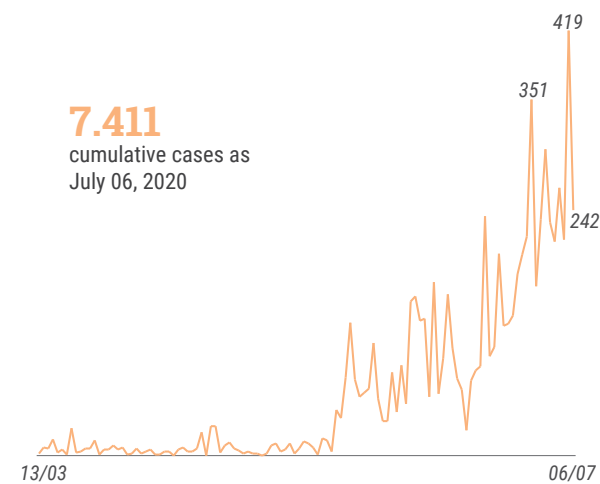


Source: MPPS, 2018

In the response to communicable disease outbreaks, water and environmental sanitation activities are critical since some diseases (foodborne diseases and vector-borne diseases) are linked to limitations in access to safe water and to the management of solid waste and stagnant water. High levels of hepatitis A have been reported, as well as the proliferation of related intestinal and dermatological diseases.¹⁹ Between December 2018 and June 2019, 714,536 cases of diarrhoea had been registered in the country, with 171 deaths, the highest incidence rates being among children under one year of age.²⁰

In addition, in health facilities, the lack of continuous and quality water supply, as well as the non-implementation of appropriate hygiene protocols, can lead to intrahospital infections. An assessment of water, hygiene and sanitation (WASH) conditions in 17 hospitals conducted by PAHO/WHO in 2019 found that 88.3 per cent of the assessed hospitals present a high risk that hygiene and sanitary conditions pose a health risk to patients and staff; the rest face a medium risk. The assessment also reported that 70.6 per cent of sanitation services and 94 per cent of the handwashing points were not functional. Hospital waste management was also found to be deficient. Taking these elements into consideration, activities are planned to ensure minimum hygiene and sanitation conditions at health facilities. The link between health and WASH is even more important in the context of COVID-19, which requires the inclusion of infection prevention and control (IPC) activities in all operational sectors.

COVID-19 DAILY CASES



Source: Presidential Commission for COVID-19, July 2020

On 13 March 2020, the authorities confirmed the first two cases of COVID-19 in Venezuela. As of 6 July, 7,411 confirmed cases had been reported. The authorities implemented timely preventive and response measures, which initially helped keep the infection rate low, with the health system’s response capacities supported by humanitarian action. In the event that there is an exponential increase in COVID-19 cases, it will be important to significantly increase the health system’s initially response capacity, including the availability of testing equipment and supplies, personal protective equipment,

and treatment capacity, including ventilators and intensive care beds. Another challenge is the lack of access to water and sanitation in health facilities, and the absence of qualified personnel where more than 30 per cent are estimated to have left the country.²¹ Elderly people, people with underlying health problems, health professionals, people with limited access to water, sanitation and hygiene, and indigenous communities are some of the most vulnerable groups to the pandemic.

In light of this situation, a priority line of action for the humanitarian response will be to strengthen the health system’s capacity to deal with outbreaks of communicable diseases, with the aim of reducing mortality and morbidity risks. The response will continue focusing on priority health facilities, including hospitals and COVID-19 sentinel centres. The response will ensure above all the provision of medicines and medical supplies and the functioning of water, sanitation and hygiene services so that critical services can be maintained. In relation to communicable diseases, strengthening the regular immunization programme to keep vaccination coverage above 95 per cent throughout the country will be a priority as will be supporting the epidemiological surveillance system which is the most effective way to prevent the reintroduction of communicable diseases.²²

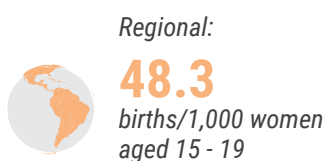
Risk communications and community engagement are key cross-cutting components in the response to COVID-19. A continuous dialogue with populations is required to transmit the latest information updates, and special attention is placed on ensuring that information is accessible to different groups (including indigenous communities and people with disabilities, among others).

A further priority line of action is to improve sexual and reproductive health services, with an emphasis on maternal and child health. According to public reports of the MPPS, between 2015 and 2016 maternal mortality increased by 65.8 per cent.²³ In 2019, 352 women died during pregnancy, childbirth and postpartum (98.87 deaths per 100,000 live births). This is a 17 per cent reduction compared to the same period in 2018 (426 deaths). Also, an average of 11 deaths per week were reported during the same period in 2019; 96.9 per cent were in-hospital deaths.²⁴ The availability of safe blood for obstetric haemorrhaging, one of the leading causes of maternal death, is limited in many facilities due to deteriorating blood bank equipment, insufficient staffing, and intermittent lack of serologic tests. The limited availability of sexual and reproductive health services and supplies, including contraceptive methods, has exposed women, and especially adolescents, to unwanted pregnancies and to sexually transmitted diseases including HIV. It is estimated that there is an 80 per cent shortage of contraceptive methods in both the public network and private pharmacies. Although the availability of contraceptive methods has improved in the last year, the range of supplies is limited and the cost is out of reach for most of the population, including adolescents. In 2019, 85 births per 1,000 women aged 15-19 were reported, well above the regional average (48.3 per 1,000 women aged 15-19).²⁵ This has prompted some women to migrate or move to have access to goods and services, including obstetric care and safe abortions, since abortion is not legal in Venezuela. Adolescent pregnancy can result in increased maternal

mortality from unsafe abortions and has an impact on school attendance of pregnant adolescents.

Early pregnancies also carry risks to the health of the newborn. In 2014, 9,065 infant deaths were reported for an infant mortality rate of 15.2 per 1,000 live births, and a neonatal mortality rate of 11.1 per 1,000 live births. The latter rate is estimated to have increased from 14.5 to 19.8 deaths per 1,000 live births between 2015 and 2017.²⁶ Infant mortality is significantly higher among indigenous people.²⁷ The response will focus on facilitating access to health services, including sexual and reproductive health, for indigenous communities in remote areas. Humanitarian health actors will continue to aim at reducing maternal and neonatal morbidity and mortality, through the training of health workers, procurement of essential drugs and family planning methods, and the delivery of emergency sexual and reproductive health kits, among others.

ADOLESCENT FERTILITY RATE



Source: PAHO, 2019

Other public health concerns include mental health and psychosocial support issues. Living in difficult conditions for a prolonged period can cause fear, anxiety, distress and depression for those affected, particularly women and girls. In the context of the COVID-19 pandemic, these sentiments may be exacerbated, as preventive quarantine may have negative psychological effects, such as confusion, anger, exhaustion and detachment, and may even lead to post-traumatic stress disorder and depression. Many of the symptoms are related to fear of infection, frustration, boredom, lack of supplies or information, financial loss and stigma. In addition, health care workers may experience additional stress due to stigmatization for working with patients with COVID-19 and spreading it to family members or friends, among others.²⁸ In this context, the response will incorporate mental health and psychosocial support activities with a gender, age and diversity approach to ensure the well-being of the most vulnerable people, which will be integrated into health, protection and education actions.

Another humanitarian priority health need is access to medicines and adequate care for people with acute and chronic life-threatening illnesses. According to the results of focus group discussions organized by the UN, the lack of availability or high cost of medicines

is reported to be one of the main difficulties faced. To address this, many affected people have adopted various coping strategies, such as purchasing medicines, including contraceptives, through alternative mechanisms, relying on family members outside the country to send medicines, leaving the country to buy medicines, and using traditional treatments. The most affected groups include the 120,000 people living with HIV.²⁹ While the national prevalence rate for HIV/AIDS infection is 0.6 per cent, it is higher for men who have sex with men and gay men (22.3 per cent), trans women (35.8 per cent),³⁰ and female sex workers along the border (3.7 per cent).³¹ Indigenous communities are also particularly vulnerable. For example, the Warao population, located in the state of Delta Amacuro, has a high rate of infectious diseases, including tuberculosis, sexually transmitted infections (STIs), and HIV (average prevalence of 9.1 per cent). In 2016, 61 per cent of people living with HIV had access to antiretroviral treatment and 48 per cent of pregnant women had access to antiretroviral treatment for the prevention of mother-to-child transmission.³²

Regarding non-communicable diseases, the mortality rate in 2014 was 123,500 (76 per cent of total deaths in the country),³³ the majority dying from heart disease, cancer, diabetes, and cerebrovascular disease. Official data reports 90,000 deaths in 2019 from chronic non-communicable diseases due to difficult access to diagnosis and treatment. Under typical humanitarian conditions, the humanitarian health response involves the provision of health services, medicines and supplies for acute diseases. However, little attention has been paid to non-communicable diseases that are widespread in the population and are exacerbated by the lack of health personnel, shortages of medicines or supplies to treat complications. In the context of Venezuela, it is necessary to include non-communicable diseases in the response, identifying some basic supplies for both institutional and community action.³⁴

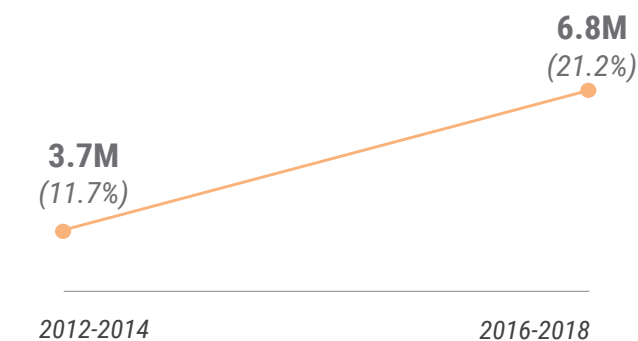
Malnutrition and food insecurity

The humanitarian situation has reduced people's access to nutritious food and a balanced diet, mainly due to a loss of households' purchasing power, but also to limitations in the availability of some products³⁵ due to challenges in guaranteeing the necessary inputs (seeds and fertilizers, among others) for local agricultural production. The preventive measures implemented in the country to deal with the COVID-19 pandemic may further impact the income and livelihoods of the most vulnerable people. Results of the survey conducted by the Government in April 2020 through the Sistema Patria indicate that 88 per cent of those surveyed perceive that food supply requires priority actions in the context of COVID-19. In 2020, the humanitarian response will seek to strengthen food and nutritional security, reaching a target population of 1.1 million vulnerable people with food support and 700,000 vulnerable children under age 5 and pregnant and lactating women, with nutritional support.

According to the State of Food Security and Nutrition in the World (SOFI) 2019, Venezuela has seen an increase in the undernourishment rate from 11.7 per cent (3.7 million people) in 2012-2014 to 21.2 per cent (6.8 million people) in 2016-2018.³⁶ Given the risk of a possible

deterioration of the current situation, the United Nations Food and Agriculture Organization (FAO) has included Venezuela in the list of countries under close observation.³⁷ In contrast, the Government of Venezuela indicates that the undernourishment rate for 2016-2018 is 10.3 percent.

UNDERNOURISHMENT RATE



Source: SOFI, 2019

Additionally, the food security assessment carried out by WFP between July and September 2019 estimates that 2.4 million people are severely food insecure. These people will be the focus of the humanitarian response because they are experiencing livelihood depletion and extended periods of low food consumption. The WFP assessment also identified some seven million moderately food-insecure people^[c].

Both the WFP assessment and UN focus group discussions report that, to cope, many households have been obliged to reduce the number of meals per day, the size of meal portions or the consumption of various types of nutritious food, especially protein, and/or to buy cheaper/less preferred food. Households have also adopted negative measures that impact their livelihoods such as taking on debt, depleting savings, selling assets and reducing health and education expenditures.

In this context, the humanitarian response will seek not only to provide immediate food assistance to the most vulnerable people through food distributions, but also to contribute to the restoration of livelihoods and strengthening household resilience through the distribution of seeds, small animals and production inputs, technical assistance and the promotion of models for local or endemic seed production and the rescue of ancestral products and traditional local recipes, among others.

The implementation of these activities considers that food insecurity has a gender-differentiated impact. Analysis based on the National Statistics Institute's (INE, Instituto Nacional de Estadística) Household Sampling Survey (EHM, Encuesta de Hogares por Muestreo) for the second half of 2018 indicate that around 46 per cent of all households are headed by women, of which 34.8 per cent have a low level of education and hold low-skilled jobs or are engaged in household

tasks, and are likely to experience greater difficulty in meeting their basic needs including food. In addition, the burden of women's unpaid family care work has increased due to the time needed to acquire and prepare food,³⁸ as well as changes to the diet and nutrition (for example, prioritizing feeding their children). In the context of COVID-19, UN Women has warned about the survival strategies and economic autonomy of women headed households, who tend to be over-represented in informal employment.³⁹ In this situation, the response will provide nutritional care services appropriate to the needs of women and girls and will seek to promote more income-generating opportunities through local initiatives with a gender perspective.

Food insecurity also has an age-differentiated impact. Several sources, including focus group discussions with affected people, report that elderly people often have more difficulty accessing food.⁴⁰ In relation to children and adolescents, school feeding programmes are critical for food security and school attendance. The Ministry of People's Power for Education (MPPE, Ministerio del Poder Popular para la Educación) reports having provided five million meals through the School Feeding Program in 2018. The WFP assessment carried out in 2019 also reports that 59 per cent of children and adolescents receive daily or near daily school meals. The humanitarian response in 2020 will include support to school feeding programmes as part of its priority actions to strengthen children's food security and increase motivation to attend and stay in school.

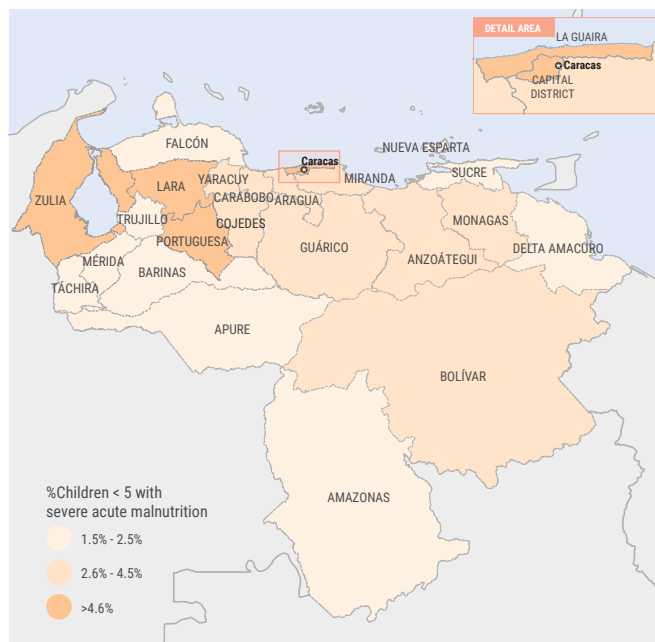
Limitations on access to food, safe water, hygiene items and basic information on good feeding practices in the most vulnerable households have also affected the nutritional status of children under age 5. These have had repercussions on their physical and cognitive health and development. According to data from the National Institute of Nutrition (INN, Instituto Nacional de Nutrición), in 2019, 106,326 children under age 5 (4 per cent of this population group) are affected by severe acute malnutrition. The highest malnutrition rates are found in the states of Zulia, Miranda, Lara, Capital District, Carabobo and Portuguesa. The INN also estimates that 284,591 children under age 5 (10.6 per cent of this population group) are at risk of acute malnutrition. Some civil society organizations report additional cases in their areas of intervention that are not included in the INN's screening. Children from more vulnerable households who have recovered from malnutrition are at risk of relapsing due to the difficulties faced by poorer families in providing a varied and nutritious diet. The most vulnerable groups also include adolescents, who tend to receive smaller food portions in the most vulnerable households where food is rationed.

In addition, pregnant and lactating women, particularly those from indigenous and adolescent groups, are more vulnerable to malnutrition and are more exposed to complications related to lack of access to WASH. According to INN data, an estimated 125,305 pregnant and lactating women are underweight (9.8 per cent of the population group), with the highest rates reported in the states of Mérida, Trujillo, Yaracuy and Táchira. The SOFI also reports 304,910 pregnant and lactating women are affected by anaemia (24 per cent of the population group).

[c] The Government of Venezuela has expressed reservations with regards to the methodology of the WFP food security assessment; their analysis also differs from the WFP estimate that 7 million people are moderately food insecure.

Based on the analysis of the nutritional situation, ensuring the survival, recovery and well-being of those most affected by malnutrition will be a priority for the humanitarian response in 2020. Humanitarian actors' nutrition programmes will focus on providing nutritional supplements for the prevention of acute malnutrition, conducting nutritional screening for the identification, diagnosis and treatment of cases of acute malnutrition, and promoting appropriate infant and young child feeding protocols, integrated with key health, food security and WASH messages and practices.

CHILDREN UNDER AGE 5 WITH SEVERE ACUTE MALNUTRITION



The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Source: INN, 2019

Human mobility and protection risks

As a coping strategy, a significant number of people have decided to move both outside and within the country, impacting their communities of origin, transit areas and host communities. In 2020, humanitarian actors will provide a multi-sectoral response to people on the move and communities affected by such human mobility, with a focus on mitigating associated protection risks and ensuring safe and dignified shelter conditions for people on the move most in need.

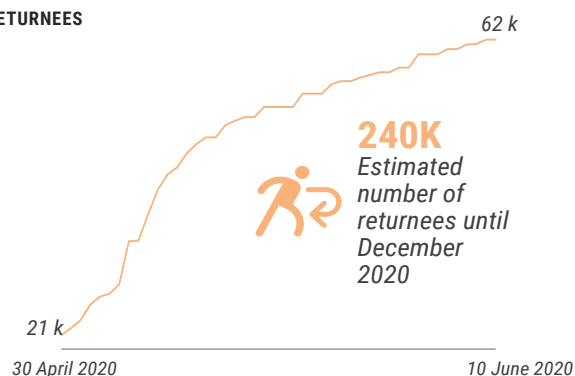
In relation to external mobility, as of 5 May 2020, the Regional Interagency Coordination Platform for Refugees and Migrants of Venezuela, based on data reported by host governments, estimated there were about 5.1 million Venezuelan migrants and refugees worldwide, most of them in countries of the region.⁴¹ In contrast, the Government of Venezuelan indicates that migration is significantly more limited in scale, estimating that there were about 1.2 million national migrants between 2015 and 2019 according to data from the Administrative Service for Identification, Migration and Foreigners (SAIME, Servicio Administrativo de Identificación, Migración y

Extranjería).

Since 2019, but especially with the COVID-19 pandemic, a new phenomenon of human mobility has taken place with an increasing number of returnees to Venezuela. The returns are the result of many factors including: fewer economic opportunities and the lack of social protection and housing in neighbouring countries; the lack of legal status in these countries; the experience having not met migrant expectations; and greater support networks among their families and communities in times of crisis. According to official figures, between 6 April, when the mandatory quarantine for returnees was established, and 10 June, 56,633 people returned to Venezuela. This gives an average of almost 1,100 people returning to the country daily. Additionally, since the beginning of the national quarantine and the closing of the border by Colombia in mid-March, some 40,000 people have returned, many engaged in pendular movements, equating to a total return of more than 90,000 people during the COVID-19 pandemic, according to official figures.

Most of the returnees have entered Venezuela through the state of Táchira and, to a lesser extent, Apure, Zulia and Bolívar, as well as with humanitarian flights organized by the Foreign Ministry. Since returnees must comply with established health protocols, including a minimum quarantine period of 14 days in accommodation centres in border areas and in the state of La Guaira, where returnees arrive by air, the authorities have requested support to ensure the provision of essential services to this population. It is expected that the flow of returnees to Venezuela will continue. Based on the average daily flow since 6 April, it could reach around 240,000 people by the end of the year. The Government estimates that the number could increase rapidly when quarantine measures are relaxed in neighbouring countries.

RETURNEES



Source: OCHA estimate based on Ministry of Foreign Affairs data, 2020

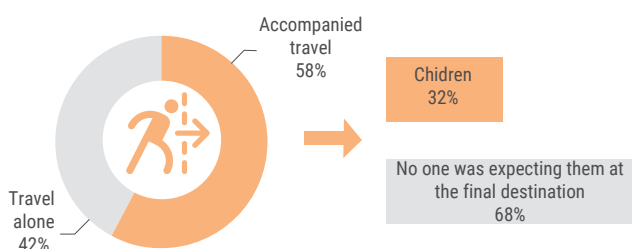
Although there are no official figures on the scope of internal mobility at the national level, various monitoring tools show that a significant number of people have moved from the interior of the country to border areas. Before the COVID-19 quarantine and the increased border controls, people made regular back-and-forth movements across the border for economic purposes. Others have moved to municipalities and communities in urban areas such as Caracas and to mining areas such as in the state of Bolívar in search of economic opportunity. The pilot exercise of the Mobility Tracking Matrix carried

out by the International Organization for Migration (IOM) between September and October 2019 in the state of Táchira and Caracas showed that some border communities such as Nueva Arcadia in Caracas have seen their populations increase by 75 per cent over the 2011 census population. In some communities in the Caracas metropolitan area, the tool reported a population increase of 10 per cent, and up to 32 per cent in some communities in the state of Miranda. It is possible that some of these trends have slowed or reversed due to COVID-19 quarantine measures. In 2020, the expansion of data collection efforts on human mobility will improve the understanding and analysis of the situation and facilitate a more efficient response to the needs of people on the move.

External and internal human mobility is mainly caused by the search for economic opportunities and better access to essential goods and services. A United Nations Population Fund (UNFPA) study on the profile of women on the move in border areas in 2019 showed that 91 per cent of respondents (almost 10,000 women) decided to move because they hope to increase their incomes and improve their economic situations.

