IOM
UN MIGRATION

COVID-19 RESPONSE PROGRESS REPORT

FEBRUARY – AUGUST 2020

About this document

In April 2020, IOM published its revised Strategic Preparedness and Response Plan (SPRP), building on the February iteration, to strengthen its response to the coronavirus disease 2019 (COVID-19). The SPRP focuses on 140 affected countries in order to cover emerging health, humanitarian and socioeconomic needs, while ensuring that migrants and mobility considerations are included in the global, regional and national responses. Now in its eight month of the pandemic, and in response to the complex challenges created, IOM continues to adapt its approach to respond to evolving needs through its comprehensive preparedness and response plan by building on its extensive footprint and operational advantage. IOM's work contributes to global efforts to halt further transmission of the disease, limits the humanitarian and socioeconomic effects of the pandemic, and supports affected communities to prepare for recovery. This progress reports aims to highlight key progress made by IOM from February to August 2020. Activities mentioned in this report serve as illustrative examples and do not aim at representing exhaustedly IOM's footprint and response in all countries.

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Photo credits:
IOM Bangladesh's Transition and Recovery Division, along with partner organizations, are manufacturing cloth-made washable masks and distributing those to local government. / © IOM 2020 (Abdullah Al Mashrif)

SITUATION UPDATE

Since the COVID-19 outbreak began, over 27 million confirmed cases and 894,241 deaths have been reported globally, as of 9 September, with confirmed cases reported in over 200 countries, territories or areas (source: WHO). The daily increase in reported COVID-19 cases continues to impact countries globally, putting health, social and economic systems in countries under pressure.

The impact of the COVID-19 emergency on global health and mobility is historically unprecedented in size and scope. As of 1 September 2020, a total of 219 countries, territories or areas had issued 86,722 travel restrictions which have been put into effect by governments worldwide to contain and reduce the spread of COVID-19. Containment policies and measures to restrict global human mobility, which are aimed at mitigating the spread of the virus and its consequences, have affected various population categories, including migrants, in diverse and complex ways. The COVID-19 mobility policies and measures – spanning from various travel restrictions and health requirements or measures to full border closures and nationwide and/or localized lockdowns – have, in some cases, created new challenges for migrants and other mobile populations while exacerbating existing vulnerabilities. The imposition of border closures and travel bans have left a significant number of migrants stranded, including seasonal workers, temporary residence holders, international students, migrants that who travelled for medical treatment abroad, beneficiaries of assisted voluntary return and reintegration, seafarers and many others.

Forcibly displaced and international and national migrant populations are among the most affected by the subsequent crisis. Loss of jobs and income, residence permits and resources have all impacted mobile populations, resulting in hundreds of thousands of stranded migrants globally, who may lack the discretionary income to fund their return journey home and are often in irregular situations, rendering them more vulnerable to exploitation, including trafficking in persons. Out of desperation, they might also be likelier to take up unsafe employment or accommodations, increasing their exposure to COVID-19. The disease has also intensified stigma, xenophobia and discrimination against migrants and other vulnerable populations in many settings, due to perceived linkages with the origin or transmission of the virus. Movement restrictions imposed at national and local levels have also limited the continuation of livelihood activities, leading to a drop in global remittances further affecting remittances-dependent households in their countries of origins, eroding coping capacities. Forcibly displaced populations already face dire situations, such as in protracted conflicts, living with limited access to social, health and protection services. Internally displaced persons (IDPs) living in crowded shelters and camp-like settings, often with inadequate sanitation and health-care facilities, also face increasing risks as COVID-19 cases continue to emerge.

Weak health systems and high health-care costs pose challenges in ensuring access to care for COVID-19 and for other health conditions neglected during the pandemic. The immediate and longer-term gaps in response mechanisms are resulting in heightened protection risks for affected communities and vulnerable populations. Barriers in accessing hard-to-reach populations include difficulties maintaining supply chains, increased demand and movement restrictions.

KEY ACHIEVEMENTS

58 countries where IOM plays leadership role on COVID-19 coordination fora.

173 countries, territories and areas and **1,494** other key locations of internal mobility where IOM is tracking the mobility impacts of COVID-19

3.5 million people reached through IOM's awareness campaigns on COVID-19

Over **6 million** health screening of travelers for COVID-19

3,800 points of entry assessed to enhance disease surveillance and national capacities

8 countries where IOM supports the expansion of COVID-19 testing

Over **3,000 handwashing stations** established

10 countries where IOM procured and delivered PPEs from its Global Prepositioning Mechanisms

8 global webinars organized by IOM to strengthen different aspects of CCCM operations in relation to COVID-19.

3,500 individuals trained on COVID-19 related issues including the implementation of enhanced hygiene measures to ensure the continuation of essential services.

225,000 people assisted through IOM's Mental Health and Psychosocial support in over **35 countries** with pre-existing humanitarian needs.

430,000 vulnerable persons affected by COVID-19 assisted through livelihood support, including cash transfers in over **40 countries**.

Strategic Priority 1: *Ensure a well-coordinated, informed and timely response through mobility tracking systems and strengthening partnership and coordination structures established at the community, national and regional levels.*

COORDINATION AND PARTNERSHIPS

Globally, IOM provides technical support to global, regional, national and sub-national coordination mechanisms. Within these mechanisms, IOM is advocating to ensure that migrants, displaced persons, returnees and other vulnerable populations are included in regional and national preparedness and public health planning. In addition, IOM is advocating to ensure that migrants, including stranded migrants and displaced populations, have access to national health systems and other basic services. Through its coordination efforts, IOM continues to work with partners and stakeholders at all levels to ensure synergy between various actors and responses, ensure monitoring of COVID-19 preparedness measures and avoid duplication of efforts.