Some people are also moving because of the risk of violence in their places of origin and the negative impact on systems of protection. Based on the results of United Nations High Commissioner for Refugees' (UNHCR) participatory assessment with communities, the main protection risks are related to: violence and armed conflict; sexual and gender-based violence and abuse; human trafficking, especially labour and sexual exploitation; recruitment and forced labour of children and adolescents; family separation, particularly in border and mining areas.⁴² This situation affects women and girls in particular, as they represent around 70 per cent of victims of trafficking and exploitation and risks of gender-based violence. UNFPA's profile of women on the move showed that 32 per cent of respondents were travelling with their children, 42 per cent were travelling alone, and 68 per cent did not have anybody waiting for them at their final destination, increasing the risks of sexual and labour exploitation, among others.

PROFILE OF WOMEN ON THE MOVE



Source: UNFPA, 2019

Considering these risks, the institutions responsible for the protection of children and adolescents and the protection, prevention and response to gender-based violence and human trafficking and smuggling do not always have the necessary resources to identify, provide care for and follow-up on those affected. For example, the Public Prosecutor's Office reported a significant decrease in the

number of protection measures granted to gender-based violence victims, from 86,889 in 2017 to 45,188 in 2018, which suggests insufficient resources or capacities to ensure an appropriate response to all survivors, due to high staff turnover, among others.

In collaboration with relevant State institutions and with the involvement of affected communities, protection is a cross-cutting priority for the humanitarian response. People's protection needs will be addressed through identifying them through humanitarian protection monitoring, the systematic referrals of cases, the provision of quality services and assistance and strengthening community protection. For women, girls and adolescent survivors of gender-based violence, the provision of gender-based violence case management, the clinical management of rape, psychosocial care, legal counselling, material assistance, safe shelter, food and transportation will be assured. In the context of the preventive quarantine to address COVID-19, which brings the risk of increased domestic violence, coupled with the interruption of prevention and response services, it is necessary to ensure access to critical protection services for those in need, including the establishment of hotlines for individual case management.

People on the move, including returnees, need safe temporary accommodation, access to essential goods and support to deal with protection risks, taking into account age, gender and diversity dimensions. Health protocols require returnees to be housed in collective shelters, some of which are called Comprehensive Social Service Points (PASI, Puntos de Atención Social Integral). These include hotels, sports centres, schools, churches and other improvised spaces. Plans to develop temporary camps are envisaged. Given the high number of returnees who need to be accommodated, the PASI require support in terms of improving shelters, ensuring access to safe water, adequate sanitation, NFIs and food, and the provision of protection services, including those addressing gender-based violence and the protection of children and adolescents. In addition, it is necessary to ensure the use of health protocols in these spaces, including physical distancing, IPCI, and protective equipment for staff. In this context, humanitarian interventions in temporary shelters will focus on building, repairing or equipping these spaces to fulfil their basic function of ensuring adequate and dignified shelter for people on the move and providing access to food and basic goods, including hygiene kits. Information on services available for the prevention, mitigation and response to gender-based violence will also be provided. The most affected states include Táchira, Zulia, Apure, Amazonas and Bolívar.

Many of the returnees will likely need support in their places of origin; many have no income and limited economic resources because they likely sold their assets or used their savings during the migration process. In addition, many of their relatives who stayed in their areas of origin depended in part on the remittances they sent from neighbouring countries.

Other people on the move, particularly before COVID-19, need support while in transit and when trying to settle in border areas. For example, in 2019 in the border areas of the state of Táchira, such as San

Antonio, Ureña and Boca de Grita, there was a rise in the number of people arriving from the centre of the country. This put an increase in pressure on services in these communities, and people resorted to sheltering in empty warehouses or buildings. In general, these existing temporary housing options have limited capacities and often lack basic facilities and services, and as well as compliance with minimum protection and security standards. This increases the vulnerability of these people in terms of protection and gender-based violence, especially women, girls, boys, indigenous people and LGBTI people. Internal mobility may restart with the relaxation of the COVID-19 quarantine.

Other challenges faced by people on the move are associated with civil registry procedures and obtaining identity documents. The limited presence of the registration authorities in some locations, insufficient supplies, the parents' lack of awareness of the importance of the right to identity, and the high cost of applying for documents such as passports represent significant challenges. The difficulty for those leaving the country without documentation, or even without having been able to register their birth or that of their children in Venezuela, can lead to situations of statelessness. According to official estimates, the trend for timely birth registration has significantly improved since 2000, however, in 2016, 15 per cent of all births in Venezuela are not registered in a timely manner, affecting some 400,000 children under age five. In this regard, the humanitarian response will support institutions facilitating access to legal documentation for the most vulnerable people, including identity documents, birth certificates and records, and death certificates, among others.

Human mobility impacts not only transit areas and host communities, but also communities and individuals in the areas of origin, which need to be considered in the humanitarian response. Special attention will be given to elderly people and women headed households in vulnerable situations and/or caring for other family members, and to children and adolescents left in the care of others. Focus group discussions organized by the UN highlighted this as a recurring problem that affects the protection and psychosocial health of children and adolescents. Their attendance and performance at school may be affected, especially in cases where adolescents are caring for their brothers and/or sisters.

Provision of essential services

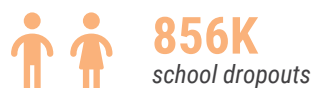
The continuity and quality in the provision of essential services (health, education, protection, water, electricity, gas, fuel and transport) have been impacted, negatively affecting people's living standards. Insufficient investment in infrastructure maintenance, the departure of qualified personnel, and the lack of supplies have been reported with negative consequences. The failure in the provision of services is interrelated: power cuts affect the regular functioning of water, health, and education services; water supply failures affect the provision of services such as health, education, and others. People also face more difficulties in accessing these essential services due to the availability of fuel and public transport, their reduced purchasing power and the prevention measures taken in the context

of COVID-19. In 2020, the humanitarian response will seek to improve equitable and safe access to essential services in health, water and sanitation, education, electricity, energy for cooking, and protection.

Beyond the health and protection services mentioned already, the education system has also been affected. During the focus group discussions organized by the UN, the main barriers for access to education were said to be the lack of teachers, interruptions in school feeding programmes, the lack of services such as water and electricity, lack or high cost of transportation, and insufficient school materials and uniforms.

These factors have contributed to school dropouts, which, based on the MPPE's administrative registries, are estimated to affect 856,794 children and adolescents. Likewise, partners from the Education Cluster estimate that a similar number of children and adolescents could be at risk of dropping out of school. While the education system has been affected in a across the board, the states of Anzoátegui, Apure, Bolívar, Carabobo, Guárico, La Guaira, Mérida, Monagas, Nueva Esparta and Yaracuy have been particularly affected.

SCHOOL DROPOUTS



Source: MPPE, 2019

In relation to gender equality and equity, a 2018 study by the United Nations Children's Fund (UNICEF) found that school attendance tends to be higher among girls than boys. The reason for this disparity is because families prioritize girls' education and often boys began working early to contribute to the family's income. The same applies to rural areas where girls' attendance is about 9 per cent higher than boys in the 13-17 age group. The UNICEF study also identified a trend among adolescents dropping out of school in recent years, particularly between the ages of 13 and 17, and that it is increasing within the indigenous population.

Access to education for children and adolescents facing protection risks requires attention with a multi-sectoral perspective. This includes children of primary school age who take on additional responsibilities in their home, or work to contribute to family income; child survivors of trafficking and/or victims of gender-based violence and/or engaged in hazardous work, such as mining and begging; unaccompanied or separated children in the care of family members, neighbours or friends, often without sufficient support to ensure their needs and/or at risk of exploitation, violence, neglect, abuse and trafficking.

In these circumstances, the humanitarian response aims to promote attendance and permanence in school, through activities that improve the educational experience such as the distribution of learning and teaching kits and school feeding programmes, among others. Initiatives will also be implemented to reintegrate children and adolescents into education, to retain and enhance teachers' skills and

to use schools as an entry point for protection assistance.

It should be noted that the preventive closure of educational facilities, on 16 March, to mitigate the spread of COVID-19, affected approximately 8.9 million students.⁴³ The MPPE has promoted the "Every Family, One School" programme, a remote educational modality to ensure the continuity of learning and safe spaces for the completion of the 2019-2020 school year. The effectiveness of the programme and levels of access to it vary by state. The programme can be affected by power failures and problems with connectivity and internet access, especially for vulnerable groups. The closure of schools has also resulted in a disproportionate increase in care work for women. The pandemic has led to the use of some schools as temporary shelters for returnees. It is important that every effort be made to ensure that schools are evacuated and sanitized before the new school year begins.

With respect to water, sanitation and environmental sanitation systems, service providers face multiple challenges to ensure continuous operations and regular maintenance. The country has a water pipeline network that covers 90 per cent of the population. However, the WFP assessment showed that 59 per cent of households interviewed reported recurrent interruptions in water service and 14 per cent stated that they did not have access to piped water at home. As a result, households use alternative strategies to access safe water, such as buying bottled water or using water trucking services. Overall, 25 per cent of households reported not having access to a stable source of drinking water at the time of the survey. Supply failures are partly due to power cuts as they stop water pumping stations from functioning. The states most affected by this situation are Amazonas, Bolívar, Cojedes, Delta Amacuro, Guárico, Falcón, La Guaira, Nueva Esparta and Zulia.

The lack of water supply in appropriate quality, quantity, continuity and pressure makes it difficult for people to consume the water necessary to digest food, to ensure the adequate handling and preparation of food, and to carry out appropriate personal and environmental hygiene practices. Such circumstances, combined with challenges in garbage collection, sewage and drainage systems, and vector control activities, increase public health risks and malnutrition, and can lead to absenteeism from work and school due to gastrointestinal or vector-borne diseases (e.g. dengue fever, malaria). This also impacts the ability to make time management decisions, especially for women and girls who are often responsible for household maintenance, who must adapt their lifestyles to the availability or collection of water. Household budgets are affected because of the allocation of resources to purchase trucked or bottled water. The most vulnerable households that do not have the financial means to access safe water are forced to use unsafe sources, increasing public health risks. In addition, the lack of water availability limits the proper functioning of sanitation facilities.

Basic hygiene habits are affected by the lack of access to soap, chlorine and other sanitation items. Occasionally, the absence of domestic gas makes it difficult to wash hands, clothes and utensils, as well as to treat water in the home and carry out prevention and

disinfection measures related to COVID-19. The situation especially affects girls, adolescents and women, since they must manage their menstrual hygiene without reliable access to water and with problems procuring quality menstrual hygiene products due to their high costs and scarcity.

In the context of the global COVID-19 pandemic, the lack of access to water and hygiene products is a serious concern and a priority for the humanitarian response to limit the spread of the virus. Humanitarian WASH interventions will be implemented at the level of health and nutrition facilities, educational institutions, learning spaces and community centres/spaces, as well as at the community level. They will aim to improve access to safe water and basic sanitation, promote good hygiene practices, distribute hygiene kits, improve garbage collection services and solid waste management, and provide training in the maintenance of services and infrastructure.

Regarding the electricity supply, it has become a problem since the national-level blackouts that occurred in March and July, and in 11 states of the country in August 2019. Public institutions have made efforts to resolve supply disruptions, but the immediate capacity to resolve the problem has been limited. At the national level, 43 per cent of households surveyed in the WFP assessment reported experiencing daily electricity service interruptions. Currently, it is estimated that among the states most affected by the electricity situation power situation (those where there was no electricity reported for at least one full day a month) are Zulia, Carabobo, Aragua and Lara.⁴⁴ Power failures also affect the provision of other critical services, for instance in hospitals and health centres, where the functioning of lifts, air conditioning units and water supply systems are impacted.

Deficiencies in domestic gas availability have also had an impact on living conditions, as it is used for cooking food and boiling water. The WFP assessment found that 55 per cent of the households surveyed had to wait a long time to buy gas cylinders and that service provision was intermittent; 21 per cent of respondents said that the cost of the gas cylinder was too high and accessing the service was generally a problem because payment must be made in cash, which is increasingly scarce, or through the intermediary of community councils, which sometimes cannot cope with the demand. To cope with the shortage of cooking gas, people resort to eating food that does not require cooking, sharing their cooking facilities with other families or using unsafe alternative sources (charcoal and biomass) for cooking, which can lead to respiratory diseases.

To address this situation, humanitarian interventions will focus on strengthening energy availability in key infrastructure such as hospitals, health centres, schools and temporary shelters, through the provision of generators and photovoltaic plants. In addition, in some communities without access and/or connectivity to essential services, improved access to energy sources will be achieved through the distribution of solar lamps and basic appliances, including cooking utensils.

It should be noted that people in detention centres face specific constraints in accessing essential goods and services, including food,

water and sanitation, and health, and are therefore often dependent on their families for basic coverage of these needs. In the context of the COVID-19 pandemic, the spread of the virus in detention facilities is a concern in addition to the limited access of family members to bring basic goods to people in detention due to social quarantine measures.

PROVISION OF SERVICES



25%
of the people surveyed
report no access to a
stable water source



43%
of the people surveyed
report daily power
outages



21%
of the people surveyed
report high cost of gas
cylinders

Source: WFP, 2019

Coping mechanisms of those affected

Confronted by the lack of access to goods, basic services and economic opportunities, people in need resort to various coping mechanisms. Some of the adopted strategies are positive, such as entrepreneurship, diversification of economic activities, development of family gardens and solidarity mechanisms (mothers sharing childcare, carpooling to reduce gasoline consumption, creation of support networks and exchange of information in social networks, family remittances, barter). On the other hand, many people are forced to resort to negative coping mechanisms. During the needs analysis workshops and focus group discussions with affected people, the following negative coping strategies were identified:

- Increased buying in informal economies.
- Changes in diet and quantity of meals to cope with reduced access to food.
- Work in exchange for food; using savings or selling household assets to meet basic needs.
- Reducing health and education expenses to save money for food.
- Begging for food / scavenging.
- Use of solid and alternative fuels for cooking (including use of firewood).
- Use of water from unsafe sources and paying for trucked or bottled water.
- Family separation, with protection risks for both those on the move and those who remain, especially children and older people.
- Internal and external human mobility in search of better living conditions and/or protection.
- Child labour, with impacts on school attendance.
- Risky jobs, including criminality, smuggling and survival strategies affecting people's dignity.
- Irregular payments and corruption to obtain services.

The humanitarian response will seek to support and strengthen the positive coping mechanisms developed by families and communities, while preventing and mitigating the negative mechanisms that affect people's physical and mental well-being, as well as their living conditions and protection.

Part 1

Strategic Response Priorities



LOS CARACAS, LA GUAIRA STATE
Photo: OCHA/ Gema Cortés

1.1

Strategic Objectives and Response Approach

Based on the analysis of humanitarian needs and operational capacity, humanitarian organizations in Venezuela aim to reach 4.5 million vulnerable people by the end of 2020, including 53 per cent of women and 47 per cent of men.

The target population of the 2020 HRP corresponds to the number of people that would receive multi-sectoral assistance in 2020 with the required funding and access. Each Cluster identified its target population based on the projects presented by humanitarian partners, focused on direct assistance to beneficiaries^[d].

The Plan has three interconnected strategic objectives to respond to humanitarian needs: first, to ensure the survival and well-being of the most vulnerable people; second, to contribute to the sustainability of basic services provision, build resilience and support livelihoods; and third, to prevent, mitigate and respond to protection risks by strengthening community and institutional mechanisms. The multi-sectoral humanitarian response will be implemented in line with the humanitarian principles, using a rights-based approach, which takes age, gender and diversity into account.

The strategic objectives seek to respond to critical issues identified in the humanitarian needs analysis, recognizing the need for flexibility to respond to new challenges, such as the impact of the COVID-19 pandemic.

Under the first Strategic Objective, humanitarian partners aim to provide life-saving assistance addressing priority needs related to physical and mental well-being. These include critical activities in the areas of health, nutrition, food security, protection, and water, sanitation and hygiene.

The second Strategic Objective aims to address critical needs regarding living standards by strengthening livelihoods, maintaining safe and effective access to basic services (including health, education, water, sanitation and hygiene, and protection), and ensuring safe and appropriate shelter for people on the move.

Under the third Strategic Objective, humanitarian partners will contribute to the prevention, mitigation and response to protection risks associated with human mobility, gender-based violence, and violence, neglect, abuse and exploitation of children and adolescents.

[d] In order to avoid possible duplications of beneficiaries, the projects with the greatest geographic and programmatic coverage were used for the target population calculation, either by age group or by state. Once the target populations by cluster were defined, OCHA at the intersectoral level calculated the maximum number by state, age group, and gender to determine the total target population.

The response strategy in Venezuela adopts an intersectoral approach. It includes 11 intersectoral specific objectives which strengthen connections between the three strategic objectives and sectoral interventions. In addition, out of the 234 projects included in the Plan, 21 per cent include activities related to more than one cluster, reinforcing the intersectoral approach.

NUMBER OF MULTI-SECTORAL PROJECTS

| NUMBER OF CLUSTERS | NUMBER OF PROJECTS | % OF THE TOTAL OF PROJECTS |
|-----------------------------------|---------------------|----------------------------|
| Response activities in 1 cluster | 184 projects | 78,6% |
| Response activities in 2 clusters | 26 projects | 11,1% |
| Response activities in 3 clusters | 15 projects | 6,4% |
| Response activities in 4 clusters | 8 projects | 3,4% |
| Response activities in 5 clusters | 1 project | 0,4% |
| TOTAL | 234 PROJECTS | 100% |

Prioritized population groups

Based on the analysis of humanitarian needs, and including age, gender and diversity dimensions, the Plan prioritizes the following vulnerable populations:

| | | |
|--|---|--|
|  <p>Adolescents and women of reproductive age, pregnant and lactating women</p> |  <p>People on the move, including returnees, people in transit to other countries or within the country, as well as people in need of international protection</p> |  <p>People with communicable and non-communicable diseases with limited access to medicines, including those living with HIV and COVID-19</p> |
|  <p>Newborns</p> |  <p>Vulnerable women heads of household</p> |  <p>Indigenous populations</p> |
|  <p>Children and adolescents at risk</p> |  <p>Elderly people</p> |  <p>People with disabilities</p> |

Within these population groups requiring attention, the humanitarian response will focus on the most vulnerable persons.

In addition to the groups above, health care professionals, people in detention centers and people in nursing homes and other care facilities require attention in the context of the COVID-19 pandemic.

The Plan aims to meet the urgent basic needs of asylum seekers,

refugees, and people at risk of statelessness, and to strengthen institutional capacities to provide access to asylum and durable solutions. UNHCR, jointly with the National Commission for Refugees (CONARE), the Ombudsman's Office, and other institutional partners, base their interventions on the Brazil Declaration and Plan of Action, adopted in December 2014.

Geographic prioritization

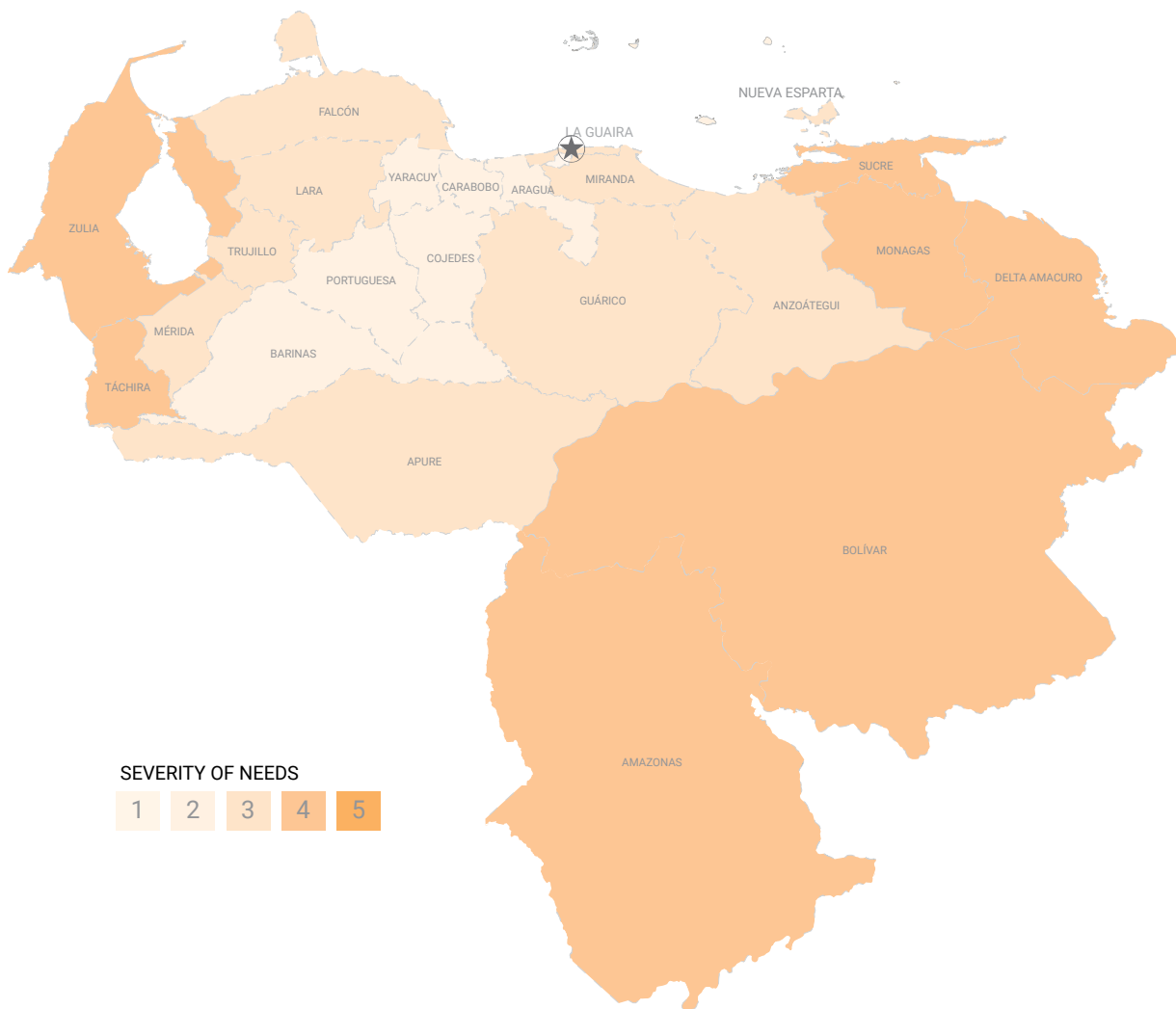
The severity of needs by state is estimated based on multiple factors including key needs indicators, expert judgment (through needs analysis workshops held at the field level and Caracas), and community perceptions (through focus group discussions and the survey on accountability to affected populations).