Since the beginning of the response, IOM has been working closely with external and internal partners and stakeholders. For example, IOM is active at the global level in UN coordination forums, as the global co-lead for the Camp Coordination and Camp Management (CCCM) Cluster and sits on the global Strategic Advisory Groups of the Health and Water, Sanitation and Hygiene (WASH) Clusters. IOM has been a partner in the Global Outbreak Alert and Response Network and has actively participated on the Global Health Cluster COVID-19 Task Team. As the co-lead of the Trade and Travel Working Group, IOM is also part of the UN's Crisis Management Team.

IOM VOLUNTEERS USE MEGAPHONES TO DISSEMINATE KEY COVID-19, MESSAGES TO THOSE FACING INCREASED MOBILITY RESTRICTIONS IN THE ROHINGYA SETTLEMENTS / © IOM 2020 (PHOTO: A. AL MASHRIF)

Moreover, IOM contributes to and aligns with WHO and Inter-Agency Standard Committee (IASC) technical guidance. For example, IOM has participated in the development of several IASC guidance documents, including the Interim Guidance on Public Health and Social Measures for COVID-19 Preparedness and Response Operations in Low Capacity and Humanitarian Settings. IOM mental health and psychosocial support teams (MHPSS) have also supported the development of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, as well as the Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of the COVID-19 Outbreak. IOM provided support to the ad hoc working groups for COVID-19 response, which produced the IASC Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic and Basic Psychosocial Skills such as: A Guide for COVID-19 Responders, the IASC Interim Guidance on COVID-19 – Focus on Persons Deprived of their Liberty, the UN Blueprint on Human Rights in COVID-19, and the guidance developed by the Alliance for Child Protection in Humanitarian Action: Child Protection Technical Note. Within the Global CCCM Cluster, IOM worked with cluster partners and stakeholders to host and organize a series of webinars related to different aspects of camp management activities impacted by the pandemic to ensure adaptation for continuous preparedness and response to COVID-19. This includes a joint webinar with gender-based violence (GBV) and child protection areas of responsibility to explore challenges in referrals and ensure continuous access to the most vulnerable. IOM also joined the Centrality of Protection and Protection Mainstreaming sub-groups, contributing to the elaboration of a briefing paper on the impact of COVID-19 on protection.

IOM is also an active member of regional, national and sub-national taskforces in many regions and countries and has a

leading technical role in particular in working groups for points of entry. In coordination with the broader UN system, IOM is closely engaged with other partners in the response to include migrants and migration in the COVID-19 response, such as with the UN Children's Fund (UNICEF) on migrant children or the World Health Organization (WHO) and partners on migrants and refugees in camps and non-camp/humanitarian settings, as well as with the UN Migration Network Secretariat for advocacy on non-discrimination and against stigma at principals level.

Through its Displacement Tracking Matrix (DTM), IOM has increased coordination and collaboration on COVID-19 data and information with key actors at the global level including WHO, the World Food Programme, the UN Office for the Coordination of Humanitarian Affairs (OCHA), global clusters by co-leading the Global Information Management, Assessment and Analysis Cell with OCHA, WHO and the Office of the UN High Commissioner for Refugees (UNHCR), as well as joint work and discussions with WFP and WHO on data and analysis. IOM has also contributed to the joint work on INFORM's COVID-19 Risk Index and dynamic component. At country level, IOM is currently co-leading an initiative with UNICEF, REACH and UNHCR, combining DTM flow monitoring data in South Sudan with geographically disaggregated data for COVID-19 cases in neighbouring countries.

TRACKING MOBILITY IMPACTS OF COVID-19

COVID-19 continues to affect global mobility in complex and unprecedented ways in the form of various travel restrictions, suspension of air travel and border closures. To better understand how COVID-19 affects global, national, and sub-national mobility, since the beginning of the crisis, IOM has developed and maintains a **global database to monitor, analyse, and report on international travel restrictions implemented around the world and to map, track and analyse the impact the COVID-19 pandemic is having on points of entry (PoE) and other key points and locations of internal mobility with restrictive measures and impacted populations.** This has particularly importance when addressing specific needs faced by migrants, including stranded migrants and other mobile populations, disproportionately affected by the global mobility restrictions. In August, IOM had assessed 3, 852 PoEs (including 953 airports, 2,302 land border crossings and 597 blue border crossing points) in 173 countries, territories and areas and 1,494 other key locations of internal mobility (internal transit points, areas of interest and sites with populations of interest) in 135 countries, territories and areas. Of the total number of locations of internal mobility assessed, 383 were internal transit points, and 1,111 comprised other areas and sites of interest. In addition, IOM is providing regular updates on the impact COVID-19 is having on the **situation of migrants and IDPs in countries in relation to the pandemic. Further, since the beginning of the response, IOM continues to intensify data collection and reporting from flow monitoring exercises across borders as well as main migration routes and in areas affected by the crisis.**

IOM CONTINUES TO INTENSIFY DATA COLLECTION AND REPORTING FROM FLOW MONITORING EXERCISES ACROSS BORDERS / © IOM 2020 (PHOTO: M. MOHAMMED)