The response focuses on states with the highest severity of multi-sectoral needs and/or the highest percentage of people in need in relation to the total population, mostly states in the eastern part of the country (Amazonas, Bolivar, Delta Amacuro, Monagas and Sucre),

as well as border states with Colombia (Zulia and Tachira). About one-third of the Venezuelan population lives in these states.

Beyond these seven states, the Capital District and 11 states (Anzoategui, Apure, Barinas, Falcon, Guarico, La Guaira, Lara, Merida, Miranda, Nueva Esparta and Trujillo) also evidence a high severity of needs and a high percentage of people in need. Half of the Venezuelan population live in these states.

Activities in other states are also included, based on the needs identified by each cluster in their sectoral prioritization.



The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Source: OCHA based on multiple sources, 2020

Humanitarian principles

In line with UN General Assembly Resolution 46/182 (1991), the provision of humanitarian assistance will be based on the humanitarian principles of humanity, neutrality, impartiality and independence. Humanitarian organizations participating in the Plan do not engage in political disputes or adopt partisan positions. They have committed to the Joint Operating Principles (see annexes), developed for the response in Venezuela through a consultative process and endorsed by the HCT in December 2019.

The Joint Operating Principles seek to ensure a response based on

the humanitarian principles and standards, including accountability to affected populations, centrality of protection, and protection against sexual exploitation and abuse (PSEA).

The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) will organize workshops with humanitarian organizations that are part of the Plan, and with other stakeholders, to strengthen the understanding of humanitarian principles and their application in practice.

| HUMANITY | NEUTRALITY | IMPARTIALITY | INDEPENDENCE |
|---|--|---|--|
| Human suffering must be addressed wherever it is found. The purpose of humanitarian action is to protect life and health and ensure respect for human beings. | Humanitarian actors must not take sides in hostilities or engage in controversies of a political, racial, religious or ideological nature. | Humanitarian action must be carried out on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions. | Humanitarian action must be autonomous from the political, economic, military or other objectives that any actor may hold with regard to areas where humanitarian action is being implemented. |

Humanitarian communication

Taking into account the importance of promoting principled humanitarian action, joint communication efforts will be expanded in 2020, within the framework of the humanitarian communication strategy endorsed by the HCT. The strategy aims to raise visibility of the results of the humanitarian response and promote a greater understanding of the humanitarian principles in order to achieve greater support and acceptance from all stakeholders, including affected populations.

The Humanitarian Communication Group, created in 2019 to strengthen cooperation in the area of communication, leads the implementation of the strategy. Due to the politicization of humanitarian aid, establishing and consolidating a unified voice for the humanitarian community is essential to ensure neutral and impartial communication.

In 2019, progress was made on strengthening social media presence, and publishing regular situation reports and other public information products on the response, needs and operational environment. The Under-Secretary-General for Humanitarian Affairs and Emergency Relief Coordinator, Mr. Mark Lowcock, also visited Venezuela in November 2019. These elements contributed to amplifying the voice

of humanitarian actors and promoted depoliticized communications on the humanitarian situation in Venezuela.

In the context of COVID-19, communication efforts have focused on providing timely and accurate information to the population, and a specific working group for risk communications and community engagement has been established.

Response financing

In 2019, the Humanitarian Response Plan received 33.8 percent of the financial requirements. Underfunding of the humanitarian response is the main constraint to expanding humanitarian assistance to a greater number of people in need.

In 2020, advocacy for resource mobilization will focus on increasing resources allocated by international donors to the humanitarian response in Venezuela, securing the necessary financial commitments to establish a humanitarian Country-Based Pooled Fund, which would allow for increasing the resources allocated to NGOs, and exploring other sources of funding, including mechanisms that can facilitate the use of national resources. As of 14 June, more than US\$116 million⁴⁵ has been received for the response in 2020.

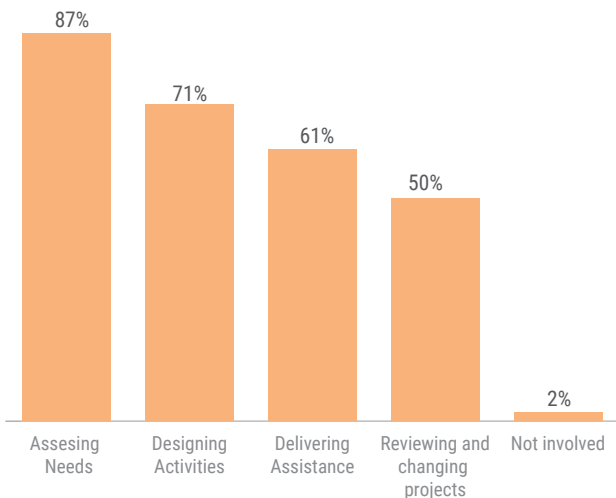
Gender and age mainstreaming across the humanitarian response

During the 2020 Humanitarian Programme Cycle (HPC), gender mainstreaming in humanitarian needs analysis and project design was reinforced through trainings and the use of the Gender and Age Marker (GAM) for the first time. The GAM tool invites humanitarian actors to reflect on the specific needs of the population based on gender and age, and allows for the planning of a differentiated and inclusive response for women and men, girls and boys and the LGBTI population.

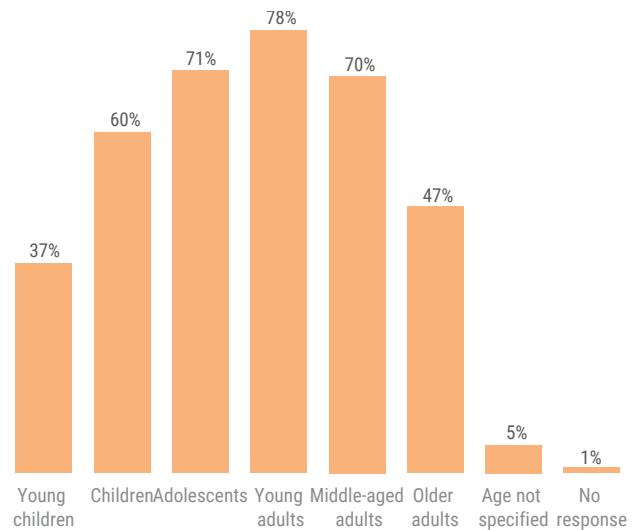
From the 191 projects approved for the 2020 Plan (excluding specific COVID-19 projects), 68 per cent (129 projects) have used the GAM tool, which demonstrates an increased gender and age mainstreaming into analysis and programming. In 2020, efforts will be made with partners to strengthen the use of the GAM tool and to reach the Inter-Agency Standing Committee (IASC) global target for GAM implementation of 80 per cent. From the 129 projects having used the GAM tool, 88 per cent (113) plan to respond in a way that takes into account gender and age differences, including 6 projects with targeted or specific activities to reduce inequality. A total of five projects include only the gender dimension.

In 2020, more support is necessary to consolidate the commitment to gender equality and its promotion in project implementation. Efforts will focus on strengthening capacity on gender and age mainstreaming in humanitarian analysis and programming, as well as promoting the sharing of good practices and gender programming tools.

PARTICIPATION OF AFFECTED PEOPLE



PARTICIPATION - AGE GROUPS THAT INFLUENCE THE PROJECT



Source: GAM analysis using HPC tools, 2020

An inclusive humanitarian response

In 2020, the humanitarian response will aim for greater inclusion of people with disabilities. The Venezuelan Confederation of Deaf People (CONSORVEN) facilitated a module on inclusive humanitarian response as part of the trainings in the framework of the 2020 HPC. Most projects included in the 2020 Plan (59 per cent) reported having engaged with people with disabilities and/or their representative organizations during the needs assessment for project design. Based on the consolidated data from the projects in the Plan, it is estimated that people with disabilities represent 13.9 per cent of the target population and efforts will focus on strengthening their visibility in response monitoring tools.

Cash Transfer Programmes

The lack of financial resources is a major constraint for the affected populations to access essential goods and services. It could be effectively addressed through Cash Transfer Programmes (CTP) by humanitarian organizations. With the increasing dollarization of the economy since mid-2019, access to digital cash transfer mechanisms and the general acceptance of CTP are factors that may facilitate further implementation of these programmes. However, their use in Venezuela also includes a number of operational risks related to inflation, protection, market functionality and access.

The 2019 HRP included 15 organizations that proposed to allocate about US\$14 million through CTP. At least four organizations implemented pilot CTP interventions in 2019 and six planned to do so in early 2020. The pilot projects were promising, and humanitarian actors had found ways to mitigate risks and meet people's basic needs without the logistical challenges and high cost of in-kind assistance, considering the functionality of the commodity market.

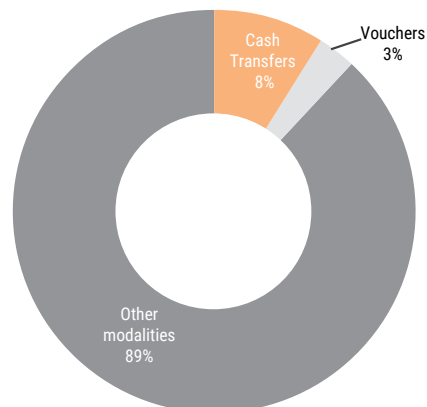
Therefore, the 2020 Plan seeks to scale up CTP implementation by humanitarian organizations and includes 38 projects proposed by 32 organizations using this modality mostly in the areas of food security (19 projects), education (10 projects), and WASH (9 projects). Cash-based response amounts to US\$57.8 million (8 per cent of the total), while voucher modality totals US\$20.9 million (3 per cent of the total).

The Cash and Vouchers Working Group, led by FAO and the Norwegian Refugee Council (NRC), will, if there is donor support, continue to strengthen the intersectoral coordination of the humanitarian response based on CTP, especially in terms of strengthening coordination for risk management, mapping of financial service providers, and periodic market monitoring.

NUMBER OF PROJECTS WITH A CASH COMPONENT

| CLUSTER | NUMBER OF PROJECTS WITH CASH COMPONENT |
|-------------------------------|--|
| Food Security and Livelihoods | 19 |
| Education | 10 |
| Water, Sanitation and Hygiene | 9 |
| Protection | 8 |
| Health | 4 |
| Nutrition | 4 |
| Shelter, Energy and NFIs | 3 |

PERCENTAGE OF THE HRP BUDGET IMPLEMENTED THROUGH CASH TRANSFER PROGRAMMES



Source: CASH analysis using HPC tools, 2020

Response to critical problems related to physical and mental well-being



Strategic Objective 1

Ensure the survival and well-being of the most vulnerable people through a multi-sectoral response under a rights-based approach, including age, gender and diversity dimensions

Prioritized critical problems

The first strategic objective prioritizes four critical problems concerning physical and mental well-being. These problems may

affect people's lives and have severe consequences that require immediate attention.

| CRITICAL PROBLEMS | MOST AFFECTED GROUPS |
|---|---|
| Health issues related to the high rate of communicable and non-communicable diseases, the spread of COVID-19 and mental health problems, having a differentiated impact according to gender, age and diversity dimensions | <ul style="list-style-type: none"> • Indigenous people • newborns • children and adolescents at risk • women at risk including pregnant and lactating women; • vulnerable women heads of household; • the elderly; • people on the move; • people with non-communicable diseases; • people with disabilities; • people living with HIV; • people in detention; • health workers; • survivors of gender-based violence including sexual violence; • sex workers. |
| Sexual and reproductive health, with a focus on maternal and child health and unwanted pregnancies with emphasis on adolescent girls | <ul style="list-style-type: none"> • Pregnant and lactating women; • newborns; • women of reproductive age with a focus on adolescent girls; • survivors of gender-based violence. |
| Malnutrition and severe food insecurity | <ul style="list-style-type: none"> • Children under age five; • pregnant and lactating women, specifically indigenous women and adolescents; • the elderly; • adolescents at risk; • returnees. |

Impacts on physical and mental well-being resulting from different forms of violence, exploitation, neglect and abuse

- Indigenous people;
 - afrodescendants;
 - children and adolescents at risk;
 - children and adolescents taking care of the elderly and/or vice versa;
 - people on the move;
 - stateless people or people at risk of statelessness;
 - refugees;
 - the elderly;
 - people with disabilities;
 - people with chronic health conditions and serious illnesses;
 - LGBTI people;
 - health workers;
 - survivors of gender-based violence; survivors of human trafficking;
 - sex workers;
 - people in detention;
 - women at risk, particularly single women and women heads of household.
-

Expected results and coordinated response

The first Strategic Objective includes four specific objectives. The WASH, Nutrition, Food Security and Protection Clusters will provide a multi-sectoral and inclusive response to critical problems related to physical and mental well-being.

The activities implemented will seek to reduce the vulnerability of 3.5 million people among the prioritized groups to mortality and morbidity risks from communicable and non-communicable diseases and mental health conditions. This will be achieved by increasing access to basic goods and services, such as health and water and sanitation, and by building the operational and functional capacity of the prioritized health-care centres. Access to sexual and reproductive health, with special emphasis on maternal and child health, will be enhanced for over 238,000 vulnerable women and children through referral services. Response activities integrate gender, age and diversity dimensions and will be implemented in prioritized health facilities, including those at high risk of ceasing to operate without additional support.

Response activities will reduce malnutrition among 700,000 children under age five, pregnant and lactating women and vulnerable children and adolescents. A total of 848,000 severely food-insecure people will be assisted with access to food, and short-cycle food production will be promoted and technical support to foster sustainable agricultural livelihoods will be provided to reduce dependence on food distribution.

Partners will also strengthen the physical, mental and psychosocial well-being of 290,000 people exposed to violence, exploitation, neglect and abuse by providing specialized assistance, such as the establishment of community centers offering group and individual psychosocial assistance.

Specific objectives

| # | SPECIFIC OBJECTIVE | TARGET POPULATION OF THE 2020 HRP |
|--------|--|-----------------------------------|
| SO 1.1 | Reduce the vulnerability of affected people to mortality and morbidity risks from communicable, non-communicable and mental health diseases by improving their access to basic goods and services related to health, water and sanitation, incorporating age, gender and diversity dimensions. | 3,5 M |
| SO 1.2 | Enhance sexual and reproductive health, with special emphasis on maternal and child health by strengthening access to referral goods and services with attention to the age, gender and diversity dimensions. | 238 k |
| SO 1.3 | Reduce malnutrition and severe food insecurity in children under age five, pregnant and lactating women, and other vulnerable groups. | 848 k |
| SO 1.4 | Strengthen the physical, mental and psychosocial well-being of people suffering from violence, exploitation, neglect and abuse, with attention to age, gender and diversity dimensions. | 290 k |

Response to critical problems related to living standards



Strategic Objective 2

Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions

Prioritized critical problems

The second strategic objective prioritizes four critical issues associated with living standards. Negative impact on living standards

may affect the physical and mental well-being of affected people if additional assistance is unavailable.

| CRITICAL PROBLEMS | MOST AFFECTED GROUPS |
|--|---|
| Moderate food insecurity | <ul style="list-style-type: none"> • Poor households, households with a large number of under 18-year old or over 60-year old dependents; • vulnerable women heads of households; • vulnerable children and adolescents; • indigenous communities; • people with disabilities; • people on the move; • people with non-communicable diseases; • people in detention. |
| Limited access to basic goods and regular, sustainable and quality services (including health, water and sanitation, education, electricity and energy for cooking) incorporating age, gender and diversity dimensions | <ul style="list-style-type: none"> • Children and adolescents at risk; • women of reproductive age, pregnant and lactating women, vulnerable women heads of household; • newborns; • the elderly; • people on the move; • people with disabilities; • people with communicable and non-communicable diseases with limited access to medicines and treatment, including people living with HIV; • people in detention. |
| Precarious living conditions for people on the move in individual or collective housing, those who are homeless and host communities | <ul style="list-style-type: none"> • People on the move, including returnees, living in individual or collective housing built with poor quality materials and/or in overcrowded conditions or homeless; • host communities with overcrowded housing and services. |
| Lack of access to official documentation for the full enjoyment of human rights. | <ul style="list-style-type: none"> • People without documentation or access to documentation |

Expected results and coordinated response

The second Strategic Objective comprises four specific objectives. The Food Security and Livelihoods, Health, WASH, Education, Shelter, Energy and NFIs, and Protection (including both Child Protection and Gender-based Violence AoR) Clusters will provide a coordinated response to increase resilience and access to basic services for the most vulnerable people.

Humanitarian organizations will support the restoration, maintenance and protection of livelihoods for 593,000 vulnerable people, mainly women-headed households and those with acutely malnourished children under age five. Activities will promote small-scale food production that respects local practices and habitat. These interventions will take into account environmental considerations and analyze the agro-climatic risks that can affect livelihoods, such as droughts, floods, water contamination, etc. These analyses will allow the development of long-term strategies for sustainable livelihoods.

The response will be implemented in a comprehensive and intersectoral way to improve equal and safe access to basic services for the most vulnerable populations. Humanitarian activities will strengthen the operational capacity of 208 hospitals and 178 prioritized healthcare centers, complementing specific objective 1.1, which includes, among other things, prioritized interventions in hospitals and sentinel centres for the COVID-19 response. To achieve the desired outcomes, information and epidemiological surveillance systems and response capacities will be strengthened

with an emphasis on the most vulnerable, including the provision of critical services to respond to gender-based violence such as clinical management of sexual violence. Humanitarian partners also plan to reach 1.5 million children and adolescents through interventions seeking to improve educational services, with a priority focus on areas with the highest dropout rates or dropout risks. The activities include distribution of kits, implementation of school feeding programmes and capacity-building for education professionals through trainings and incentives.

WASH conditions and electricity supply in health, educational and some nutritional care facilities will be improved. The construction or rehabilitation of these spaces will comply with international standards for persons with disabilities. Partners will distribute supplementary food to the most vulnerable people at the facilities.

Regarding shelter, the response targets 400,000 people including people on the move living in individual or collective temporary shelters, returnees in temporary shelters complying with their quarantine, the homeless, and those at risk of mobility. Response activities will seek to improve the living conditions in individual and collective shelters, minimize protection risks, guarantee dignity and ensure gender and age sensitivity of the programmes and activities.

Humanitarian organizations, through institutional and community support, will enable access to official documentation, including identity cards and birth and death certificates, for 430,000 vulnerable people in need.

Specific Objectives

| # | SPECIFIC OBJECTIVE | TARGET POPULATION OF THE 2020 HRP |
|--------|---|-----------------------------------|
| SO 2.1 | Strengthen food security of the most vulnerable people by increasing access to food and supporting the restoration, maintenance and protection of livelihoods, incorporating age, gender and diversity dimensions. | 593 k |
| SO 2.2 | Improve equal and safe access to essential goods and services in the areas of health, water and sanitation, education, electricity and energy for cooking for the most vulnerable populations, seeking appropriate quantity, quality and sustainability of the provision of the services, incorporating age, gender and diversity dimensions. | 2.2 M |
| SO 2.3 | Guarantee access to adequate and age-gender sensitive shelter and energy provision for people on the move who are in informal settlements, homeless people, and those at risk of displacement. | 400 k |
| SO 2.4 | Provide access to legal documentation for affected people, incorporating age, gender and diversity dimensions. | 430 k |



DELTA DEL ORINOCO
Phoro: OCHA/Gema Cortés

Response to critical protection problems



Strategic Objective 3

Strengthen institutional and community mechanisms to prevent, mitigate and respond to protection risks faced by affected people, according to humanitarian principles and with respect for human rights

| PRIORITIZED CRITICAL PROBLEMS | MOST AFFECTED GROUPS |
|---|---|
| Protection risks including those related to human mobility | <ul style="list-style-type: none"> • Indigenous people; • afrodescendants; • children and adolescents at risk; • children and adolescents in care of the elderly and/or vice versa; stateless people or people at risk of statelessness; • refugees; • the elderly; • people with disabilities; • people with chronic health conditions and serious illnesses; dependent people; • LGBTI people; • survivors of gender-based violence and sex workers; • people without documentation or access to it. |
| Gender-based violence risks, with emphasis on sexual exploitation and abuse | <ul style="list-style-type: none"> • Children, adolescents and women who are on the move, including returnees; • homeless children and adolescents; • separated and unaccompanied children and adolescents; • vulnerable women heads of household; • indigenous women; • adolescents, especially those out of school; • sex workers; • women in detention. |
| Risks of violence, abuse, exploitation and neglect towards children and adolescents | <ul style="list-style-type: none"> • Separated and unaccompanied children and adolescents; • homeless children and adolescents; • children and adolescents in vulnerable households; • children and adolescents in care of the elderly and/or vice versa; • children and adolescents in care of other children and adolescents. |

Expected results and coordinated response

To achieve the third Strategic Objective, partners will seek to prevent, mitigate and respond to protection risks associated with human mobility, gender-based violence (with an emphasis on exploitation and abuse), and violence, abuse, neglect and exploitation of children and adolescents.

As a complement to the first and second Strategic Objectives, humanitarian organizations, together with public and civil society actors, will increase the quality and number of protection services at three levels (individual, community and institutional) using a rights-based approach.