For example, in Afghanistan, IOM has been monitoring and reporting ongoing cross-border population movements, cross-analysed with regional COVID-19 case data, to identify destination areas at greater risk of cross-border transmission of COVID-19 to better inform better-targeted, evidence-based health responses and recovery programming. **Flow monitoring activities have been accompanied with migrant sensitization activities** to raise the awareness on COVID-19 transmission risks, for example in Djibouti and Somalia. IOM has expanded its rapid

emergency event tracking by implementing additional data collection components. In order to do so, IOM has continued to gather weekly multi-sectoral updates, types of measures imposed, population movements, affected population categories, ongoing responses and needs to feed into ongoing COVID-19 responses at the national level. For example, in Mozambique, IOM has been conducting in-depth assessment and monitoring surveys assessments on the types of preparedness and precautionary measures that are available in 76 IDP resettlement sites, supporting decision makers plan interventions as well as to and recommend health and site preparation measures for outbreak prevention and containment. In addition, **IOM is making use of its DTM networks to collect information on the socio-economic impact of COVID-19.** In Libya, IOM's Mobility tracking activities aimed to understand the significant socio-economic impact, including the loss of livelihoods, of mobility restrictions and curfews on vulnerable people on move in Libya. It was observed that the restrictions of movements resulted in consequent loss of livelihoods. In Bosnia and Herzegovina, IOM conducted a survey to assess the impact of COVID-19 on the diaspora and on onward migration including to seasonal and irregular migrants workers in irregular situations having returned due to loss of income.

IOM IS MAKING USE OF ITS DTM NETWORKS TO COLLECT INFORMATION ON THE FOR SOCIO-ECONOMIC IMPACT OF COVID-19/ © IOM 2020 (PHOTO: M. MOHAMMED)

Strategic Priority 2: Contribute to global, regional, national and community-level preparedness and response efforts for COVID-19 to reduce associated morbidity and mortality.

RISK COMMUNICATION AND COMMUNITY ENGAGEMENT (RCCE)

Since the crisis started, IOM has scaled up its work with critical risk communication and community engagement (RCCE) counterparts at the global, regional, national and community levels. IOM implements RCCE programming that ensures that mobility is properly considered in public health messaging, and that migrants and mobile communities have access to timely, context-specific, and reliable information. IOM continues to refine and adapt its RCCE strategies and programming, based on iterative analysis, and feedback from beneficiaries and community members to ensure that messaging is appropriate, effective and far-reaching. In the past six months, IOM has reached over 3.5 million people with information campaigns on COVID-19 at household and community levels globally, disseminating messages on COVID -19 transmission, the importance of physical distancing, and frequent and thorough handwashing. In particular, IOM continues to support RCCE activities around points of entry and among border communities to ensure that cross-border mobility is considered in public health messaging. For example, in the Democratic Republic of the Congo (DRC) and Bangladesh, IOM supported door-to-door RCCE in communities surrounding points of entry and health screening points, while in Haiti, the Dominican Republic, Kyrgyzstan, Lesotho and Cambodia, information campaigns with COVID-19 prevention messages took place in close cooperation with government and local partners. In Afghanistan, Bangladesh, Haiti, Nepal, Papua New Guinea, Timor-Leste, Federated States of Micronesia, Marshall Islands and Palau, IOM also integrated COVID-19 RCCE into its disaster risk programming, such as training on prevention and preparedness for cyclone volunteers and for evacuation management in case of new disaster. In Zimbabwe, billboards have been set up in the main PoEs to ensure information dissemination on COVID-19 prevention measures. In Colombia, IOM implemented a virtual care and prevention strategy for victims of the armed conflict taking into account the COVID-19 context and supported national health authorities and the hospital network in the development of health information and education activities.

Since July 2020, IOM also co-chairs with UNICEF and UNHCR the Risk Communication and Community Engagement Working Group for migrants, refugees, IDPs and host communities at global level. In an effort to build the capacities of responders and support information-sharing at all levels, inter-agency guidelines were developed, and five webinars have been co-organized by IOM so far.

DISEASE SURVEILLANCE

During the reporting period, **IOM has continued to strengthen existing national-level disease surveillance systems through active health screening and surveillance for COVID-19** at, for example, PoEs in Bangladesh, DRC, Guinea, Libya, Somalia and South Sudan, among other countries. Front-line workers have been equipped with PPEs, health screening materials and other equipment to support contact tracing. In DRC, IOM is currently supporting 31 health screening points, screening over 5.4 million people. As part of IOM's engagement to anticipate preparedness measures to be implemented in a strategic and prioritized manner in multiple locations in Cox's Bazar (Bangladesh), IOM has also contributed to WHO-led contact tracing and has been coordinating a team of contact tracing supervisors, volunteers and medical support teams in 13 camps since the first detected COVID-19 cases in May 2020. Due to the large return of migrants workers as a direct result of movement restrictions and loss of income, community tracing, screening and awareness-raising in areas of return were prioritized, such as in Mozambique, where IOM further traced 11,300 returned migrant workers, also inquiring on the health of over 55,700 relatives.

POINTS OF ENTRY

IOM HAS SUPPORTED THE IMPLEMENTATION OF PUBLIC HEALTH MEASURES AT POES / © IOM 2020

Between February and August 2020, IOM has scaled up its support to Ministries of Health and border authorities to enhance preparedness and response efforts of prioritized points of entry. IOM has been nominated as lead/co-lead of COVID-19 PoE taskforces/coordination platforms in many countries and regions, including but not limited to, East, Horn and Southern Africa as well as for West and Central Africa and in countries such as Bangladesh, Burundi, Guinea, Libya, Nepal, South Sudan, Sudan, the United Republic of Tanzania, and Zimbabwe. In addition, IOM has supported the implementation of public health measures at PoEs, including exchange of information through cross-border coordination; health screening; capacity-building for disease surveillance as well as preventive measures for PoE workers, reaching more than 1,900 front-line workers globally.