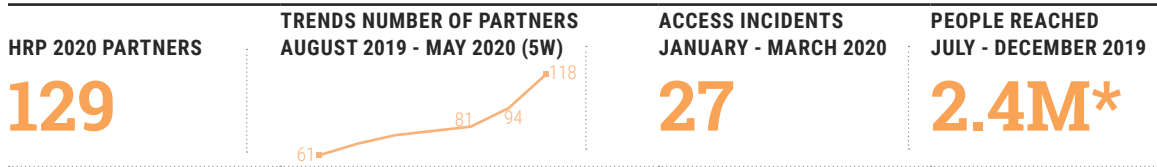
Response activities include reinforcing protection networks, community discussion spaces, including women’s and LGBTI people’s organizations, and information roundtables to raise awareness in communities. Partners will also support and collaborate with public institutions and humanitarian and civil society organizations to strengthen their capacities to assess, analyze, prevent and respond to specific protection needs, taking into account gender, age and diversity dimensions.

Specific Objectives

| # | SPECIFIC OBJECTIVE | TARGET POPULATION ON THE 2020 HRP |
|--------|---|-----------------------------------|
| SO 3.1 | Prevent, reduce and respond to protection risks associated with human mobility | 490 k |
| SO 3.2 | Prevent, reduce and respond to risks associated with gender-based violence, with a focus on sexual exploitation and abuse | 660 k |
| SO 3.3 | Prevent, reduce and respond to violence, abuse, neglect and exploitation of children and adolescents | 410 k |

1.2

Humanitarian Access and Operational Capacity



Operational capacity and response scale-up in 2019

The opening of humanitarian space and the establishment of the humanitarian coordination architecture in 2019 has enabled the expansion of the humanitarian response. At the national level, a Humanitarian Coordinator and Deputy Humanitarian Coordinator were appointed, the HCT and the ICCG were established as were eight clusters and two AoRs. These mechanisms have facilitated more effective intersectoral programming and the definition of joint priorities, as seen in the 2019 Humanitarian Response Plan for Venezuela and the timely prevention and response to COVID-19 since

March 2020, in support of the National Response Plan. The increase in the number of qualified humanitarian personnel has enabled the expansion of the response, the improvement of analysis and the strengthening of national capacities. The humanitarian architecture in Venezuela is decentralized to be closer to the people in need of assistance. Four Field Coordination Hubs have been established in Maracaibo (Zulia), San Cristobal (Tachira), Ciudad Guayana (Bolívar) and Caracas, each covering several states and supporting coordination mechanisms at the sub-national level.

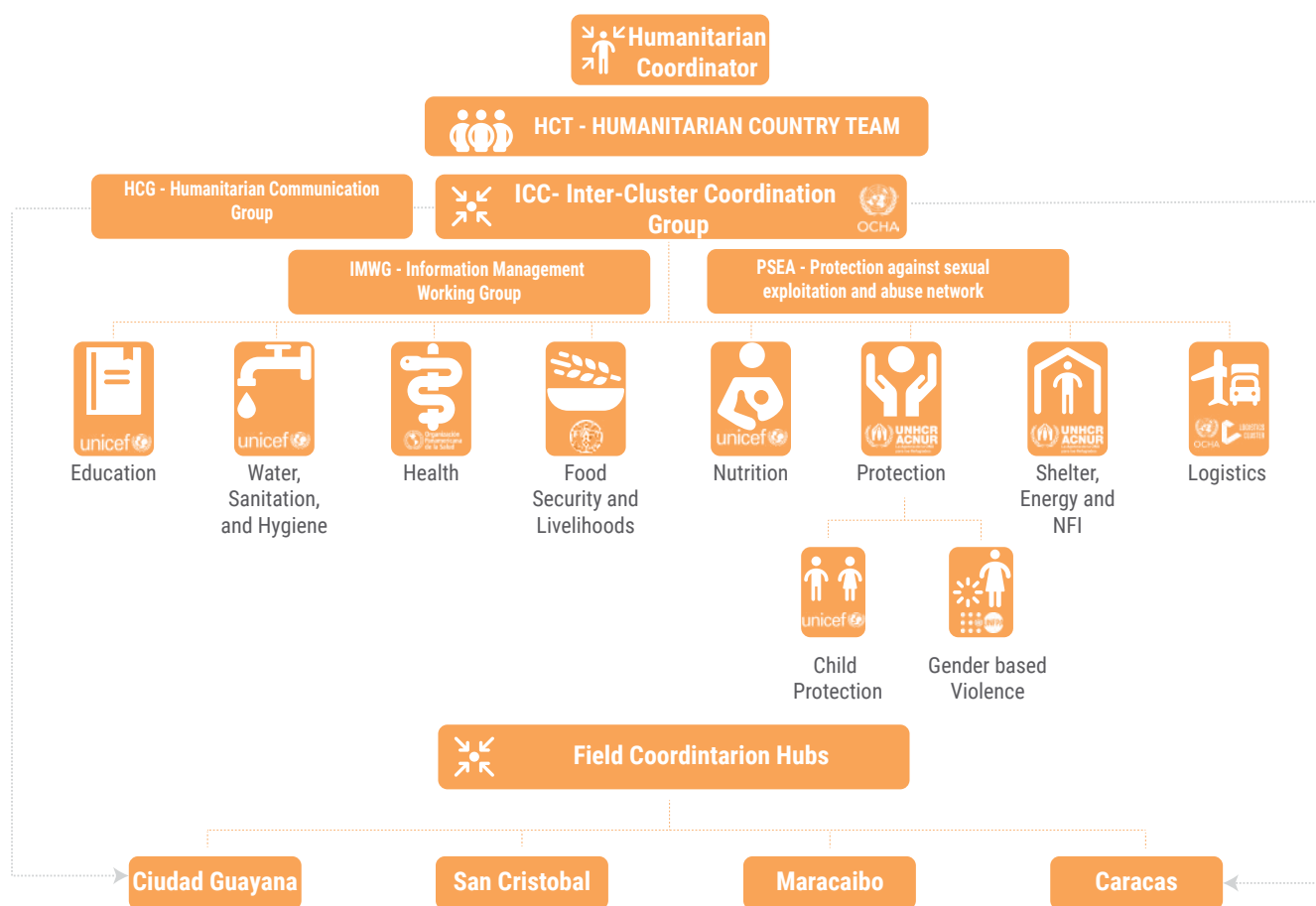
GEOGRAPHICAL COVERAGE OF FIELD COORDINATION HUBS



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* Estimated number of people who have been reached with humanitarian assistance at least once. This does not mean that all their needs have been met.

HUMANITARIAN ARCHITECTURE



The number of humanitarian actors participating in humanitarian coordination structures in Venezuela has increased significantly in the last year. In August 2019, 61 organizations reported on the implementation of humanitarian activities in 161 municipalities, compared to 118 organizations in all 335 municipalities in May 2020^[e]. In 2020, efforts will be made to increase access to remote locations where humanitarian actors are less present.

National NGOs are vitally important in Venezuela and the Plan seeks to ensure their direct and meaningful participation in the development of humanitarian strategies and coordination mechanisms at the field and national levels. Additionally, many national NGOs have a long-standing experience in providing services. Their extensive presence across the country has built solid connections with communities and local public institutions. In light of the need to develop specialized knowledge on humanitarian standards and principles, OCHA organized 31 trainings on coordinated humanitarian action and collective responsibilities for over 1,000 people from local NGOs and other humanitarian actors in 2019. Cluster-specific trainings were also organized. A larger presence of international NGOs is another

[e] The increase in coverage for this period is partly due to the registration of UNICEF activities implemented by MPPS in access to birth documentation (birth certificates) and high impact interventions aimed at immune-preventable diseases. The coverage without the MPPS would be 217 municipalities.

key element for further expansion of response capacity. Discussions are ongoing with the Government to establish a special mechanism to facilitate their registration and temporary entry as international entities. WFP and the Government are also working on an agreement to facilitate WFP’s presence in Venezuela, which would result in greater food security and logistical operational capacity.

Well-functioning institutions are vital to ensure sustainable provision of basic services and to scale up the response. As foreseen in the Joint Operating Principles for Venezuela, humanitarian organizations support relevant public institutions and technical departments, in line with humanitarian principles. This includes the MPPE, MPPS, INN, CONARE, Protection Councils and Civil Protection, among others.

Number of partners by cluster

| CLUSTERS | NUMBER OF PARTNERS |
|-------------------------------|--------------------|
| Food Security and Livelihoods | 52 |
| Protection | 39 |
| Health | 40 |
| Education | 37 |
| Nutrition | 30 |
| Water, Sanitation and Hygiene | 29 |
| Shelter, Energy and NFI | 24 |
| Coordination and Logistics | 7 |

Number of partners by type

| TYPE OF ORGANIZATION | NUMBER OF PARTNERS |
|----------------------|--------------------|
| National NGOs | 79 |
| Local NGOs | 16 |
| International NGOs | 15 |
| UN Agencies | 10 |
| Other | 7 |
| Red Cross | 2 |

Operational independence in terms of logistics

Operational independence is a priority for humanitarian actors. Humanitarian organizations mostly procure supplies in the local market and, where possible, move the supplies to distribution sites by road.

When importing goods, humanitarian organizations hire local providers of logistics services to comply with customs procedures and facilitate clearance, transportation and storage of goods and supplies in private warehouses. Humanitarian organizations hire shipping companies to transport supplies from central warehouses to the implementation areas. In other cases, the supplies are delivered to implementing partners or institutions providing public services (health facilities, nutrition treatment centers, education institutions, etc.), who are then responsible for the final distribution to communities or affected people.

The logistical capacity of private providers in Caracas and other main urban areas is strong. However, organizations implementing activities in remote areas report limitations on available logistics services, mainly due to the lack of fuel. There are also fewer road transportation fleets, while basic services and road conditions are poor resulting from insufficient maintenance and investment. Payments to suppliers are challenging due to the scarcity of national currency, high price fluctuations and restrictions on bank transfers, resulting in higher operational costs. In addition, access to remote locations, particularly in the Delta Amacuro, Bolivar and Amazonas states, is limited due to the lack of fuel and transport, spare parts for fleets, insecurity and difficulties with access and permits. In

these areas, the response will be coordinated with partners to find solutions.

Humanitarian access

During 2019, as the presence of humanitarian actors expanded, they faced challenges regarding access to the most affected people. The politicization of humanitarian aid by political actors hampers the acceptance in some areas of assistance and highlights the importance of guaranteeing respect for the humanitarian principles by all stakeholders, at all levels. Logistical constraints due to lack of fuel and the deterioration in basic infrastructure and public services such as electricity, transport and telecommunications limit the capacity of humanitarian organizations to access vulnerable people, as well as the capacity of affected people to access assistance and services. In some areas, the lack of trust or reticence regarding humanitarian action by some local actors is a challenge for the acceptance of humanitarian activities and collection of the information needed to design tailored interventions. Administrative constraints affect the entry of organizations, personnel and supplies, especially for international NGOs, and limit operations and movements throughout the country. The localized presence of irregular armed groups in some areas and temporary roadblocks due to demonstrations organized by communities also limit access to the most vulnerable people.

These limitations affect all humanitarian actors and clusters, but international NGOs face specific challenges because of the lack of legal mechanism recognizing their status as an international organization, preventing the implementation of large-scale humanitarian programmes. This situation exists because historically,

Venezuela has not needed humanitarian aid from the international system. To provide support to Venezuelans affected by the humanitarian context, several international NGOs have attempted to follow processes to register as civil associations or national foundations. However, once legally recognized, these entities face operational limitations when trying to obtain work visas for international staff, importing humanitarian supplies, and other administrative and financial procedures. The lack of recognition of international NGOs also limits their ability to coordinate with public institutions and the movement of personnel throughout the territory. Joint advocacy is underway to accelerate the ongoing processes with the authorities to address this legal gap and to find a way to facilitate the registration and response activities of international NGOs in the framework of the Humanitarian Response Plan.

National NGOs have faced several challenges, including the apparent suspension of registration processes or updating of records in September 2019. In December 2019, the Ministry of People's Power for the Interior, Justice and Peace sent a letter of clarification in response to the Office of the UN High Commissioner for Human Rights, stating that there is no suspension of NGOs registration. However, national NGOs continue to report some challenges and excessive revisions of documents, which lead to operational delays. National NGOs have also reported confiscation of supplies by the authorities and cases of trespassing on their premises.

As highlighted in the Joint Operating Principles, the protection of humanitarian personnel is a priority. Incidents reported by humanitarian actors to the Humanitarian Coordinator and the Deputy Humanitarian Coordinator are assessed and raised with the relevant authorities to guarantee the safety of humanitarian personnel, facilities and property.

These limitations cause temporary or sometimes permanent suspension, reduction and significant delays in the implementation of programmes and increase operational costs. They can also place humanitarian organizations and personnel at risk in terms of legal and physical security. Lack of access also impedes needs analysis and hampers adequate project design and the mobilization of resources.

A mapping of access severity, which is the result of the humanitarian access monitoring exercise carried out in September-October 2019 that included the participation of more than 150 humanitarian actors, showed that from 236 municipalities where humanitarian actors had information, 61 per cent present had regular access limitations, while 39 per cent present occasional access limitations. These limitations mainly refer to logistical challenges, such as the lack of fuel. Information was not available with regards to access in 30 per cent of the municipalities where there is limited humanitarian presence.

This analysis at the municipality level does not capture the access differences within the same municipality; for example, urban areas may be more easily accessible than rural areas. There are significant logistical challenges resulting in difficult access to some communities, for example, in areas south of the Orinoco River. In some localized areas, mostly in border and mining areas, access was reported as very difficult or impossible due to insecurity.

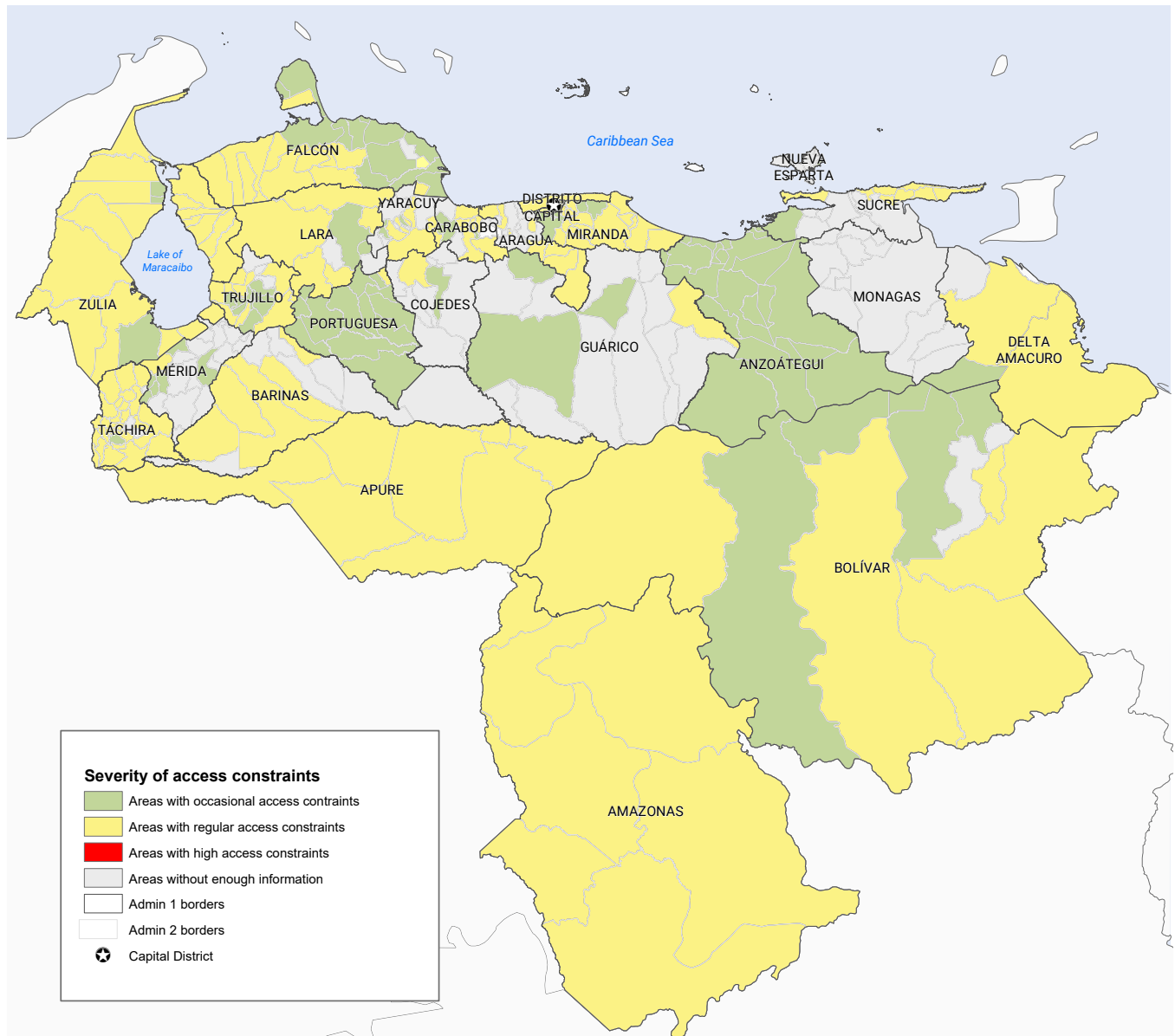
Since March 2020, the COVID-19 outbreak has affected humanitarian access. Quarantine measures limit movements between states and municipalities, compounded by the impact of fuel shortages. Many humanitarian actors initially suspended or limited their routine activities as a precaution measure and have developed new modalities to ensure the continuity of operations taking into account the well-being of staff and communities. Other actors have reallocated their resources to take action to prevent and respond to COVID-19. However, challenges remain to facilitate the importation and movement of supplies and to monitor the implementation of projects. To address this, the UN and the COVID-19 Presidential Commission agreed to establish a mechanism for special movement authorizations (*salvoconductos*) partially facilitating access. So far, 276 *salvoconductos* have been granted (64 for the UN, 98 for partners and 114 for private companies) to maintain critical life-saving activities. On 3 April, the UN Secretary-General made a global call to facilitate access to humanitarian workers and to designate them as essential workers in the fight against COVID-19 and its socio-economic impacts⁴⁶.

Regular consultations with national authorities to address the challenges faced by humanitarian organizations and strengthen their response capacity will continue throughout 2020. Regular publication of information products will be critical to raise visibility on humanitarian access challenges. An access incident monitoring and reporting system was established in January 2020 to monitor access challenges and inform advocacy. Twenty-seven access incidents were reported through the system in the first quarter of 2020, mainly in Bolívar, Zulia and Tachira states. The strengthening of the Logistics Cluster has also facilitated the analysis of the operational context and unmet logistics needs.

Strengthening civil-military coordination will be another key action to ensure an adequate relationship between humanitarian actors and the National Bolivarian Armed Forces (FANB, *Fuerza Armada Nacional Bolivariana*), particularly in the context of COVID-19 where the FANB is involved in the management of temporary shelters; and to explore how some logistical challenges, including fuel shortages, can be mitigated.

Furthermore, enhanced joint communication, at all levels and with all actors (communities, public authorities and the military), based on the humanitarian principles, will help to depoliticize aid and increase the understanding of all parties of the mandate of humanitarian action.

SEVERITY OF HUMANITARIAN ACCESS LIMITATIONS



The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.


























Source: Humanitarian access workshops in the field coordination hubs and a national survey on humanitarian access, 2019



For latest operational updates visit:

reliefweb.com/country/ven

HUMANITARIAN ARCHITECTURE TIMELINE 2018 - 2019

| | | | | |
|------------------|---|---|--|--|
| November - 2018 |  |  | Central Emergency Response Fund (CERF) allocation \$9.2M | Response scale-up |
| December - 2018 |  | | | |
| January - 2019 |  | | | |
| February - 2019 |  |  | Activation of the Cooperation and Assistance Coordination Team (ECCA in Spanish) and sectors | |
| March - 2019 |  |  | 2019 humanitarian needs analysis | |
| April - 2019 |  | | | |
| May - 2019 |  |  | Appointment of the Humanitarian Coordinator | |
| June - 2019 |  |  | Activation of Clusters and AoR | |
| July - 2019 |  |  | Activation of the field coordination hubs in San Cristobal and Ciudad Guayana | |
| August - 2019 |  |  | Publication of the 2019 HRP | Statement by the Humanitarian Coordinator for World Humanitarian Day |
| September - 2019 |  |  | Publication of monthly situation reports | |
| October - 2019 |  |  | CERF allocation \$10M | Activation of the field coordination hub in Maracaibo |
| November - 2019 |  |  | Visit of the Emergency Relief Coordinator, Mark Lowcock | Activation of the field coordination hub in Caracas |
| December - 2019 |  |  | 2.4 million people reached with humanitarian assistance between July and December 2019 | |

Part 2

Monitoring and Accountability



PHOTO: UNFPA

2.1

Monitoring

Although increased operational capacity and presence in the field has strengthened response monitoring, further enhancing it remains a priority for the HCT to ensure that assistance reaches the most vulnerable populations in a timely, predictable and effective manner, with full adherence to the humanitarian principles. The monitoring approach in Venezuela includes four lines of action, focused on the monitoring of results, humanitarian needs, project implementation and feedback from affected communities (see section 2.2).

Monitoring, risk management and due diligence

As foreseen in the Joint Operating Principles, humanitarian organizations have a strict zero tolerance approach towards the diversion of humanitarian assistance and other forms of corruption, fraud and conflicts of interest. Humanitarian organizations, at both the inter-agency and the agency level, implement checks and balances measures to monitor service delivery and to ensure that humanitarian assistance reaches people most in need. This includes system-wide guidance, monitoring and collection of data on incidents of interference, outreach to parties that may interfere in humanitarian activities, and promoting due diligence with partners.

Humanitarian organizations use risk management and due diligence procedures throughout the HPC, including independent beneficiary selection methodologies and regular programme monitoring. Operational processes, including those related to selection of implementing partners, procurement of supplies, recruitment and financial transactions, are also monitored.

Humanitarian organizations are committed to organizing regular trainings on monitoring and procurement mechanisms for humanitarian staff and partners and to raise awareness on risks of aid diversion and other integrity issues (such as prevention of fraud and corruption and conflict of interest, among others).

Results monitoring

Under the guidance of the HCT, the ICCG and the Information Management Working Group (IMWG) will lead the monitoring of the response, including monitoring of the indicators measuring progress against the specific and sectoral objectives. Regular progress reports on the response will be published, principally through the Humanitarian Dashboard and products of relevance to each cluster. OCHA, jointly with the ICCG, is developing a new information system to collect data, including a 5W tool (Who does what, where, when and for whom), a humanitarian response monitoring tool adapted to the Venezuelan context. This tool is used to monitor the number of people reached with the activities implemented by humanitarian partners, and to identify gaps and avoid duplications in the humanitarian

response. Clusters receive monthly reports on the results achieved by their partners through the 5W tool. These feed into the joint analysis of results at the sectoral and multisectoral level. The Response Planning and Monitoring Tool (RPM) and other OCHA online tools will complement this monitoring.

Monitoring will enhance the transparency of the humanitarian response, promote accountability to affected people, ensure the effectiveness of programmes and the adoption of evidence-based corrective measures.

HRP partners will report the funds they have received through the Financial Tracking Service (FTS) to monitor the level of funding and identify potential gaps, which may limit the humanitarian response and the achievement of expected results.

Humanitarian needs monitoring

In addition to monitoring the progress of the response, efforts will be made to ensure that evidence is regularly gathered on humanitarian needs as these evolve and influence response priorities, particularly in relation to the most vulnerable groups, the number of people in need, the most affected areas and the type of assistance required to reduce their vulnerability. Humanitarian needs assessments by humanitarian organizations are key components of the HPC, which should focus on information gaps at the intersectoral level. The development of joint assessment tools to standardize indicators for humanitarian needs data collection at the sectoral and inter-sectoral levels will be encouraged. The IMWG will use the Assessment Registry to follow-up on assessments carried out by humanitarian actors and will ensure coordination and cooperation between OCHA and the clusters.

Needs analysis will also be informed by regular dialogue with public institutions, such as the National Institute of Statistics and line Ministries for access and review of official data. Data collected by the observatories and civil society organizations will also be reviewed, and the Field Coordination Hubs will provide regular analysis of the needs identified to OCHA and the ICCG. In addition, and contingent on funding availability, several projects will contribute to needs monitoring, including protection monitoring, the Mobility Tracking Matrix, and market monitoring to inform the development of cash transfer programmes.

Project monitoring

The projects outlined in the Plan will have their own specific monitoring arrangements. All projects included in the HRP are aligned with the activities and indicators defined by the clusters. All partners commit to using the 5W tool to contribute to response monitoring.

The expanded presence of the UN in the country, with over 500 staff

members in 14 states, and the coverage of NGOs across the country, allows for closer monitoring of project implementation, with regular visits in project areas and direct interviews with families and people reached.

To complement the individual initiatives of humanitarian actors, OCHA has recruited 18 United Nations Volunteers (UNV) at the community level, in prioritized areas with limited UN presence. The volunteers will be based in the field coordination hubs and will report to OCHA field offices. Community monitoring will be an additional source of information on people's needs, response, humanitarian access and community perceptions.

Efforts will continue to strengthen local organizations' capacities related to project management and monitoring. Regarding information management, secure systems will be developed and implemented to facilitate the collection, storage, analysis, consultation and visualization of data collected.



SAN ANTONIO, TACHIRA STATE
Photo: OCHA/Gema Cortés

2.2

Accountability to Affected Populations and Protection against Sexual Exploitation and Abuse

Accountability to Affected Populations (AAP) is part of the Joint Operating Principles, which apply to all HRP partners. In line with these principles, all partners are committed to placing the affected people at the centre of the response, ensuring that affected communities and individuals are aware of their rights, have access to humanitarian information and participate in decisions that affect them at all stages of the HPC. Partners also have a responsibility to establish mechanisms that enable affected populations to identify their priorities and needs, share with humanitarian actors their perspectives on the adequacy and relevance of the response actions, and receive feedback on corrective actions implemented in response to their observations.

The capacity-building workshops for organizations participating in the 2020 HPC included AAP and presented the Core Principles for Accountability and the 2017 IASC Commitments to AAP. In 2019, partners also benefited from trainings on integrating prevention, risk mitigation and response to sexual exploitation and abuse into their programmes.

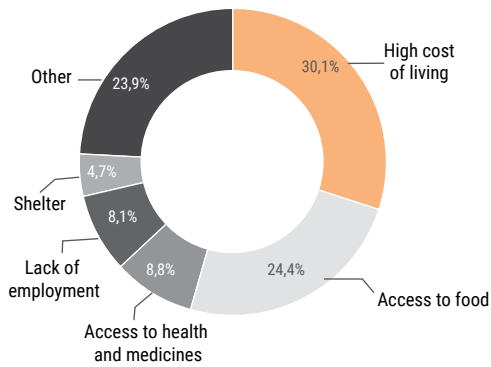
In 2020, the HCT in Venezuela will continue to consolidate AAP systems and strengthen coordination in this area. Strengthened capacities for a comprehensive approach to the AAP processes will be ensured. The creation of a safe and accessible interagency complaints and feedback mechanism, including a potential call centre, will be a priority, to complement already existing mechanisms at agency level. Projects in the 2020 Plan include various mechanisms to receive community feedback and ensure community engagement, such as satisfaction surveys (including post-distribution surveys), suggestion boxes, telephone lines and e-mails, feedback on social media platforms and organizations' websites, the creation of community committees, regular follow-up meetings with communities and focus group discussions, ensuring the active participation of women, men, girls, boys, adolescents, young people and LGBTI people, as well as the presence and regular visits of community facilitators, among others. All mechanisms seek to guarantee accessibility and confidentiality.

The link between AAP and Protection against Sexual Exploitation and Abuse (PSEA), two collective responsibilities of the humanitarian community at the global level, will be strengthened. In line with the UN policy and IASC principles, humanitarian organizations in

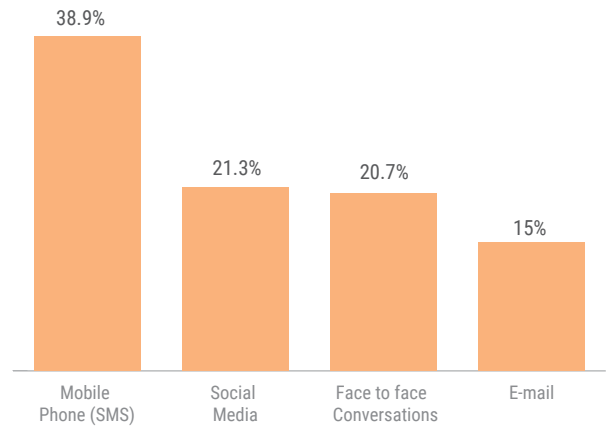
Venezuela have a zero-tolerance policy towards SEA. Implementation capacities of PSEA measures were considered in the project selection process. The Inter-Agency Network of PSEA Focal Points, created in 2019, defined a plan of action focused on four priorities: to strengthen organizations' capacity on PSEA; to establish community complaints mechanisms; to assist survivors; and to strengthen coordination at national and sub-national levels. The PSEA Inter-Agency Network will create a group of trainers who will further strengthen staff capacities. An inter-agency protocol for PSEA complaints will be established to clarify referral procedures and survivors' assistance process.

Efforts to implement AAP and PSEA mechanisms will be based on the results of the AAP survey conducted between January and March 2020, which reached some 7,900 people in all states to consult them on the humanitarian response, in addition to 19 focus group discussions in nine states and 16 interviews with key informants in seven states. The results of the telephone survey indicate that the main challenges facing affected populations include the high cost of living (30.1 per cent of those surveyed), access to food (24.4 per cent) and access to health services and medicines (8.8 per cent). A total of 29.4 per cent of the respondents expressed satisfaction about the work of humanitarian personnel in their community, while 59.1 per cent mentioned that they had not seen any humanitarian staff in their community in the previous six months. Regarding complaints and feedback mechanisms, receiving and reporting information via telephone, social media, and in-person conversations are preferred. Respondents preferred face-to-face surveys, telephone surveys, and group discussions to be used for their involvement in decision-making regarding assistance. A total of 86 per cent were not aware of existing mechanisms regarding humanitarian activities in their community. These results underline the importance of establishing complementary AAP mechanisms (digital and face-to-face) and strengthen the information about the existence of these reporting and feedback channels.

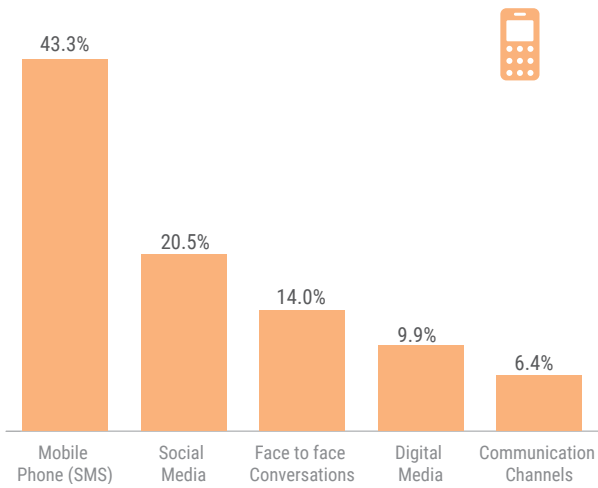
MAIN DIFFICULTIES REPORTED BY THE COMMUNITY



PREFERRED COMMUNICATION CHANNELS TO SEND INFORMATION



PREFERRED COMMUNICATION CHANNELS TO RECEIVE INFORMATION



Source: Accountability to Affected Population Survey, OCHA 2020
























Part 3

Sectoral Plans



PUERTO ORDAZ, BOLIVAR STATE
Photo: OCHA/Gema Cortés

Overview of Sectoral Response

| CLUSTER | REQUIREMENTS (US\$) | PARTNERS | NUMBER OF PROJECTS | PEOPLE TARGETED BY THE 2020 HRP* |
|--|--|----------|--------------------|---|
|  Health | \$251.9 M  | 40 | 55 | 4.0 M  |
|  Food Security and Livelihoods | \$158.1 M  | 52 | 66 | 1.1 M  |
|  Education | \$106.1 M  | 37 | 42 | 1.5 M  |
|  Water, Sanitation and Hygiene | \$105.1 M  | 28 | 33 | 2.7 M  |
|  Protection** | \$69.3 M  | 39 | 56 | 1.6 M  |
|  Shelter, Energy and NFIs | \$42.5 M  | 24 | 29 | 1.1 M  |
|  Nutrition | \$19.0 M  | 30 | 29 | 0.7 k  |
|  Coordination and Logistics | \$10.5 M  | 7 | 8 | |

*The target population of the 2020 HRP corresponds to the number of people that would receive multi-sectoral assistance in 2020 with the required funding and access. Each cluster identified its target population based on the projects presented by humanitarian partners, focused on direct assistance to beneficiaries.

** The Protection funding requirement includes all the AoR requirements which form part of the Protection Cluster [Child Protection and Gender-based violence]

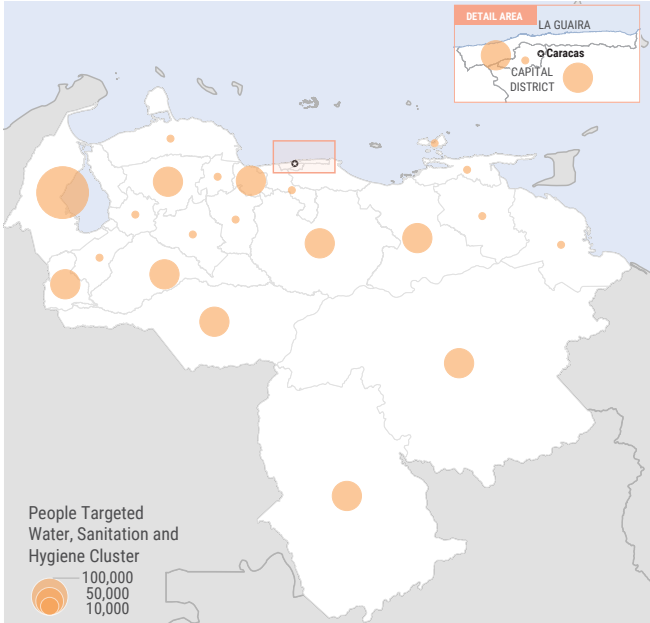
3.1 Water, Sanitation and Hygiene

PEOPLE TARGETED BY THE 2020 HRP

2.7M

REQUIREMENTS (US\$)

\$105.1M



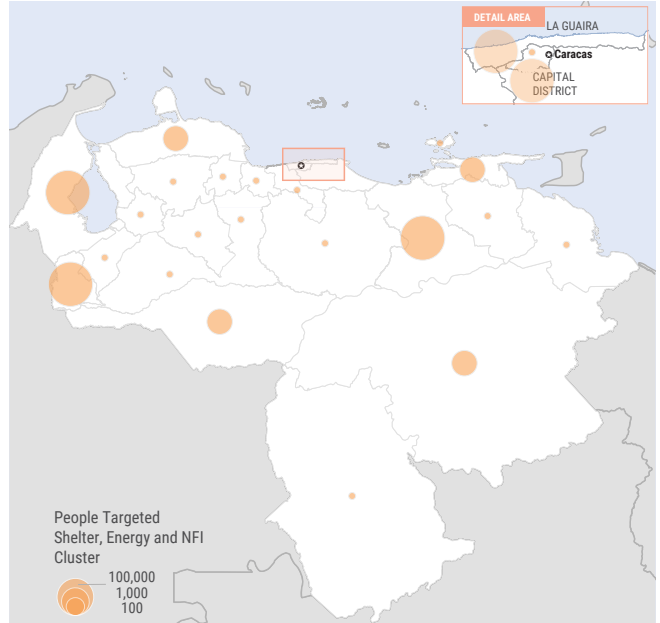
3.2 Shelter, Energy and NFIs

PEOPLE TARGETED BY THE 2020 HRP

1.1M

REQUIREMENTS (US\$)

\$42.5M



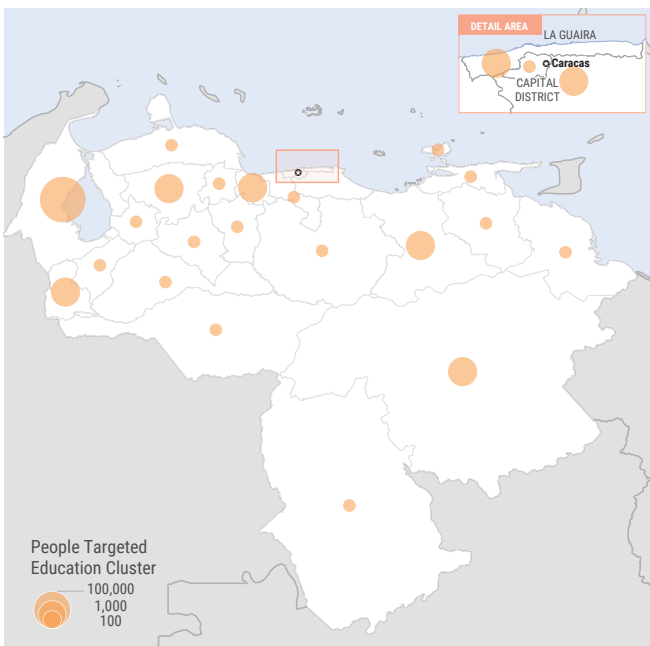
3.3 Education

PEOPLE TARGETED BY THE 2020 HRP

1.5M

REQUIREMENTS (US\$)

\$106.1M



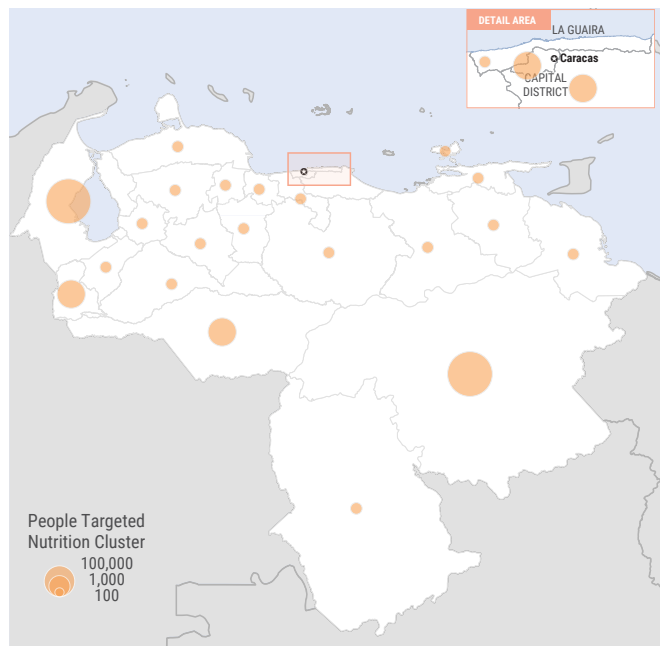
3.4 Nutrition

PEOPLE TARGETED BY THE 2020 HRP

700k

REQUIREMENTS (US\$)

\$19.0M



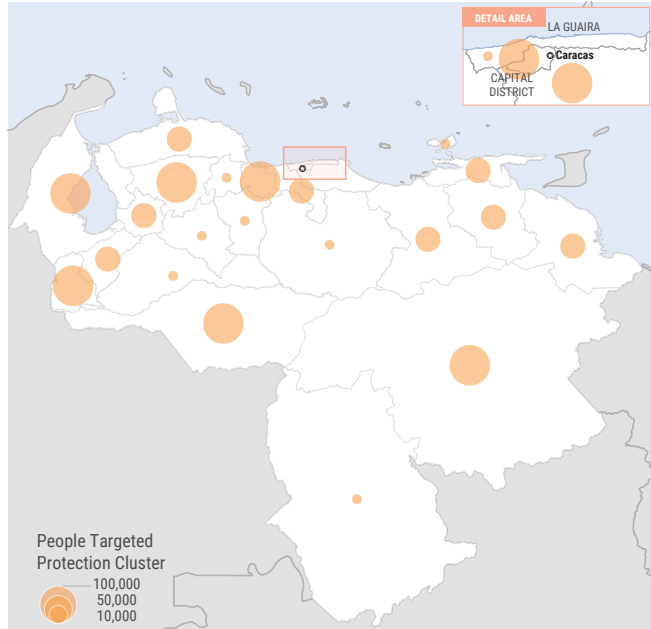
3.5 Protection

PEOPLE TARGETED BY THE 2020 HRP

1.6M

REQUIREMENTS (US\$)*

\$69.3M



* The Protection funding requirement includes all the AoR requirements which form part of the Protection Cluster [Child protection and Gender-based violence]

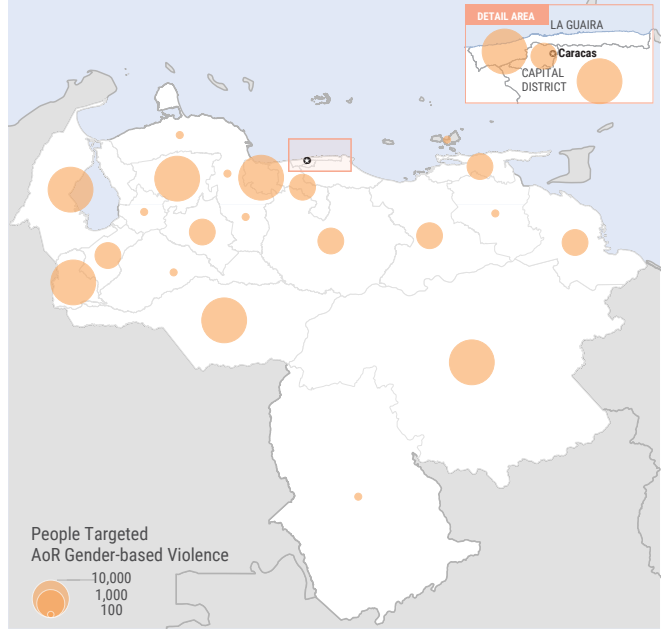
3.5.1 Gender-Based Violence AoR

PEOPLE TARGETED BY THE 2020 HRP

300k

REQUIREMENTS (US\$)

\$12.2M



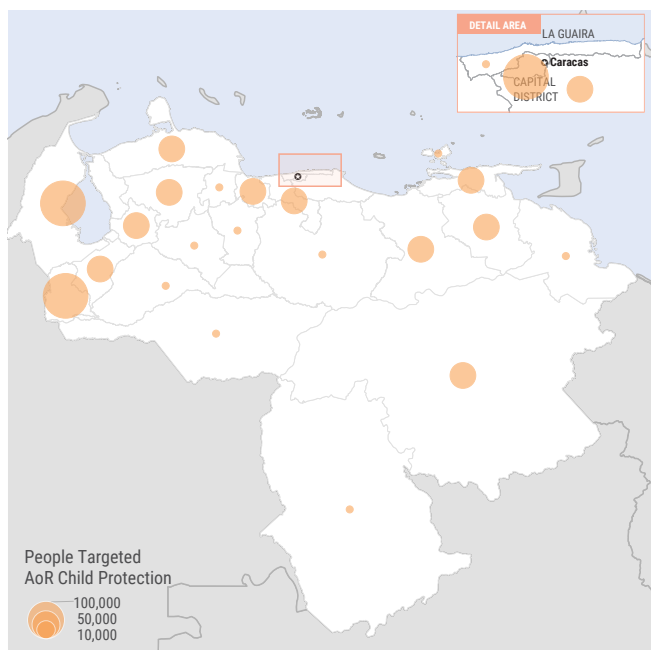
3.5.2 Child Protection AoR

PEOPLE TARGETED BY THE 2020 HRP

700k

REQUIREMENTS (US\$)