IOM also conducted a number of baseline assessments at over 3,853 PoEs across 173 countries in cooperation with relevant national authorities to assess needs and capacities for effective COVID-19 preparedness and response efforts – in some cases with a view to safely reopen borders. As an example, in Cameroon, Mongolia, Viet Nam, Burundi, Sudan and Burkina Faso, assessment missions were conducted in border areas to measure the need for effective screenings and referrals of suspected COVID-19 cases, and assess infrastructure/equipment needs.

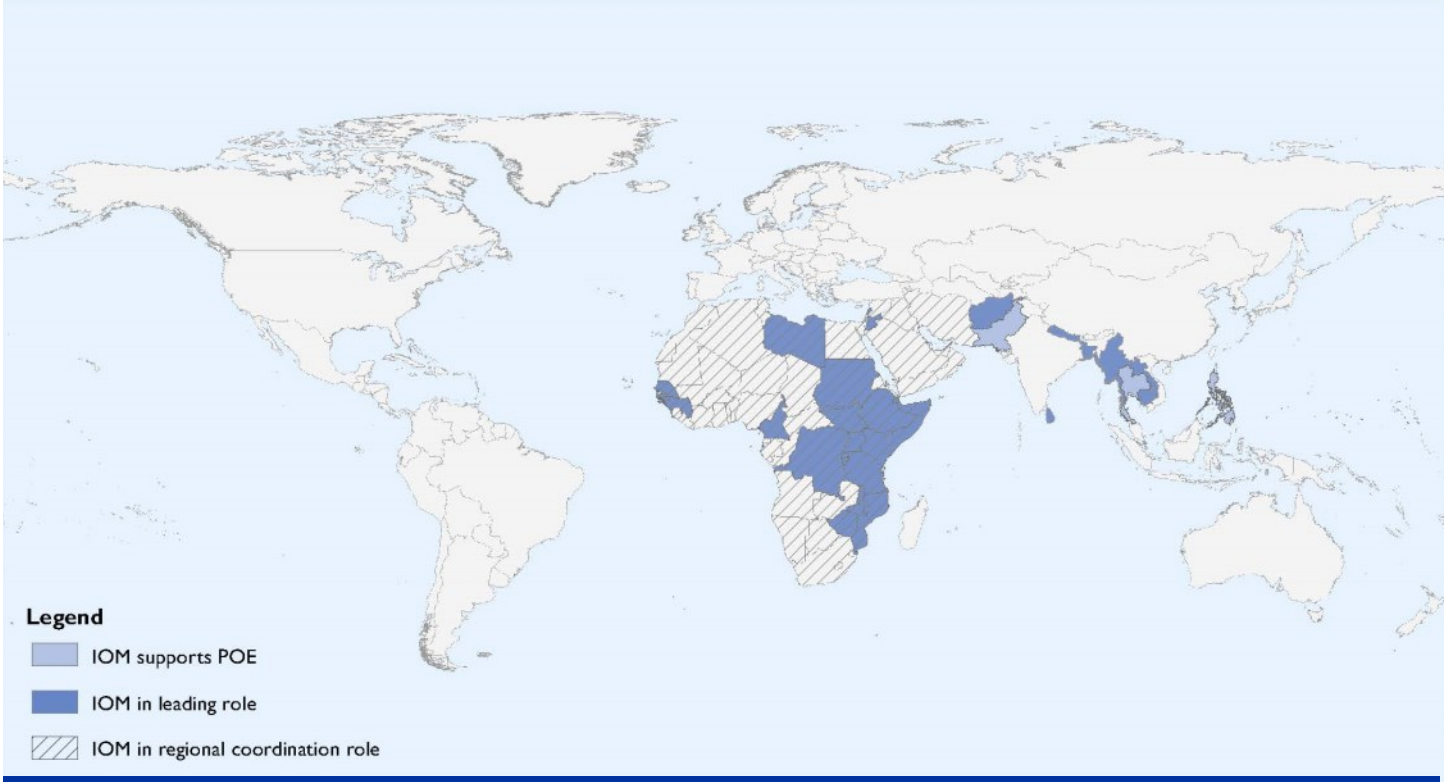
To support this work, IOM developed its "Standard Operating Procedures (SOPs) for Front-Line Border Officials at Point of Entry in Response to COVID-19 Outbreak", in April 2020, now translated into a number of languages including Arabic, Burmese, Dari, English, French, Khmer, Lao, Pashto, Portuguese, Romanian, Serbian/ Albanian, Somali, Spanish, Swahili, Thai and Vietnamese, and piloted in Bangladesh, Lao People's Democratic Republic, Marshall Islands, Federated States of Micronesia and Thailand. These SOPs provide guidance to front-line border officials who deal with passengers and travellers at points of entry. At the national level, IOM has also contributed to the development of SOPs and referral pathways in countries like Bangladesh, Pakistan, Senegal and the United Republic of Tanzania.

Further to the UN Secretary General's Policy Brief on COVID-19 and People on the Move, at the global level, in June 2020, IOM issued a Policy Paper on Cross-Border Human Mobility amid and after COVID-19 with the aim of highlighting points of entry as key intervention spaces within the mobility continuum. Based on a review of presently available evidence on migration, health and border management impacts of the COVID-19 pandemic, the paper encompasses the short- and medium-term challenges and selected solutions for human mobility, including possible and preferred scenarios to promote a coordinated and 'healthy' reopening of borders and lifting of travel restrictions, as well as longer term recommendations for the future of cross-border human mobility.