\$18.5M



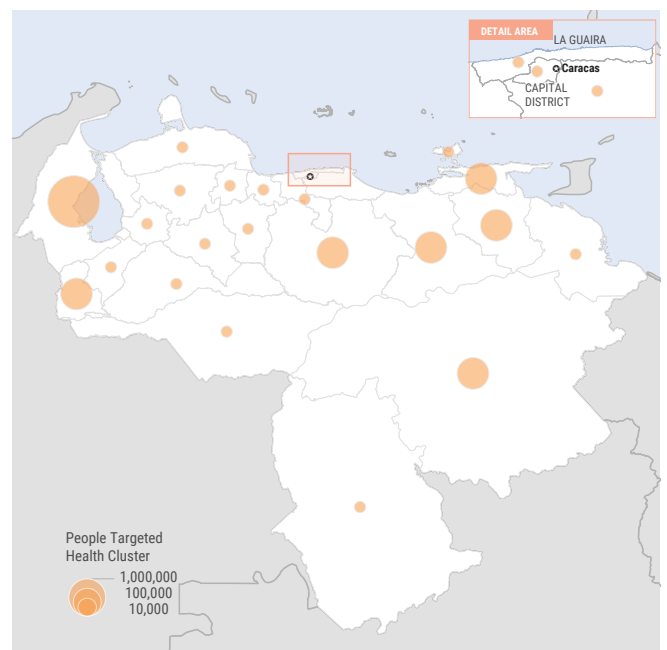
3.6 Health

PEOPLE TARGETED BY THE 2020 HRP

4.0M

REQUIREMENTS (US\$)

\$251.9M



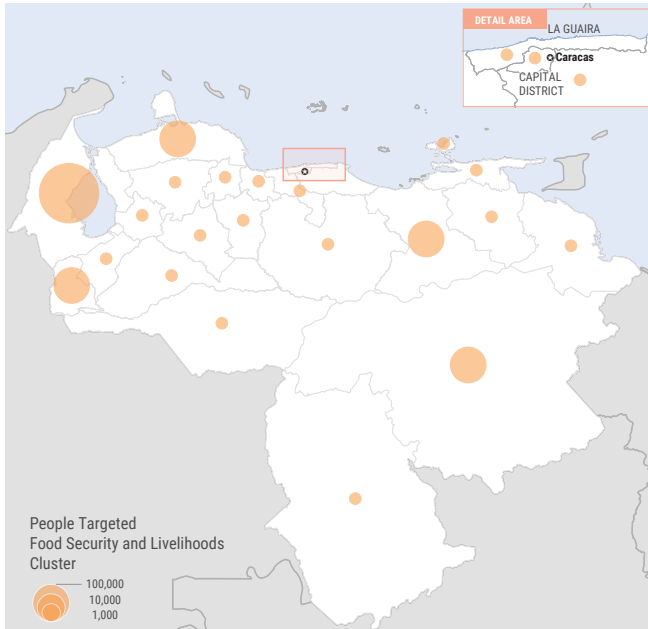
3.7 Food Security and Livelihoods

PEOPLE TARGETED BY THE 2020 HRP

1.1M

REQUIREMENTS (US\$)

\$158.1M



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3.1

Water, Sanitation and Hygiene



PEOPLE TARGETED BY THE 2020 HRP

2.7M

REQUIREMENTS (US\$)

\$105.1M

PARTNERS

28

PROJECTS

33

Sectoral Objectives

The WASH Cluster has two sectoral objectives:

SECTORAL OBJECTIVE 1:

Ensure access to basic water, sanitation, hygiene and environmental sanitation services for vulnerable populations (especially children, adolescents, pregnant and lactating women) in health and nutrition facilities, education institutions, learning spaces, community centers and temporary shelters.

SECTORAL OBJECTIVE 2:

Ensure access to safe water, sanitation and hygiene in vulnerable communities, and empower people to adopt appropriate evidence-based practices for access to safe water, hygiene, environmental hygiene, and household water treatment and storage.

The first sectoral objective will contribute to Strategic Objective 1/ Specific Objective 1.1, which aims at reducing the vulnerability of affected people to mortality and morbidity risks from communicable, non-communicable and mental health diseases, by improving their access to basic goods and health, water and sanitation services.

The recovery of essential services to ensure minimum aseptic conditions in health and nutrition facilities, as well as access to water and sanitation, is critical to improve health and nutrition services and to contribute to the reduction of mortality and morbidity. In the context of the COVID-19 outbreak, it is critical to strengthen IPC capacities in prioritized health-care facilities, including sentinel hospitals and health centers, as well as temporary shelters including the PASIs.

Expanding access to WASH in schools and community spaces will contribute to improving the health of children and adolescents, teachers, administrative and labour staff. It will also help to improve school attendance and work performance.

Planned activities will cover all WASH components: ensuring safe water supply and basic sanitation; hygiene promotion; distribution of hygiene kits; solid waste management for households/hospitals; and training and technical advice for maintenance staff.

The second sectoral objective will contribute to Strategic Objective 2/Specific Objective 2.2, which aims at enhancing equal and safe access to, and ensuring quantity, quality and continuity of, basic services in the areas of health, water and sanitation, education, electricity and energy for cooking.

The WASH cluster will contribute to improving water and sanitation services in communities through restoring essential services at community level and supporting the most vulnerable at the individual level. This includes: 1) improving access to safe water and basic sanitation through specific repairs to distribution and sewage systems; 2) promoting adequate hygiene practices; 3) distributing hygiene kits to the most vulnerable people; 4) improving garbage collection and drainage services; 5) reducing the risk of vector-borne diseases; and 6) providing training and equipment for technical committees or community councils for the maintenance of services and infrastructure.

Response approach

The response will target the most vulnerable groups, including children (especially children under age five), pregnant and lactating women, people with disabilities and those with specific health needs. People living in poverty are at a higher risk of death related to water-borne diseases (caused by lack of access to safe water and poor sanitation conditions). Malnourished children, pregnant and lactating women are more vulnerable to complications due to lack of access to basic WASH services. Similarly, the lack of access to safe water services increases the risks of malnutrition. People on the move, including returnees, are also considered to be among the most vulnerable.

The WASH Cluster will ensure a gender-based approach to facilitate the meaningful participation of girls, adolescents and women in identifying and assessing needs, decision-making and project design.

Water and sanitation services are essential for the optimal implementation of activities in all clusters. Consequently, most WASH interventions correspond to WASH activities integrated within health, education, nutrition and protection programmes among others, and have been coordinated and prioritized with the relevant clusters.

In the context of COVID-19, the WASH response will be provided in prioritized health-care facilities. Efforts will also include improving WASH conditions in temporary shelters for returnees.

The states of Amazonas, Bolivar, Delta Amacuro, Falcon, Guarico, La Guaira, Nueva Esparta and Zulia will be prioritized for response. COVID-19 response includes the provision of WASH services in urban communities from prioritized states with a higher population density and higher risk of exposure to the virus.

Activities will include technical repairs / rehabilitation at pumping and

/ or treatment and / or distribution stations; the installation of wells in some critical facilities (including hospitals); the installation of storage tanks and community filters; water trucking; voucher distribution for trucked water, and promotion / provision of treatment at the household level.

The sustainability of WASH assistance will be achieved through the creation as well as provision of training and technical advice to technical committees, communal councils and staff at health facilities and educational or community spaces. Capacity-building efforts will focus on the importance of water and hygiene in public health, the management and maintenance of systems, and the culture of individual and community responsibility. This will enable the development of sustainable solutions for families and communities.

Since the 2019 HRP, the operational capacity of the WASH Cluster has increased from 18 partners to 29, with presence in all prioritized states.

The cluster will seek to organize training and knowledge-exchange sessions on technical WASH subjects among members and

to develop technical guidelines based on best practices and lessons learned. It will incorporate key elements from national contextualization exercises, as well as cross-cutting themes. It will also promote and share market-based approach initiatives and pilots, in collaboration with other relevant clusters.

Monitoring

Monitoring the WASH response will be mainly through the 5W tool. WASH Cluster members also undertake internal monitoring, including through site visits to projects.

For needs monitoring, the WASH Cluster will use common needs assessment and monitoring tools. These are linked to the minimum standards defined by the cluster for data collection in communities, at household level and in health and educational facilities. Finally, the WASH Cluster will seek to build capacity, support and monitor the implementation of the five minimum commitments.⁴⁷

Contact

David Alford, dalford@unicef.org



PHOTO: UNICEF

Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|--|---|-----------------------------------|
| <p>Strategic Objective 1: Ensure the survival and well-being of the most vulnerable people through a multi-sectoral response under a rights-based approach, including age, gender and diversity dimensions</p> | | |
| <p>Specific Objective 1.1: Reduce the vulnerability of affected people to mortality and morbidity risks from communicable, non-communicable and mental health diseases by improving their access to basic goods and services related to health, water and sanitation, incorporating age, gender and diversity dimensions</p> | | |
| <p>Sectoral Objective 1: Ensure access to basic water, sanitation, hygiene and environmental sanitation services for vulnerable populations (especially children, adolescents, pregnant and lactating women) in health and nutrition facilities, education institutions, vocational learning institutions, community centers and temporary shelters</p> | <p># health and nutrition facilities, educational institutions, learning spaces and community spaces/centres benefiting from WASH interventions</p> | 2.5 k |
| <p>Strategic Objective 2: Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions</p> | | |
| <p>Specific Objective 2.2: Improve equal and safe access to essential goods and services in the areas of health, water and sanitation, education, electricity and energy for cooking for the most vulnerable populations, seeking appropriate quantity, quality and sustainability of the provision of the services, incorporating age, gender and diversity dimensions</p> | | |
| <p>Sectoral objective 2: Ensure access to safe water, sanitation and hygiene in vulnerable communities, and empower people to adopt appropriate evidence-based practices for access to safe water, hygiene, environmental hygiene, and household water treatment and storage</p> | <p># people with access to basic safe water and sanitation services in the communities</p> | 2.2 M |
| | <p># people who have access to basic information on household hygiene and/or essential hygiene products</p> | 1.3 M |
| | <p># people benefiting from environmental sanitation activities, to reduce the risk of vector-borne diseases</p> | 76.7 k |

3.2

Shelter, Energy and Non-food items



| PEOPLE TARGETED BY THE 2020 HRP | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---------------------------------|---------------------|----------|----------|
| 1.1M | \$42.5M | 24 | 29 |

Sectoral objectives

The Shelter, Energy and NFIs Cluster has five sectoral objectives:

SECTORAL OBJECTIVE 1:

Support institutions and organizations by improving basic infrastructure, including small works with the greatest impact on affected vulnerable people.

SECTORAL OBJECTIVE 2:

Support health centers, schools, and other community spaces or institutions that deliver services to affected populations, with repairs and construction work.

SECTORAL OBJECTIVE 3:

Assist the target population through distributions of basic items.

SECTORAL OBJECTIVE 4:

Provide shelter to the target population and improve their housing and energy conditions in collective shelters, including the PASIs for returnees.

SECTORAL OBJECTIVE 5:

Improve housing and energy conditions for the target population in individual shelters.

The cluster will contribute to improving living conditions and resilience of vulnerable populations (Strategic Objective 2), with special emphasis on people on the move, including returnees, ensuring that they receive assistance to improve their housing conditions and access to energy, goods and basic equipment (Specific Objective 2.3). In parallel, the cluster will contribute to enhancing safe access to essential goods and services, through repairs and constructions in community spaces, the distribution of supplies, and support to key institutions for the improvement of infrastructure such as health-care centers and schools (Specific Objective 2.2).

Response approach

During 2020, the 24 partners of the Shelter, Energy and NFIs Cluster aim to reach 1,124,753 people with a protection focus. This includes people on the move, returnees, indigenous communities, people with disabilities, people with non-communicable diseases, the elderly, and refugees and people at risk of statelessness, who display the following characteristics:

- Living in communities with limited access to basic services, such as electricity and energy for cooking; benefiting from

assistance at community centers and spaces (e.g. sports facilities, gymnasiums, community meeting spaces) or from competent organizations lacking sufficient resources to provide comprehensive assistance in the areas of shelter, energy and NFIs.

- On the move, staying in PASIs or other temporary shelters overnight, in border areas or transit states.
- Living in overcrowded conditions in individual shelters or inadequate homes in host communities, especially in border areas.

To enhance communities' access to basic services, the cluster will seek to improve their access to energy sources, by distributing solar lamps and providing power generators and photovoltaic plants to key service providers. Partners will also construct, repair and rehabilitate community centers and spaces managed by organizations that serve a relevant part of the community or have a wide coverage area for shelter, energy and NFIs, aiming to reach 670,136 targeted people. All interventions will comply with international standards for people with disabilities and will ensure a gender, age and diversity focus. The proposed energy solution is based on hybrid and renewable energy systems.

Interventions in temporary shelters will focus on the construction, repair or provision of equipment, including access to energy, to ensure adequate accommodation for 484,094 targeted people. In the COVID-19 context, the priority is to ensure decent and safe temporary accommodation for the increasing number of returnees complying with quarantine protocols and prevent the spread of the virus. The Shelter, Energy and NFIs Cluster will support responsible institutions to establish temporary shelters for returnees, by providing and installing tents, setting up handwashing points and water supply systems, installing chemical toilets, among other activities, and by providing trainings on temporary shelter management, hygiene conditions, hygiene protocols and gender-based violence risks, in coordination with the Health, WASH and other clusters. Returnees at the shelters will receive hygiene and cleaning materials, dignity kits, mats, filters, mosquito nets, solar lamps and other NFIs. Food distribution will be coordinated with the Food Security and Livelihoods Cluster partners. Efforts will be made with the Protection Cluster and its AoR to identify and refer protection cases to the appropriate services, and to provide psychosocial assistance.

Finally, to assist people on the move as well as host communities, the cluster plans interventions in overcrowded individual homes and homes built using sub-standard materials, including repair and rehabilitation. Partners will also distribute appropriate kits and supplies for people on the move. The proposed interventions plan to reach 333,010 targeted people.

Prioritized states are: Amazonas, Apure, Bolivar, Delta Amacuro, Sucre, Tachira and Zulia; and to a lesser extent, Anzoategui, Carabobo, Capital District, Falcon, Guarico, Miranda and Monagas. Border municipalities with official and informal crossings to neighboring countries, including pendular movements, and migratory movements with and without the intention of permanence will be prioritized. Some central states reporting the transit of migrants returning to Venezuela in the context of the COVID-19 pandemic have also been identified for prioritization.

Monitoring

The response will be monitored using the 5W tool. The mapping of temporary shelters is a key element for monitoring their functionality and host capacity. Partners will contribute to the measurement of the

impact of their activities through a post-distribution/implementation monitoring system.

Response and needs monitoring will be coordinated with other sources including bilateral discussions with focal points in relevant institutions, primary and secondary data collection and analysis, partner reports and AAP mechanisms.

To implement the monitoring protocols, training will be provided for partners, and visits to prioritized states will be carried out. Data collection processes through primary sources will be reinforced, where possible.

Contact

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LA GUANA, LA GUAJIRA, ZULIA STATE

Photo: OCHA/Gema Cortés

Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|--|---|-----------------------------------|
| <p>Strategic Objective 2: Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions</p> | | |
| <p>Specific Objective 2.2: Improve equal and safe access to essential goods and services in the areas of health, water and sanitation, education, electricity and energy for cooking for the most vulnerable populations, seeking appropriate quantity, quality and sustainability of the provision of the services, incorporating age, gender and diversity dimensions</p> | | |
| <p>Sectoral Objective 1: Support institutions and organizations by improving basic infrastructure, including small works with the greatest impact on affected vulnerable people.</p> | <p># people benefiting from improved access to electricity or energy sources in community centers or institutions</p> | <p>160 k</p> |
| <p>Sectoral Objective 2: Support health centers, schools, and other community spaces or institutions that deliver services to affected populations, with repairs and construction work.</p> | <p># people benefiting from repairs, constructions and improvements in community centers or institutions providing basic services, with a gender, age and diversity focus</p> | <p>650 k</p> |
| | <p># women, men, girls and boys benefiting from training at community centers and in indigenous communities</p> | <p>200 k</p> |
| <p>Sectoral Objective 3: Assist the target population through distributions of basic supplies.</p> | <p># people receiving material assistance through NFIs, which responds to their specific needs, with a gender, age and diversity focus</p> | <p>260 k</p> |
| <p>Specific Objective 2.3: Guarantee access to adequate and age-gender sensitive shelter and energy provision for people on the move who are in informal settlements, homeless people, and those at risk of displacement</p> | | |
| <p>Sectoral Objective 4: Provide shelter to the target population and improve their housing and energy conditions in collective shelters, including the PASIs for returnees.</p> | <p># people on the move, including returnees, whose access to accommodation in collective shelters is improved</p> | <p>230 k</p> |
| | <p># people on the move who benefit from awareness on the sustainability of the activity (safety protocols, maintenance and optimal functionality)</p> | <p>100 k</p> |
| <p>Sectoral Objective 5: Improve housing and energy conditions for the target population in individual shelters.</p> | <p># people whose housing conditions in individual temporary shelters are improved</p> | <p>70 k</p> |

3.3

Education



| PEOPLE TARGETED BY THE 2020 HRP | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---------------------------------|---------------------|----------|----------|
| 1.5M | \$106.1M | 37 | 42 |

Sectoral objectives

The Education Cluster has two sectoral objectives:

SECTORAL OBJECTIVE 1:

Enhance the conditions and provision of educational services to guarantee inclusive access, retention and quality learning for children and adolescents in areas most affected by school dropouts.

SECTORAL OBJECTIVE 2:

Strengthen institutional and technical capacities of the educational community to ensure equal access and continuity of education in areas most affected by student dropouts and teacher departures.

Under the two sectoral objectives, the Education Cluster will contribute to the sustainability of basic services and strengthen the resilience and livelihoods of the most vulnerable people with a gender, age and diversity focus (Strategic Objective 2). The cluster will focus its efforts on Specific Objective 2.2, aiming at improving equal and safe access to basic goods and services in the areas of health, water and sanitation, education, electricity, and energy for cooking, ensuring quantity, quality and continuity of the services and with a gender, age and diversity focus.

Under the first sectoral objective, efforts will be made to provide learning materials to 1.5 million students and to reach 622,000 students with school feeding programmes, in coordination with the Food Security and Livelihoods Cluster. This will enhance the educational experience and improve motivation to attend and remain in school.

The strategy also aims to reach 356,000 out-of-school children and adolescents with non-formal education opportunities and mechanisms for re-entry into formal schooling as a first step towards their educational inclusion. This will be complemented by awareness-raising campaigns on the importance of general education while including health and hygiene messages for more than 3.7 million people.

To help children and adolescents out of school or at risk of dropping out, the cluster plans to implement psychosocial support activities in educational spaces benefiting 353,000 children and adolescents. The strategy includes recreational, artistic and sports after-school activities that promote a culture of peace and recognition of diversity for 309,000 children and adolescents in vulnerable contexts. The response aims to promote schools and educational centers as safe

spaces for the well-being and peace of the country.

Finally, as a new component, the response targets adolescents and young people who, having graduated from regular education, are unemployed and/or without access to technical or higher education opportunities. The cluster proposes to implement programmes on life and work skills, vocational training and technical education for 117,000 low-income adolescents and young people.

To meet the second sectoral objective, partners will focus on strengthening the capacities of the education system, particularly those of the teaching staff. To ensure quality learning, the cluster will strengthen the capacities of at least 41,000 teachers, caregivers and other educators. Out of the total number of trained teachers, at least 25,000 will be targeted with allowances to encourage their continuous presence and professional development, linked to the improvement of their working conditions and the development of their technical skills.

The strategy includes capacity-building at the local level to anticipate risks. Towards this end, the cluster proposes the development of contingency plans with the education authorities at the national and sub-national levels in Zulia, Tachira and Bolivar.

In response to the COVID-19 outbreak and the preventive measures to guarantee the right to education through distance learning modalities, the Education Cluster has re-prioritized its activities towards two objectives: (1) to guarantee the continuity of learning in safe and protective spaces for children and adolescents affected by the closure of schools; and (2) to strengthen the capacities of the education system to efficiently respond to the situation and to prepare to return to school in the best possible way.

Response approach

The Education Cluster seeks to reach 1.5 million people with a focus on the most vulnerable groups, including indigenous people; children and adolescents with disabilities; and children and adolescents living in border, mining and rural areas. Identifying out-of-school children and adolescents and designing flexible and relevant strategies for their full re-insertion will be a priority. Of the total target population, 11 per cent are indigenous communities, 7 per cent are people with disabilities and 7 per cent are pregnant teenagers.

The response will focus on the states with the most urgent education needs: Anzoategui, Apure, Bolivar, Carabobo, Guarico, La Guaira, Merida, Monagas, Nueva Esparta, and Yaracuy. Some interventions

will be implemented in other states with important education needs, including Zulia and Tachira.

Given that many factors peripheral to school discourage children and adolescents from continuing their schooling, the response will have an intersectoral approach. The Education Cluster will work closely with the WASH Cluster (raising awareness on hygiene practices and improving sanitation systems), Food Security and Livelihoods Cluster (implementing school feeding activities), Protection Cluster (referring cases to specialized services), and Shelter, Energy and NFIs Cluster (minor repairs to school infrastructure), among others. Towards that end, the link between schools and communities will be strengthened, encouraging the community-based management of educational centers. In the context of COVID-19, the Education Cluster will strengthen linkages with other clusters to ensure an integrated response, including psychosocial support for children and adolescents during quarantine, and continuation of school feeding programmes through adapted modalities, for instance through individual distributions.