IOM HAS SUPPORTED THE IMPLEMENTATION OF PUBLIC HEALTH MEASURES AT POES, INCLUDING HEALTH SCREENING / © IOM 2020 (PHOTO: M. MOHAMMED)

Additionally, between May and June 2020, **IOM conducted 10 webinars to reach wider audiences, including virtual trainings on PoEs and the International Health Regulations (IHR)**, in coordination with WHO's regional office for Africa

and the International Civil Aviation Organization (ICAO), as well as a virtual webinar on cross-border coordination focusing on the importance of considering truck drivers in the COVID-19 pandemic in the East and Southern Africa, which contributed to the development of a cross-border surveillance strategy in the region. The strategy on "Cross-Border Management of COVID-19 Outbreak in East and Southern Africa" responds to the need to prevent, control and suppress cross-border transmission of COVID-19 in the sub-region and increasing cases among truck drivers. It presents a harmonized approach to PoE surveillance, testing of transnational truck drivers and their assistants, timely operational, strategic cross-border information-sharing and the use of mobility and surveillance data to guide the investment of public health actions along major transport corridors.



IOM INVOLVEMENT IN POINT OF ENTRY (POE) TASKFORCES AND WORKING GROUPS

NATIONAL LABORATORY SYSTEM

IOM continued to ensure health services were accessible at all levels for beneficiaries, inclusive of host communities, while further expanding its testing and screening capacity. IOM continued large-scale screening efforts globally, and also began facilitating COVID-19 testing and logistical support related to testing.

In particular, IOM's testing capacity for COVID-19 has been established in Nairobi (Kenya), Abuja (Nigeria) and Ghana using the GeneXpert platform. Testing is expecting to start shortly in Burundi, DRC, Ethiopia, Nepal, the Philippines, Rwanda, South Africa, Tanzania and Uganda. In Kenya, IOM has also established high throughput testing using the Thermofisher system. Another system has been established by IOM in Mogadishu, in collaboration with the UN Support Office in Somalia, while high throughput testing hubs are being proposed for Ethiopia, Nigeria and DRC. In addition, seroprevalence surveys have also been conducted in various locations, including the Dominican Republic in order to better understand the effects and prevalence of COVID-19 among target populations.

As part of its capacity-building efforts, IOM has also strengthened national-level capacities to conduct COVID-19 testing in Yemen, aiming at contributing towards addressing widespread testing and surveillance gaps and the safe use of GeneXpert systems for COVID-19 testing. In countries like Afghanistan and Ethiopia, IOM has seconded laboratory technicians.

INFECTION PREVENTION AND CONTROL

IOM AND RETURNEES DEMONSTRATE HYGIENE MEASURES AND HANDWASHING TO MIGRANTS IN TRANSIT AND DISPLACED PERSONS IN NIGER/ © IOM 2020

The provision of safe water, sanitation and hygiene (WASH) is an essential part of prevention efforts during infectious disease outbreaks, including COVID-19. **Combined with improved access to WASH services, IOM has scaled up its operations to support national capacities to implement infection prevention and control (IPC) measures as an effective way to prevent or limit the transmission of the disease.** IOM is undertaking IPC interventions at PoEs, health -care facilities, isolation centres, in camps and camp-like settings, to provide clean water for drinking, handwashing and cleaning purposes. In addition, COVID-19 specific hygiene kits are being distributed, with additional soap, detergent and chlorine, including but not limited to countries like Guinea, Morocco and South Sudan. While maintaining physical distancing remains a challenge in crowded areas, IOM has been working on the improvement of WASH facilities, including marker points being drawn out at water, sanitation and hand-hygiene facilities to encourage compliance.

Populations in camps and camp-like settings can face exacerbated risks due to overcrowding, which hinders physical distancing measures, lack of adequate and safe water and sanitation, and other factors. In response, IOM has been supporting health care and IPC in such settings globally. For example, in Bangladesh, IOM has supported the Rohingya response through the installation of over 300 no-touch handwashing stations throughout Cox's Bazar. These handwashing stations, called "tippy taps", are placed in key locations and allow users to wash their hands without the need to touch any part of the station. In countries like Yemen, water supply infrastructure rehabilitation has been upgraded to account for the extra water supply required for hand-hygiene and cleaning.

At the global level, IOM has developed several guidelines to support field operations in delivering comprehensive and qualitative WASH programming. Four technical guidance notes were produced to address specific IPC measures: handwashing, disinfection and waste management, and RCCE. The documents distinguish between COVID-19, Ebola or cholera outbreak situations given the confounding impacts of these diseases in some contexts. A Guidance on WASH services at *Points of Entry during a Public Health Emergency of International Concern (PHEIC)* was also produced to comprehensively address the dimension of WASH at PoEs. Additionally, programmatic guidance on WASH response in the context of COVID-19 was also produced by IOM to support the development of projects, as well as preparedness and response plans in countries. In order to ensure a handover of facilities at national levels, IOM is also in the process of developing an online IPC Operations and Maintenance training for country offices with IPC interventions.

IOM STAFF DEMONSTRATE COVID-19 PREVENTIVE MEASURES DURING AN AWARENESS RAISING SESSION IN GELANA WOREDA, ETHIOPIA FOLLOWING AN NFI DISTRIBUTION / © IOM 2020

LOGISTICS, PROCUREMENT AND SUPPLY CHAIN

The COVID-19 pandemic has caused an unprecedented spike in demand for personal protective equipment, essential commodities, multipurpose space and laboratory items for testing. At the same time, mobility restrictions have contributed to the closure of several transportation routes, leaving many countries unable to procure essential items on the open market, and therefore unable to access potentially life-saving equipment. IOM has been playing a central role in accelerating the supply chain process from procurement to distribution of essential commodities through the global prepositioned tocks along with the various long-term agreements with international suppliers in place. In coordination with the Pandemic Supply Chain Network and utilizing the UN/WFP common cargo service, since the beginning of the crisis, IOM procured and delivered basic equipment and relief items with a total volume of 476 m3, including in-transit. In particular, through IOM's support to the supply chain, IOM procured and transported 20 ventilators for Somalia, over 18,000 pieces of coveralls for South Sudan, more than 8,000 pieces of PPE including multipurpose tents for Mozambique, as well as 200,000 surgical masks for Yemen, 8,000 for the Democratic Republic of Congo and over 2,500 in Nepal. IOM has also released mobile storage units and multipurpose tents for assistance to vulnerable populations in Djibouti, Panama and the Philippines.

Strategic Priority 3: Ensure access of affected people to basic services and commodities, including health care, and protection and social services.

CASE MANAGEMENT AND CONTINUITY OF ESSENTIAL SERVICES

Since the beginning of the crisis, IOM has continuously provided life-saving support to vulnerable communities affected by widespread transmission of COVID-19 in order to reduce morbidity and mortality rates. In particular, IOM has focused on countries and regions suffering from vulnerable health systems and with high prevalence of malaria, HIV/AIDS, measles and tuberculosis, as well as other preventable infectious and non-communicable diseases.

IOM continued to provide support to vulnerable communities affected by COVID-19 in over 37 countries through the continued provision of essential health-care services and information for migrants, IDPs, refugees and host populations. As such, in Bangladesh, IOM facilitated the procurement, construction, and recruitment processes for the Leda **treatment and isolation centre**, while ensuring that: essential primary health-care consultations continued for thousands of beneficiaries; that delivery, antenatal and sexual and reproductive health services were uninterrupted; and that emergency referral support to secondary and tertiary care was facilitated outside of the camps for those requiring it. In Yemen, 20 health facilities have been supported and 9 mobile health teams deployed, ensuring continued access to primary health-care services, cholera treatment and MHPSS to over 290,000 beneficiaries. In Albania, medical clinics and isolation wards are being established in two reception centres and at a border crossing. In Afghanistan, IOM mobilized its extensive mobile health programming to treat patients, and screen returning undocumented migrants for tuberculosis (TB) in IOM transit centres. In Mozambique, IOM rehabilitated two treatment centres and is continuing to support district health authorities to deliver outreach services to resettlement sites, at border points and in locations of return of migrant workers, with particular attention to people living with chronic conditions. In Brazil, IOM continues to facilitate ambulance services to support the transport of patients.

To ensure continuity of care and case management despite the pandemic, IOM also utilized and united technology and community in the fight against COVID-19. For example, in response to the restrictions on movement imposed by the lockdown in Uganda, IOM supported the continuity of care for persons living with HIV/AIDS in the cross-border communities, through the use of mobile technologies (e.g. SMS), linking health facilities to community peer networks. Community peers, with support from local health workers, are working to ensure that people living with HIV are still able to get antiretrovirals.

COVID AWARENESS SESSION CONTINUES IN BAIDOA, SOMALIA/ © IOM 2020

SYRIAN REFUGEES UNDERGO A PCR TEST FOR COVID-19 WITH IOM STAFF THREE DAYS AHEAD OF THEIR SCHEDULED RESETTLEMENT FLIGHT TO EUROPE / © IOM 2020 (PHOTO: M. MOHAMMED)

CAMP COORDINATION AND CAMP MANAGEMENT

At the onset of the pandemic, in consultation with its field missions, IOM globally developed **the Camp Management Operational Guidance that put forward possible adaptation and key considerations for continuing core camp management activities while preparing for potential infections in displacement sites.** The Guidance has since been adapted and contextualized for use across all of IOM's CCCM operations as well as many of its partners.

At operational level, IOM has been working to support regional, national and local authorities to develop **contingency and response plans, and to ensure the continuation of services in existing displacement sites at risk.** For instance, in Iraq, IOM worked to develop a position paper on camp consolidation and closure in the context of the COVID-19 pandemic, working with Ministry of Displacement and Migration to temporarily put on hold camp consolidation and closure plans. In the Philippines and Vanuatu, prevention measures were integrated into protocols for evacuation shelters and outbreak preventions as part of the disaster risk reduction work into CCCM.

In order to contain the transmission of COVID-19 collective sites, IOM CCCM operations worked with health actors and authorities in 33 countries to facilitate isolation, physical distancing and, where appropriate, quarantine for migrant populations. This includes rehabilitation of existing health and other built structures to be used for COVID-19 in displacement sites and transit centres, construction of new facilities as well as developing management and maintenance SOPs for facilities such as in Bangladesh and Nigeria. In El Salvador, Honduras and Costa Rica, IOM works with local authorities to improve the accommodation conditions for ad hoc quarantine facilities being used to host migrants and to ensure their access to life-saving assistance and services. In the large sites of South Sudan, Nigeria and Bangladesh, IOM also worked with authorities and partners to put into place plans for dignified burials where some pre-existing services may be disrupted, as well as promoting information of safe practices.