Regarding operational capacity, the number of partners has increased from 11 in the 2019 HRP to 37 in 2020, with presence in all states with the most urgent needs. The Education Cluster has incorporated specialized organizations in key areas such as assistance to people with disabilities, children, adolescents and young people in precarious situations, women at risk and indigenous populations in remote areas. In addition, Save The Children has become the co-lead of the Education Cluster, thus strengthening UNICEF's ongoing coordination efforts.

In coordination with the education authorities, linkages between humanitarian activities and the education system will be established; the institutionalization of several key activities (e.g. the use of the education kits as part of the national policy on learning resources) will be promoted; and quality standards (e.g. training for teachers and education personnel and the use of the shortened curriculum for populations out of school) will be defined.

Monitoring

The response will be monitored mainly using the 5W tool. In addition, partners have developed monitoring tools to track the distribution of kits. The Education Cluster will continue to contribute to the assessment of secondary data in line with its analytical framework to identify operational gaps and redirect actions.

The cluster proposes to support the MPPE in updating the School Management and Information System. By the end of 2019, discussions had been initiated between the MPPE and two UN agencies to advance this initiative.

Contact

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VALLE HONDO, BOLÍVAR STATE
Photo: OCHA/ Gema Cortés

Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|--|--|---|
| <p>Strategic Objective 2: Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions</p> | | |
| <p>Specific Objective 2.2: Improve equal and safe access to essential goods and services in the areas of health, water and sanitation, education, electricity and energy for cooking for the most vulnerable populations, seeking appropriate quantity, quality and sustainability of the provision of the services, incorporating age, gender and diversity dimensions</p> | | |
| <p>Sectoral Objective 1: Enhance the conditions and provision of educational services to guarantee inclusive access, retention and quality learning for children and adolescents in areas most affected by school dropouts</p> | # children who receive school kits | 1,5 M |
| | # children benefiting from adequate school feeding programmes in line with hygiene standards | 622 k |
| | # people who receive messages on hygiene and are sensitized to the importance of education | 3,7 M |
| | # out-of-school children who have access to formal and non-formal, initial, basic and secondary education opportunities | 356 k |
| | # adolescents and young people participating in educational catch-up programmes, life skills initiatives and technical training | 117 k |
| | # children participating in psycho-educational support activities in educational spaces | 353 k |
| | # children participating in recreational activities outside school hours | 309 k |
| | <p>Sectoral Objective 2: Strengthen institutional and technical capacities of the educational community to ensure equal access and continuity of education in areas most affected by student dropouts and teacher departures.</p> | # teachers and other educators participating in quality training programmes |
| # teachers and other educators who benefit from continuous presence and professional development allowances | | 25 k |
| # active preparedness and contingency plans at the national and local levels | | 5 |

3.4 Nutrition



| PEOPLE TARGETED BY THE 2020 HRP | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---------------------------------|---------------------|----------|----------|
| 700k | \$19.0M | 30 | 29 |

Sectoral Objectives

The Nutrition Cluster has four sectoral objectives:

SECTORAL OBJECTIVE 1:

Enhance access to outpatient health services and nutrition programmes at community level for children under age five and pregnant and lactating women, for the prevention of acute malnutrition and micronutrient deficiencies.

SECTORAL OBJECTIVE 2:

Enhance access to and provision of health services for the treatment of acute malnutrition as part of the efforts to reduce child morbidity and mortality.

SECTORAL OBJECTIVE 3:

Promote and support Infant and Young Child Feeding in Emergencies (IYCF-E) practices through a multi-sectoral approach by establishing effective coordination mechanisms and providing high-quality services and qualified technical support.

SECTORAL OBJECTIVE 4:

Enhance access to outpatient health services and nutrition programmes at community level for children ages 5-15, for the prevention of acute malnutrition and micronutrient deficiencies, integrated within health, food security and WASH activities.

The Nutrition Cluster will contribute to the survival and well-being of affected people through a multi-sectoral response under a rights-based approach, with a gender, age and diversity focus (Strategic Objective 1). The cluster will focus its efforts on reducing malnutrition among children under age five, pregnant and lactating women (Specific Objective 1.3) through its four sectoral objectives.

Under the first sectoral objective, the response will focus on preventing the risk of acute malnutrition in children under age two and pregnant and lactating women by providing nutritional supplements that compensate for their micronutrient deficiencies. The strategy includes nutritional screening of children under age five for the diagnosis of acute malnutrition. These actions also target pregnant and lactating women and include the treatment of intestinal parasitosis.

The second sectoral objective promotes the reduction of child morbidity and mortality by treating children under age five with moderate and severe acute malnutrition (with and without complications) in health-care services. In addition, the capacities

of health, civil society and community personnel in the preventive management and treatment of acute malnutrition will be strengthened. The response also includes the treatment of pregnant women who are anemic or underweight, to ensure the well-being of mothers and children.

Given the high risk of child mortality in the first 1,000 days of life, the third sectoral objective seeks to ensure child survival by integrating a dialogue with pregnant women, mothers, fathers and caregivers on appropriate infant feeding into key health, food security and WASH activities.

To reduce malnutrition in children ages 5-15, the fourth sectoral objective includes nutritional screening and preventive treatment of intestinal parasitosis. At the community level, outpatient treatment of acute malnutrition will also be guaranteed to restore the nutritional status of children and adolescents.

Response approach

The response will focus on pregnant and lactating women, newborns, children and adolescents at risk, people with disabilities, and indigenous people. The states with the most severe nutrition needs include Anzoategui, Bolivar, Monagas and Zulia; and to a lesser extent, the states of Amazonas, Apure, Barinas, Cojedes, Delta Amacuro, Distrito Capital, Falcon, La Guaira, Merida, Miranda, Portuguesa, Sucre, and Yaracuy. In the context of the COVID-19 pandemic, the response may imply changes in the modalities of intervention and in the prioritization of assistance to the most vulnerable groups. Examples include case monitoring using distance modalities and undertaking larger distributions of supplies to health centers to avoid multiple movements. New areas of intervention may include activities at temporary shelters for returnees where some cases of malnutrition have been identified.

The response will consider the age, gender and diversity dimensions and will be implemented through support to programmes at the community level and strengthening the capacities of the authorities at the national and state levels. Most projects are inter-sectoral with linkages between nutrition and food security, WASH, education and protection activities. Dialogue is maintained with the other sectors to guarantee a comprehensive response.

The number of partners of the Nutrition Cluster has increased from 10 in the 2019 HRP to 30 in 2020 with a presence in 23 states. Collaboration with the INN will ensure broad coverage across the country. Partners will ensure the presence of specialized

professionals providing nutritional services to the most vulnerable groups in remote and disadvantaged locations.

The participation and training of local health professionals, communities and civil society actors will ensure the sustainability of the response throughout 2020 by replicating these trainings with other key actors for nutritional services, thus strengthening capacities in the identification, treatment and monitoring of malnutrition in vulnerable groups. Similarly, partnerships and cooperation with local organizations and community leaders will allow for the expansion of the scope and sustainability of the response.

Finally, the Nutrition Cluster plans educational and counselling activities with the aim of empowering beneficiaries to become agents of change within their community.

Monitoring

The response will be monitored mainly using the 5W tool.

Mechanisms for community engagement will be promoted among

partners to monitor the level of satisfaction of the beneficiaries regarding nutritional assistance.

Monitoring includes visits to healthcare centers where nutrition projects are being implemented. This will facilitate the collection of primary information on the situation, based on data from the population treated for malnutrition. The regular visits also allow the verification of compliance with international protocols and the monitoring of supplies delivered to public and private entities.

Partners with the technical capacity and scope to assist and treat pregnant women with anemia could contribute to data generation, to contribute to the epidemiological overview of nutritional anemias in pregnant women and to strengthen its treatment and monitoring.

Contact

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PHOTO: CARITAS

Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|---|---|-----------------------------------|
| <p>Strategic Objective 1: Ensure the survival and well-being of the most vulnerable people through a multi-sectoral response under a rights-based approach, including age, gender and diversity dimensions</p> | | |
| <p>Specific Objective 1.3: Reduce malnutrition and severe food insecurity in children under age 5, pregnant and lactating women, and other vulnerable groups</p> | | |
| <p>Sectoral Objective 1: Enhance access to outpatient health services and nutrition programmes at community level for children under age 5 and pregnant and lactating women, for the prevention of acute malnutrition and micronutrient deficiencies</p> | <p># children under age 5, pregnant and lactating women with access to services for the prevention of acute malnutrition and micronutrient deficiencies</p> | <p>537 k</p> |
| <p>Sectoral Objective 2: Enhance access to and the provision of health services for the treatment of acute malnutrition as part of the efforts to reduce child morbidity and mortality</p> | <p># people who receive adequate treatment in healthcare centers as part of the Management of Acute Malnutrition Programme</p> | <p>92 k</p> |
| <p>Sectoral Objective 3: Promote and support Infant and Young Child Feeding in Emergencies (IYCF-E) practices under a multi-sectoral approach by establishing effective coordination mechanisms and providing high quality services and qualified technical support.</p> | <p># pregnant women, mothers, fathers and caregivers of children 0-23 months receiving counselling on infant and child feeding</p> | <p>322 k</p> |
| <p>Sectoral Objective 4: Enhance access to outpatient health services and nutrition programmes at community level for children ages 5-15, for the prevention of acute malnutrition and micronutrient deficiencies, integrated into key health, food security, water, sanitation and hygiene activities</p> | <p># children ages 5 - 15 with access to services for the prevention of acute malnutrition and micronutrient deficiencies</p> | <p>45 k</p> |

3.5

Protection



PEOPLE TARGETED BY THE 2020 HRP

1.6M

REQUIREMENTS (US\$)

\$69.3M

PARTNERS

39

PROJECTS

56

Sectoral Objectives

The Protection Cluster has three sectoral objectives:

SECTORAL OBJECTIVE 1:

Provide specialized assistance to people affected by all forms of violence, exploitation, neglect and abuse for the improvement of their physical, mental and psychosocial well-being (linked to Strategic Objective 1/Specific Objective 1.4).

SECTORAL OBJECTIVE 2:

Facilitate access to legal documentation for affected people (linked to Strategic Objective 2/Specific Objective 2.4).

SECTORAL OBJECTIVE 3:

Strengthen the capacities of public institutions, civil society and affected communities to prevent, mitigate and respond to protection risks related to human mobility, including those related to gender-based violence with an emphasis on sexual exploitation and abuse, and those related to violence, abuse, neglect and exploitation of children and adolescents (linked to Strategic Objective 3/Specific Objectives 3.1, 3.2 and 3.3).

Response approach

In 2020, the Protection Cluster and its 39 partners (35 in the 2019 HRP) will provide protection services based on the severity of needs and vulnerability identified in the humanitarian needs analysis on the basis of multiple parameters including age, gender, disability and coping capacity. The prioritized states are Aragua, Bolivar, Delta Amacuro, Capital District, Miranda, and Tachira. Protection risks and needs of specific population groups (including the elderly, people living with HIV or other serious health conditions, women, children and adolescents at risk, indigenous people, LGBTI people, people with disabilities, refugees, asylum seekers, and returnees) will be identified and addressed through protection monitoring, sharing information, coordinating within and with other clusters, referring cases, providing quality services and assistance, and strengthening community protection.

In the context of COVID-19, it will be necessary to review the modalities for the provision of protection services to prevent the transmission of the virus, while ensuring access to information and services for the most vulnerable. It will also be important to include returnees within priority population groups, and to strengthen communication with communities for: 1) psychosocial support in the context of 'social quarantine'; 2) prevention of stigma and discrimination; and 3) access to adequate health information for

specific groups (including people with disabilities, indigenous communities, among others).

One of the barriers for accessing services and a risk for people on the move is the lack of legal documentation. The Protection Cluster aims to work with relevant institutions to facilitate issuance of identity cards, birth and death certificates, and other legal documentation. At the institutional level, the cluster will provide training, office supplies and computer equipment. At the community level, information sessions on the right to identity documentation and the procedures for birth registration will be organized.

To ensure the sustainability of the response, the cluster will strengthen capacities to monitor, evaluate, analyze, prevent and respond to protection risks and needs at the national, state, civil society and community levels. To optimize the response, the Protection Cluster will further strengthen intersectoral linkages, ensuring the centrality of protection and integrating the protection response within multi-sectoral interventions at all levels.

Special emphasis will be placed on training people in communities on protection issues and human rights; sensitizing about referral pathways and protection services; and training authorities on the protection of people with specific needs, including victims or people at risk of trafficking or smuggling.

Monitoring

The response will be monitored using the 5W tool. To meet emerging needs, a multi-sectoral group will be created to monitor specific needs through an integrated information management system.

Partners will use standardized tools to monitor human mobility including returns and for protection monitoring. The cluster aims to consolidate a study to characterize the needs of people on the move, especially within the country, and returnees.

As a priority, gender-based violence risks will be monitored using coordinated diagnoses by geographical and thematic areas, which will show implementation progress and gaps in the response to gender-based violence, including sexual exploitation.

A data collection system to monitor child protection will be established jointly with partners. The system will strengthen the prevention and response to risks associated with family separation, increased socio-economic stress in communities and human mobility.

Contact

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SIMÓN BOLÍVAR, ZULIA STATE

Foto: OCHA/Gema Cortés

Area of Responsibility

Gender-based violence



| PEOPLE TARGETED BY THE 2020 HRP | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---------------------------------|---------------------|----------|----------|
| 300k | \$12.2M | 28 | 35 |

Objectives

The strategy of the Gender Based Violence (GBV) AoR focuses on contributing to the survival and well-being of people affected by GBV, particularly survival sex, early or forced marriage, domestic violence, sexual exploitation, abuse and trafficking for sexual exploitation. The GBV AoR will ensure high quality and adequate access to life-saving GBV services (contributing to Strategic Objective 1/Specific Objective 1.4). In addition, the GBV AoR seeks to strengthen community resilience and multi-sectoral capacities for GBV risk prevention and mitigation by strengthening institutional and community mechanisms (contributing to Strategic Objective 3/Specific Objective 3.2).

Response approach

The GBV AoR has increased its operational capacity (from 10 partners in the 2019 HRP to 28 partners in 2020). Partners will work to meet the specific needs of GBV survivors and those at risk of GBV. These include women and girls of reproductive age, with an emphasis on heads of households, pregnant and lactating women, indigenous women, women with HIV and women with disabilities, and other vulnerable groups based on their gender or level of vulnerability. The provision of clinical rape management services, psychosocial care, and legal guidance will be ensured. The increase in and strengthening of case management services to improve the multisectoral response to GBV are envisaged, maintaining the link with sexual and reproductive health services.

The capabilities of GBV-related service providers are key to ensuring a quality and sustainable response. In this regard, the strengthening of the capacities of State institutions, civil society and humanitarian actors for GBV prevention, mitigation and response is important, including in temporary shelters for returnees. The response

recognizes the importance of community empowerment through the creation of community protection mechanisms against GBV and for behavioral change. To do this, involving men and boys, as the main agents for prevention, will be key. It is also envisaged to strengthen the resilience of women and girls by raising awareness of their rights, including sexual and reproductive rights and access routes to services for survivors. In the context of the COVID-19 pandemic, quarantine increases the risks of domestic violence and requires the development of new remote care modalities, for example, through hotlines, for case management and referral to key services, such as health, legal and psychosocial support.

To meet the needs of women and girls, especially basic and menstrual hygiene needs, the AoR will continue distributing dignity kits (including underwear, menstrual pads, soap, among others). The provision of these kits is a priority and an entry point to raise awareness on GBV and access to services.

The creation and strengthening of safe spaces for women and girls is another priority for 2020. These spaces are essential for the protection and empowerment of women and girls, particularly in the context of high levels of violence and the presence of armed groups.

Material assistance to State institutions and capacity-building activities will ensure the sustainability of interventions.

Contact

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Area of Responsibility
Child Protection



| PEOPLE TARGETED BY THE 2020 HRP | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---------------------------------|---------------------|-----------|-----------|
| 700k | \$18.5M | 25 | 31 |

Objectives

The AoR aims to restore the capacity of families, communities and institutions to respond to protection risks, and to support them in ensuring the fundamental rights of children and adolescents. The response will contribute to Strategic Objectives 1 (Specific Objective 1.4) and 3 (Specific Objective 3.3).

Response approach

The number of partners of the AoR has increased from 12 in 2019 HRP to 25 in 2020, strengthening its operational capacity. The Venezuelan Organic Law for the Protection of Children and Adolescents designates key institutions for risk prevention and response, and assigns specific responsibilities to families, communities, civil society organizations and government institutions. Based on this, the AoR will work at multiple levels to strengthen prevention and response capacities.

Psychosocial support for families, the prevention of separation and awareness-raising for positive parenting represent the corpus of activities dedicated primarily to families and communities.

In the context of COVID-19, it is important to provide the tools and support to both parents and children to manage daily stress and to strengthen domestic violence prevention and response modalities. Although children and adolescents do not belong to the highest risk age group for COVID-19, homeless children and those in shelters are at a higher risk of infection. It will be important to develop information and communication materials related to the virus that reach these vulnerable groups.

The strategy also includes facilitating access to legal protection (such as justice services and birth registration) and social protection services (such as services for survivors of GBV, abuse and exploitation). Work will be done in coordination with relevant public institutions to develop a case management system and link it with civil society organizations that provide services to children and their families.

Efforts will be made to sensitize and build the capacity of communities and civil society actors on protection, children’s rights, violence prevention, and prevention of and response to discrimination. Special attention will be given to the inclusion of children and adolescents from indigenous communities and those with disabilities.

The AoR will work with the Education Cluster to: 1) ensure the mainstreaming of child protection and psychosocial support in education programmes; 2) train teachers on children’s rights; 3) and promote information exchange and coordination between protection and education organizations.

Contact

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Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|---|--|-----------------------------------|
| Strategic Objective 1: Ensure the survival and well-being of the most vulnerable people through a multi-sectoral response under a rights-based approach, including age, gender and diversity dimensions | | |
| Specific Objective 1.4: Strengthen the physical, mental and psychosocial well-being of people suffering from violence, exploitation, neglect and abuse, with attention to age, gender and diversity dimensions | | |
| Sectoral Objective: 1.4.1: Ensure physical, mental and psychosocial well-being by providing specialized assistance to people affected by all forms of violence, exploitation, neglect and abuse | # affected persons who have received required specialized services | 160 k |
| | # affected and at-risk children and caregivers with access to individual and group psychosocial support activities under a differential gender, age and diversity approach | 130 k |
| Strategic Objective 2: Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions | | |
| Specific Objective 2.4: Provide access to legal documentation for affected people, incorporating age, gender and diversity dimensions | | |
| Sectoral Objective: 2.4.1: Facilitate access to legal documentation for affected people | # people benefitting from necessary legal documentation | 430 k |
| Strategic Objective 3: Strengthen institutional and community mechanisms to prevent, mitigate and respond to protection risks faced by affected people, according to humanitarian principles and with respect for human rights | | |
| Specific Objective 3.1: Prevent, reduce and respond to protection risks associated with human mobility | | |
| Sectoral Objective 3.1.1: Strengthen the empowerment of communities to prevent and mitigate protection risks including those associated with human mobility | # people benefitting from specialized protection services and material assistance provided in response to protection risks | 20 k |
| | # people in communities trained on prevention and mitigation of protection risks | 370 k |
| Sectoral Objective: 3.1.2: Strengthen the capacities of public and civil society institutions to prevent and mitigate the protection risks that cause human mobility | # public institutions and civil society staff trained on protection and human rights | 90 k |
| | # relevant public and civil society institutions receiving material assistance to strengthen their capacity to ensure the rights of people with specific needs | 10 k |

| | | |
|--|---|-------|
| Specific Objective 3.2: Prevent, reduce and respond to risks associated with gender-based violence, with a focus on sexual exploitation and abuse | | 660 k |
| Sectoral Objective 3.2.1: Strengthen the empowerment of communities to prevent, mitigate and respond to GBV risks, with an emphasis on sexual exploitation and abuse | # persons at risk of and/or survivors of GBV who have received specialized protection assistance | 20 k |
| | # persons in the community empowered to prevent and mitigate gender-based violence | 600 k |
| Sectoral Objective 3.2.2: Strengthen the capacities of public and civil society institutions to prevent and mitigate protection risks including GBV, with emphasis on sexual exploitation and abuse | # public institutions and civil society staff trained on prevention, mitigation and response to GBV | 10 k |
| | # public and civil society institutions with competence in the area of GBV receiving material assistance to prevent, mitigate and respond to protection risks, including GBV risks | 30 k |
| Specific Objective 3.3: Prevent, reduce and respond to violence, abuse, neglect and exploitation of children and adolescents | | 410 k |
| Sectoral Objective 3.3.1: Strengthen the empowerment of communities and families to prevent, mitigate and respond to violence, abuse, neglect and exploitation risks to affected children and adolescents | # affected and at-risk children and adolescents whose access to child protection services is established and/or strengthened | 110 k |
| | # people in the communities trained on child protection | 280 k |
| Sectoral Objective 3.3.2: Strengthen the capacities of public and civil society institutions to prevent and mitigate the risks associated with children and adolescents at risk or in situations of abandonment, separation or unaccompanied minors | # public and civil society institutions staff trained on and supported with technical assistance in child protection | 10 k |
| | # public and civil society institutions with competence in the area of children and adolescents receiving material assistance to prevent, mitigate and respond to violence, abuse, neglect and exploitation of children | 10 k |

3.6

Health



| PEOPLE TARGETED BY THE 2020 HRP | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---------------------------------|---------------------|----------|----------|
| 4.0M | \$251.9M | 40 | 55 |

Sectoral objectives

The Health Cluster has two sectoral objectives:

SECTORAL OBJECTIVE 1:

Strengthen the operational and functional capacity of basic and critical services in prioritized hospitals.

SECTORAL OBJECTIVE 2:

Strengthen access to a comprehensive and integrated quality health service network that meets priority needs related to communicable and non-communicable diseases, mental health and sexual and reproductive health, integrating a life-course and differential approach and with the participation of communities.