With access and movement restrictions for both the displaced and humanitarian actors, the CCCM teams identified their role in community engagement and communication to be a priority on behalf of partners working in displacement locations. Working with health and WASH actors, IOM CCCM teams conducted trainings and awareness sessions with camp committees, women groups and youth groups, working to ensure that the displaced populations are part of the planning and implementation of preparedness and response to the pandemic. In Mozambique for instance, CCCM teams worked with communities to form COVID-19 committees to assist with preparedness efforts. In various settings across countries, IOM worked with protection actors and other service providers to establish or enhance service monitoring and referral mechanisms, and worked with women's group to ensure open communication pathways following trainings.

PROTECTION

IOM continued providing most critical protection services needed by migrants and mobile populations through adjusted ways of working including remote and mobile methods in 38 countries, reaching over 400,000 individuals since the beginning of the crisis. Despite the continuous progress made, certain groups continue facing exacerbated vulnerability factors due to COVID-19 measures. In response, IOM adjusted its programming to respond to newly emerging vulnerabilities by adapting its protection activities as certain groups such as older persons, persons with disabilities, women and girls, children and LGBTIQ+ people are exposed to increased protection risks. In Ecuador, IOM produced an analysis about LGBTIQ+ migrants and refugees to identify needs, capacities and protection gaps in the COVID-19 context. In Colombia, IOM designed a geo-referencing, GPS-based mobile

application for members of the counter-trafficking national taskforce to detect trafficking victims and persons at risk and activate immediate direct assistance. In Bangladesh, IOM has reached over 89,000 people with COVID-19 and protection messages and trained 36 clinical staff on protection principles, gender-based violence, counter-trafficking, psychological first aid, safe referrals, and protection from sexual exploitation and abuse. In Belarus, IOM continues to deliver capacity-building activities on aspects of reintegration of victims of human trafficking in a COVID-19 context as well as support to stranded migrants and reintegration support to victims of trafficking in Kyrgyzstan.

IOM has also continued its efforts together with authorities to address fundamental rights of affected populations. In South Sudan, for example, IOM prepared a COVID-19 Gender and Protection Analysis and deployed staff to Kajo Keji and the Abyei Administration Area to strengthen protection services. In Yemen, IOM has put in place monitoring mechanisms among protection and health teams, to identify, mitigate and respond to protection risks and violations of human rights perpetrated within the context of COVID-19. In the Western Balkans, IOM supported the opening of new reception centres with quarantine facilities for migrants and asylum seekers in Montenegro, with ongoing work to open and improve similar facilities in Kosovo and North Macedonia.

IOM's efforts to address the increased risks of gender-based violence (GBV) have focused on adapting GBV risk mitigation measures to be responsive to the challenges created by the pandemic. For example, measures have been taken to ensure continued and safe access to services for women and girls; access to information and awareness-raising about risks and available services; meaningful participation of vulnerable groups in all stages of programming and; integration of sex and age disaggregated data in COVID-19-related assessments and planning. Additionally, IOM has responded by also adapting its GBV prevention and response efforts to recognize and address the impact of COVID-19 on women and girls, specifically. For example, in Cox's Bazar (Bangladesh), men and boys have been engaged in a curriculum on equal gender roles during COVID-19, to promote participation in maintaining and upholding sanitation and hygiene processes, as well as, in shouldering care and domestic responsibilities. Additionally, IOM ensured key continued provision of GBV case management through women and girls' safe spaces (WGSS) but in a limited capacity that respects and maintains physical distancing.

At global level, IOM has also developed the COVID-19 Guidance and Toolkit for Mental Health and Psychosocial Support (MHPSS) Teams with the aim of compiling existing material related to MHPSS for the COVID-19 crisis, as well as other resources that can be applicable .

COMMUNITY MEETING IN KISMAYO, SOMALIA / © IOM 2020

Strategic Priority 4: Support international, national and local partners to respond to the socio-economic impacts of COVID-19.

ADDRESSING THE SOCIO-ECONOMIC IMPACTS

IOM has consistently emphasized both the immediate- and medium-term need for robust socioeconomic support mechanisms to maintain resilience and support early recovery in over 40 countries already vulnerable prior to the pandemic. As exemplified in Yemen, IOM has been implementing comprehensive livelihood and capacity-building initiatives in conflict- affected communities, including cash-for-work support, small grants and vocational training activities, such as small-scale PPE manufacturing projects, to address the impacts of the COVID-19 crisis in vulnerable populations. In Ukraine, pre-existing programming for the reintegration of veterans was adapted to replace in-person activities with supplementary livelihood grants for businesspeople affected by COVID-19 restrictions. In several countries, including Armenia, Bangladesh and Iraq, IOM has been supporting local businesses that can help address COVID-19 issues through enterprise development funds and support to local business.

Further, **IOM has continued to implement cash-for-work support for IDP families and support to governments** in its efforts to assess the socio-economic support necessary for returning stranded migrants in areas such as Bangsamoro Autonomous Region in Muslim Mindanao's (Philippines). IOM programming has also supported vulnerable children with educational material in order to ensure their attendance to virtual classes restrictions in countries like Brazil or Indonesia, where IOM also supported the enrollment of children in public and private schools and engaged on-call teachers to provide additional classes and assistance.