The Health Cluster will contribute to the survival and well-being of the most vulnerable people (Strategic Objective 1), by improving access to essential goods and services to reduce people's vulnerability to risks of mortality and morbidity from communicable, non-communicable and mental health diseases; and by improving sexual and reproductive health, with particular emphasis on maternal and child health (Specific Objectives 1.1 and 1.2).

The response will contribute to the sustainability of essential health services (Strategic Objective 2), by enhancing equal and safe access to basic health goods and services (Specific Objective 2.2).

Response approach

Health Cluster interventions will seek to strengthen capacities in hospitals and primary healthcare centers to improve diagnosis and care capacities of critical services (including emergency services, intensive and intermediate care, neonatal care, delivery rooms, operating rooms, sterilization, laboratory, x-ray and ultrasound, cold chain). The response will ensure the provision of medicines and medical supplies, as well as preventive and corrective maintenance of biomedical equipment and support for basic infrastructure including water supply, electricity and medical gases.

The Health Cluster will seek to update emergency response plans including a) information management and patient referral and counter-referral; b) procedures and protocols including triage, diagnosis and treatment, infection control and patient referral; and c) training on emergency management and response, and on the registration, inventory management, monitoring and reporting on donated medicines and humanitarian supplies.

The response has among its priorities the strengthening of maternal and child health services at all levels, and sexual and reproductive health management through the implementation of 15 projects focusing on these areas. In addition, 11 projects focus on providing care for non-communicable diseases, three projects on assisting indigenous communities in remote areas, and five projects target people with physical and cognitive disabilities.

Vaccination and control activities are also required to respond to outbreaks of immune preventable diseases, mainly yellow fever, measles and diphtheria.

In the context of COVID-19, the response will aim to strengthen capacities in priority hospitals among the sentinel hospitals and healthcare centers defined by the authorities for COVID-19 response. Supporting COVID-19 case management in primary care centers in priority areas is also critical.

Health needs affect population groups differently. Therefore, the Health Cluster response will focus on the most vulnerable populations such as indigenous communities, children under age five, pregnant women, adolescents, the elderly, people with disabilities, people living with non-communicable and communicable diseases who require continuous and specialized attention, and health workers who, due to their conditions and degree of exposure, also require priority attention, especially for the prevention and care of communicable diseases, and mental and psychosocial health problems generated in the work environment. Interventions will focus on the states with the most severe health needs: Amazonas, Apure, Bolivar, Delta Amacuro, Miranda, Tachira and Zulia.

The Health Cluster works closely with the WASH Cluster for vector control, the reduction of waterborne diseases, the improvement of access to water services at both community and institutional levels, the maintenance of hospital hygiene protocols, and infection prevention and control in health facilities. Similarly, multisectoral projects are envisaged and include components from shelter, energy and NFIs, to strengthen health facilities, temporary shelters for migrants or returnees, or long-stay care facilities for vulnerable populations; and elements from nutrition, food security and protection for the most vulnerable groups, especially children and adolescents.

Health Cluster interventions are linked to basic services aimed at strengthening institutional and human resource capacities. To provide

direct assistance to the most vulnerable populations, the cluster will promote coordination between partners, including relevant ministries, other public institutions, and national and international NGOs, within the framework of health policies and strategies and humanitarian principles.

The Health Cluster includes 65 partners, among which 40 are part of the 2020 HRP, which is an increase compared to the 12 partners included in the 2019 HRP. Projects planned and/or being implemented cover all 24 states and 400 health facilities.

Monitoring

The response will be monitored mainly using the 5W tool.

The monitoring of lifelines and critical services in health facilities, and the monitoring of supply and inventory management will be strengthened by establishing a supply management system (LSS/

SUMA) in prioritized hospitals.

For needs monitoring, the Health Cluster will periodically monitor indicators considered for the control of communicable and non-communicable diseases, and indicators collected from medical records of care services.

Community-based epidemiological surveillance will contribute to addressing the gaps in administrative control and monitoring mechanisms. Monitoring capacities will be strengthened and epidemiological information systems and inventory monitoring systems will be developed to provide information on the stock of available medicines as well as medical and surgical supplies.

Contact

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SAN JOAQUIN DE NAVAY, TACHIRA STATE
 Photo: OCHA/Gema Cortés

Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|--|--|-----------------------------------|
| Strategic Objective 1: Ensure the survival and well-being of the most vulnerable people through a multi-sectoral response under a rights-based approach, including age, gender and diversity dimensions | | |
| Specific Objective 1.1: Reduce the vulnerability of affected people to mortality and morbidity risks from communicable, non-communicable and mental health diseases by improving their access to basic goods and services related to health, water and sanitation, incorporating age, gender and diversity dimensions | | |
| Sectoral Objective 1: Strengthen the operational and functional capacity of basic and critical services in prioritized hospitals | # persons who have benefited from treatments and/or procedures provided (estimate) | 3.5 M |
| Sectoral Objective 2: Strengthen access to a comprehensive and integrated quality health services network to meet priority needs related to communicable and non-communicable diseases, mental health and sexual and reproductive health, integrating a life-course and differential approach and with the participation of communities | # most vulnerable persons (disaggregated by sex and age) receiving medicines and health care (estimate) | 1.9 M |
| | # vaccinated persons (disaggregated by sex and age) | 3.2 M |
| Specific Objective 1.2: Enhance sexual and reproductive health, with special emphasis on maternal and child health by strengthening access to referral goods and services with attention to the age, gender and diversity dimensions | | |
| Sectoral Objective 1: Strengthen the operational and functional capacity of basic and critical services in prioritized hospitals | # persons who have benefited from sexual and reproductive health treatments and/or procedures provided and/or contraceptive methods dispensed (estimate) | 238 k |
| Sectoral Objective 2: Strengthen access to a comprehensive and integrated quality health services network to meet priority needs related to communicable and non-communicable diseases, mental health and sexual and reproductive health, integrating a life-course and differential approach and with the participation of communities | # most vulnerable persons (disaggregated by sex and age) who have received sexual and reproductive health care and medicines | 200 k |

Strategic Objective 2: Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions

Specific Objective 2.2: Improve equal and safe access to essential goods and services in the areas of health, water and sanitation, education, electricity and energy for cooking for the most vulnerable populations, seeking appropriate quantity, quality and sustainability of the provision of the services, incorporating age, gender and diversity dimensions

| | | |
|---|---|-----|
| Sectoral Objective 1: Strengthen the operational and functional capacity of basic and critical services in prioritized hospitals | # prioritized health-care facilities receiving equipment, supplies and/or essential medicines | 208 |
|---|---|-----|

| | | |
|--|---|-----|
| Sectoral Objective 2: Strengthen access to a comprehensive and integrated quality health services network to meet priority needs related to communicable and non-communicable diseases, mental health and sexual and reproductive health, integrating a life-course and differential approach and with the participation of communities | # facilities that are part of the health network, including community health actors, receiving equipment, supplies or essential medicines | 178 |
|--|---|-----|

3.7

Food Security and Livelihoods



PEOPLE TARGETED BY THE 2020 HRP

1.1M

REQUIREMENTS (US\$)

\$158.1M

PARTNERS

52

PROJECTS

66

Sectoral Objectives

The Food Security and Livelihoods Cluster has three sectoral objectives:

SECTORAL OBJECTIVE 1:

Provide immediate food assistance and support short-cycle food production to ensure access to food for the most vulnerable people with a gender, age and diversity focus.

SECTORAL OBJECTIVE 2:

Contribute to the restoration of livelihoods and enhance the resilience of households and communities through activities that improve access to food, protect or create productive assets and/or basic infrastructure, without harming local practices and habitat.

SECTORAL OBJECTIVE 3:

Improve food security for vulnerable groups, to ensure equitable and safe access to basic services such as health and education, without harming local practices and habitat.

The response will contribute to reducing severe food insecurity (contributing to Specific Objective 1.3), strengthening the resilience and livelihoods of the most vulnerable people (contributing to Specific Objective 2.1) and will facilitate access to basic services by providing food assistance in educational institutions, health facilities and community centers/spaces (contributing to Specific Objective 2.2).

The first sectoral objective contributes to Specific Objective 1.3, particularly to the reduction of severe food insecurity. Part of the response focuses on the distribution of cooked or uncooked food to vulnerable people (including pregnant and lactating women, families with children under age five with malnutrition, and school-age children and adolescents). Support will be given to initiatives by local institutions to produce nutritionally enriched foods aimed at vulnerable populations. In addition, interventions will be implemented for emergency production through the distribution of seeds, animals and supplies for short-cycle production of staple foods such as vegetables and small livestock production, as well as production of cereals, legumes and root crops. The response includes educational activities linked to the promotion of agriculture, with a focus on nutrition, to contribute to reducing the prevalence of malnutrition.

The second sectoral objective contributes to reducing moderate

food insecurity (Specific Objective 2.1). The response will focus on restoring livelihoods and enhancing the resilience of households and communities through activities that contribute to creating, protecting and improving productive assets and/or basic production, processing or commercialization infrastructure. The development of strategies that increase the availability of water in communities will be articulated with the WASH Cluster. The cluster will also promote sustainable seed production.

The third sectoral objective contributes to Specific Objective 2.2, which is equal and safe access to basic services. To support access to education, the Cluster proposes to provide nutritionally balanced meals for school-age children and adolescents to cover some of their caloric and nutrient requirements, through school feeding programmes (in coordination with the Education Cluster). To support the health and protection sectors, the Cluster will provide food in hospitals and cover some of the caloric and nutrient requirements for vulnerable populations, such as people with non-communicable diseases, those in detention or foster care homes, community centers and/or temporary shelters. To enhance families' resilience in the face of declining dietary diversity and access to food, the cluster will provide training and information to education personnel and community leaders in schools and community spaces on the recovery of traditional meals with high nutritional value, food hygiene and preservation, consumer rights and food processing.

Response approach

The response will focus on the most vulnerable groups, including poor households, those with the largest number of dependent members and children, those headed by women in vulnerable situations, children, indigenous communities, the elderly, and people with special care needs (people with disabilities, sick people). The response also includes returnees in temporary shelters who require food support during the preventive quarantine.

Given the key role played by women in food security as food producers and suppliers, gender will be mainstreamed in all interventions. The response will also integrate an age-differentiated approach, recognizing that boys and girls, on the one hand, and older people, on the other, face distinct challenges.

In the context of COVID-19 preventive measures, response modalities

require adaptation, including a reorganization of food distribution activities that avoid high concentrations of people, and a preference for cash transfer assistance modalities, among others.

The response will be provided through various modalities including in-kind assistance, vouchers, cash transfers, as well as capacity-building for communities and institutions on the proper use and consumption of food, and the recovery and protection of livelihoods. Assistance will be delivered based on an assessment of the food security situation, as well as a risk assessment to ensure the principle of 'do no harm'.

The number of partners of the Food Security and Livelihoods Cluster has increased from 29 in 2019 to 52 in 2020, and they have planned or ongoing activities in all 24 states. In addition, operational capacity can be rapidly increased through their collaborative networks, where the Plan's funding allows. WFP's presence is necessary to achieve the Cluster targets^[f].

The most affected states include Amazonas, Delta Amacuro, Falcon, Bolivar, Monagas, Zulia, Anzoategui, Barinas, Miranda and Trujillo. Some interventions will be implemented in other states with important needs, such as Tachira. It should be noted that some areas have less severe needs, but they should be prioritized for recovery and food production due to their high capacity to meet the food requirements in

prioritized areas.

Monitoring

The response will be monitored on a monthly basis using the 5W tool.

In 2020, the cluster will improve its mechanisms for AAP mechanisms by providing training and guidelines from Cluster Lead Agencies. In addition, partner organizations are planning studies on the condition of people reached by their projects, which will provide a baseline for response monitoring. There are proposals from partners for more extensive studies on the food security situation in areas of intervention or among some particularly vulnerable groups that will help identify the needs with precision.

Regarding needs monitoring, the Food Security and Livelihoods Cluster is working to harmonize international methodologies and indicators with national surveys and methodologies, to complement data from public authorities, and enhance monitoring of the situation. During 2020, these tools will be developed and training on these activities will be provided to partners.

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[f] WFP's presence depends on the invitation of the Government of Venezuela to implement operations based on humanitarian principles. Capacity-building of Cluster members will continue to reduce the gap between the target population and the needs.

Objectives, Indicators and Targets

| OBJECTIVES | INDICATORS | TARGET POPULATION OF THE 2020 HRP |
|---|---|-----------------------------------|
| Strategic Objective 1: Ensure the survival and well-being of the most vulnerable people through a multi-sectoral response under a rights-based approach, including age, gender and diversity dimensions | | |
| Specific Objective 1.3: Reduce malnutrition and severe food insecurity in children under age 5, pregnant and lactating women, and other vulnerable groups | | |
| Sectoral Objective 1: Provide immediate food assistance and support short-cycle food production to ensure access to food for the most vulnerable people with a gender, age and diversity focus. | # men, women, girls and boys who received food assistance / cash / vouchers | 848 k |
| | # households that received support for emergency food production | 116 k |
| Strategic Objective 2: Contribute to the sustainability of essential services and strengthen the resilience and livelihoods of the most vulnerable people incorporating age, gender and diversity dimensions | | |
| Specific Objective 2.1: Strengthen food security of the most vulnerable people by increasing access to food and supporting the restoration, maintenance and protection of livelihoods, incorporating age, gender and diversity dimensions | | |
| Sectoral Objective 2: Contribute to the restoration of livelihoods and enhance the resilience of households and communities through activities that improve access to food, protect or create productive assets and/or basic infrastructure, without harming local practices and habitat | # people who received equipment and/or supplies and/or technical support and/or training to strengthen their resilience | 593 k |
| Specific Objective 2.2: Improve equal and safe access to essential goods and services in the areas of health, water and sanitation, education, electricity and energy for cooking for the most vulnerable populations, seeking appropriate quantity, quality and sustainability of the provision of the services, incorporating age, gender and diversity dimensions | | |
| Sectoral Objective 3: Improve food security for vulnerable groups, to ensure equitable and safe access to basic services such as health and education, without harming local practices and habitat | # children who received food assistance in educational institutions | 523 k |
| | # men, women, boys and girls who received food assistance in community centers/spaces | 105 k |
| | # men, women, boys and girls who received food assistance in health facilities | 6.5 k |

3.8

Coordination and Logistics



| PEOPLE TARGETED BY THE 2020 HRP ORGANIZATIONS | REQUIREMENTS (US\$) | PARTNERS | PROJECTS |
|---|---------------------|----------|----------|
| 129 | \$10.5M | 7 | 8 |

Objectives

In a complex and fluid operational environment, humanitarian coordination, which expanded in 2019, is key to ensuring a timely, effective and principled response to the 4.5 million people targeted for humanitarian assistance in this Plan.

In 2020, coordination objectives include:

SECTORAL OBJECTIVE 1:

Ensure a coordinated, timely and efficient response, through structures established at the national and regional levels.

SECTORAL OBJECTIVE 2:

Ensure effective humanitarian information management to support needs and response analysis and monitoring, and the identification of gaps and access constraints.

SECTORAL OBJECTIVE 3:

Promote an inclusive humanitarian response based on humanitarian principles, incorporating cross-cutting issues such as the centrality of protection, gender and age, disability inclusion, prevention of sexual exploitation and abuse, and accountability to affected populations.

Regarding logistics coordination, the objectives include: identifying existing logistical capacity and solutions to the challenges faced to distribute humanitarian supplies on time by facilitating the sharing of experiences and good practices among actors, and providing updates on the status of infrastructure and processes as well as access to adequate and reliable logistical services.

These sectoral objectives will contribute to the achievement of all the strategic and specific objectives of the 2020 Plan.

Response approach

In 2020, to optimize the implementation of the response, efficient coordination structures among UN agencies, national and international NGOs, government institutions and other stakeholders will continue to be promoted. Efforts will also focus on coordinating of the HPC, promoting a common understanding of needs and developing an appropriate response strategy. Priorities include the consolidation of coordination structures at the strategic and operational levels; the strengthening of humanitarian actors' capacities; and the improvement of situational analyses, including humanitarian access and needs analysis, as well as response monitoring by strengthening information management resources and tools. This will enable joint evidence-based communication and advocacy to prioritize approaches, facilitate access to the most

vulnerable areas and mobilize more funds for the response.

A key line of action will be the strengthening of capacities to effectively participate in the HPC and provide a more effective and inclusive response, through training on humanitarian principles, humanitarian coordination and cross-cutting issues such as AAP, prevention of gender-based violence and sexual exploitation and abuse, inclusion of people with disabilities and gender. In the context of COVID-19, new distance training modalities are being explored.

In 2020, the Logistics Cluster will seek to strengthen its coordination and information management role by providing common emergency logistics and telecommunications services to the humanitarian community. Its activities will contribute to a more effective response, helping to reduce the operational time needed to reach affected populations, wherever they are. The presence of WFP is a prerequisite for increasing the operational capacity of the Logistics Cluster, especially in terms of service delivery to the humanitarian community.

The Logistics Cluster started its activity in the country in November 2019 with the deployment of two logistics officers responsible for coordination and information management. Fifteen humanitarian organizations, including UN agencies and national and international NGOs, participated in the first coordination meeting to share information on operational and logistical challenges, as well as best practices.

The Logistics Cluster has strengthened its capacity and now has more than 68 partners with presence in 156 municipalities across all states. The cluster has carried out missions to the three field coordination hubs, met with government actors and private sector representatives and started developing communication and information tools for timely exchange on logistics issues. These activities have helped the analysis of the operational context and the identification of the principal needs and logistical gaps impacting humanitarian actors, which will be the reference for the prioritization of activities in 2020. Noteworthy among these activities is the establishment of technical platforms at the field coordination level to strengthen coordination and exchange of logistical information between organizations on specific issues in each region that affect the implementation of projects.

Contacts

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How to Contribute



Contribute to the Humanitarian Response Plan

The role of humanitarian partners in achieving an effective response to the most immediate needs of the most vulnerable communities must be based on the responsibility to be as effective and efficient as possible in the response. The best way to contribute to the HRP is to guarantee the financing of the projects prioritized by the clusters in this response plan endorsed by the HCT. Donor support is essential to ensure that funds directed to partners contribute to this Plan.

<https://www.humanitarianresponse.info/es/operations/venezuela>
<https://reliefweb.int/country/ven>



Contribute through the CERF

The CERF Rapid Response and Underfunding Emergencies windows are an opportunity to respond to the dynamics of armed violence and situations generated by natural disasters, and will always benefit the most affected communities and those with the greatest needs. Advocacy before the emergency managers of the Agencies at headquarters by the Representatives of Country Offices, and the funds granted by the Member States of the United Nations, should always be seen as an opportunity to attend to the affected populations.

Visit: <https://cerf.un.org/donate>



List of projects

<https://fts.unocha.org/>



LA GUANA, ZULIA STATE
 PHOTO: OCHA/ Gema Cortés

This document is consolidated by OCHA on behalf of the Humanitarian Country Team and partners. It provides a shared understanding of the situation, including the main humanitarian needs. It represents a consolidated evidence base for joint strategic response planning. The designations employed and the presentation of material in the report do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

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Acronyms

| | | | |
|------------------|---|---------------|---|
| AAP | Accountability to Affected Populations | | |
| AIDS | Acquired Immune Deficiency Syndrome | MPPS | Ministry of People's Power for Health (Spanish acronym) |
| AoR | Area of Responsibility | NGO | Non-Governmental Organization |
| CERF | Central Emergency Response Fund | NRC | Norwegian Refugee Council |
| CLAP | Local Committees for Supply and Production (Spanish acronym) | OCHA | United Nations Office for the Coordination of Humanitarian Affairs |
| CONARE | National Commission for Refugees (Spanish acronym) | PAHO | Pan-American Health Organization |
| CONSORVEN | Venezuelan Confederation of Deaf People (Spanish acronym) | PASI | Comprehensive Social Service Points (Spanish acronym) |
| CTP | Cash Transfer Programmes | PIN | People in Need |
| ECCA | Cooperation and Assistance Cooperation Team (Spanish acronym) | PSEA | Protection against Sexual Exploitation and Abuse |
| ECLAC | Economic Commission for Latin America and the Caribbean | RPM | Response Planning and Monitoring Tool |
| EHM | Household Sampling Survey (Spanish acronym) | SAIME | Administrative Service for Identification, Migration and Foreigners (Spanish acronym) |
| FANB | National Bolivarian Armed Forces (Spanish acronym) | SOFI | State of Food Security and Nutrition in the World |
| FAO | Food and Agriculture Organization of the United Nations | STI | Sexually Transmitted Infections |
| FTS | Financial Tracking System | UNDP | United Nations Development Programme |
| GAM | Gender and Age Marker | UNFPA | United Nations Population Fund |
| GBV | Gender-based Violence | UNHCR | United Nations High Commissioner for Refugees |
| GDP | Gross Domestic Product | UNICEF | United Nations Children's Fund |
| HCT | Humanitarian Country Team | UNS | United Nations System |
| HIV | Human Immunodeficiency Virus | UNV | United Nations Volunteers |
| HPC | Humanitarian Programme Cycle | WASH | Water, Sanitation and Hygiene |
| HRP | Humanitarian Response Plan | WHO | World Health Organization |
| IASC | Inter-Agency Standing Committee | WFP | World Food Programme |
| ICCG | Inter Cluster Coordination Group | | |
| IMWG | Information Management Working Group | | |
| INE | National Statistics Institute (Spanish acronym) | | |
| INN | National Institute of Nutrition (Spanish acronym) | | |
| IOM | International Organization for Migration | | |
| IPC | Infection Prevention and Control | | |
| IYCF-E | Infant and Young Child Feeding in Emergencies | | |
| LGBTI | Lesbian, gay, bisexual, transgender and intersex | | |
| MMR | Measles, mumps and rubella | | |
| MPPE | Ministry of People's Power for Education (Spanish | | |

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VENEZUELA