As migrant workers have also been disproportionately impacted by the negative effects of COVID-19 on businesses, including through soaring unemployment rates and possible loss of income, IOM has developed a global guidance to advocate and ensure that international brands, their suppliers and other business partners respond comprehensively and collaboratively to the current situation and recognize their shared responsibility to protect migrant workers and work together with governments towards avoiding costs of economic damages being passed onto workers. At the global level, IOM has also advocated for the integration of migration into the COVID-19 socioeconomic response through the development of an IOM Toolkit for development partners and contributed to the joint call with UN agencies, the World Bank and other relevant partners to action on the use of remittances during the crisis and the impact of COVID-19 on migrant contributions.

GLOBAL SUPPORT TO STRANDED MIGRANTS

The widespread impact of the COVID-19 pandemic on global human mobility due to travel restrictions, border closures and lockdown measures has left migrants stranded across the world. In response to the complex challenge of organizing voluntary returns during the pandemic, IOM established a **COVID-19 Return Task Force** to ensure a coherent approach and effective response. The COVID-19 Return Task Force supports IOM's strategic vision, specifically as it relates to priorities within the mobility pillar as well as the strategic goal of responding to challenges in a joint manner, addressing the interplay between different programmatic areas within IOM to better assist migrants and governments.

With an estimate close to 3 million stranded migrants

whose intended movements were affected due to COVID-19, during the reporting period, IOM has received **151 requests** from various channels – directly received from migrants, governments of origin or receiving countries – to support in organizing returns of **over 113,000 migrants from 60 nationalities stranded in 53 countries**, territories, and areas and who did not have the means to return home and who are or may be exposed to situations of vulnerability should they remain stranded. While the typology of emerging issues faced by migrants due to COVID-19 becomes clearer, though increasingly complex, the number of requests and the compilation of both official and unofficial data is a large underestimation of the number of migrants stranded or otherwise impacted by COVID-19.

These stranded migrants include a wide-variety of categories, including migrant workers and their families, travellers, international students, migrants living in camps and camp-like settings, urban slums, temporary accommodation, reception centers and dormitories. **Since the lockdown, IOM has assisted over 6,000 migrants to return using existing regular AVVR programming — 10 per cent of those returns were assisted with funds received against the appeal.** In addition to return support to migrants' country of origin, IOM has been providing assistance to meet migrants' needs, including food and shelter, child-care, and health assistance including psychosocial counselling, risk communication and preventive COVID-19 measures.

CONTRIBUTION TO THE UN'S FIRST LINE OF DEFENCE

During the peak of the COVID-19 pandemic, large numbers of United Nations (UN) staff and dependents have continued to work in locations where there is little or no access to any medical facility. In locations where UN health facilities exist, some have been overwhelmed and required addition support, especially in resource-limited settings. To support the UN's duty of care for their personnel during the pandemic, ensure the safety and health of the UN staff and their dependents and, therefore, continuity of humanitarian work, IOM entered into an agreement with the UN system in order to provide critical health services to eligible UN personnel and their dependents as part of the First Line of Defence (FLoD). With its network of 71 migration health assessment centres and over 1,000 health personnel – including nurses, doctors, counsellors and laboratory technologists – in over 50 countries, IOM is able to put the surplus capacity in a number of its health centres and laboratories at the service of the UN system.

In its initial phase, 19 IOM facilities[1] have been designated to provide health services to UN staff and their dependents, including testing, general primary health care and health promotion including mild/moderate cases of COVID-19, referrals, and medical escorts. As of August 2020, testing for COVID-19 is available for UN staff in Ghana, Kenya and Nigeria, and expected to become available shortly in Burundi, the Democratic Republic of the Congo, Ethiopia, Nepal, the Philippines, Rwanda, South Africa, Tanzania and Uganda. Other FLoD-related services, have started in Cambodia, Ghana and Nigeria. In some countries like in Ukraine and Kazakhstan, IOM is piloting provision of ex-country telehealth services for Uzbekistan and Kyrgyzstan.

IOM HEALTH STAFF PICTURED OUTSIDE OF A REPURPOSED HEALTH FACILITY IN COX'S BAZAR, THAT WILL SERVE AS AN ISOLATION AND TREATMENT CENTER DURING THE COVID-19 PANDEMIC / © IOM 2020 (PHOTO: N. WEBB)

[1] Facilities are placed in the following countries: Burundi, Ethiopia, Rwanda, Kenya, Tanzania, Uganda, South Africa, Ghana, Nigeria, Democratic Republic of Congo, Bangladesh, Nepal, Sri Lanka, Cambodia, the Philippines, Thailand, Kazakhstan, Ukraine, Jordan and Egypt (as of 19 August 2020).

CHALLENGES AND IMPACT ON IOM'S OPERATIONS

During the response to the pandemic, all efforts are made by IOM to ensure continuity of care for all displaced populations and migrants, particularly vulnerable populations.

With health systems overstretched by COVID-19, ensuring the continuity of essential health services to vulnerable populations, including migrants, through the provision of life-saving primary health services, referral, procurement of essential medicines and medical supplies, and the improvement of infrastructures, particularly in countries with compounding pre-COVID-19 humanitarian needs, has become an increasing challenge due to limited resources and access constraints.

In the medium term, an overall reduction in global, regional and local mobility is expected to last. The impact of the pandemic is already expected to lead to a drop of 20 per cent of global remittances, further impacting receiving communities' capacities to cope with the now rooted impact of the pandemic. Current travel restrictions could well outlast the immediate crisis and restoring confidence of national governments and communities will be highly needed to allow travel and trade to commence, mitigating economic impacts of the crisis.

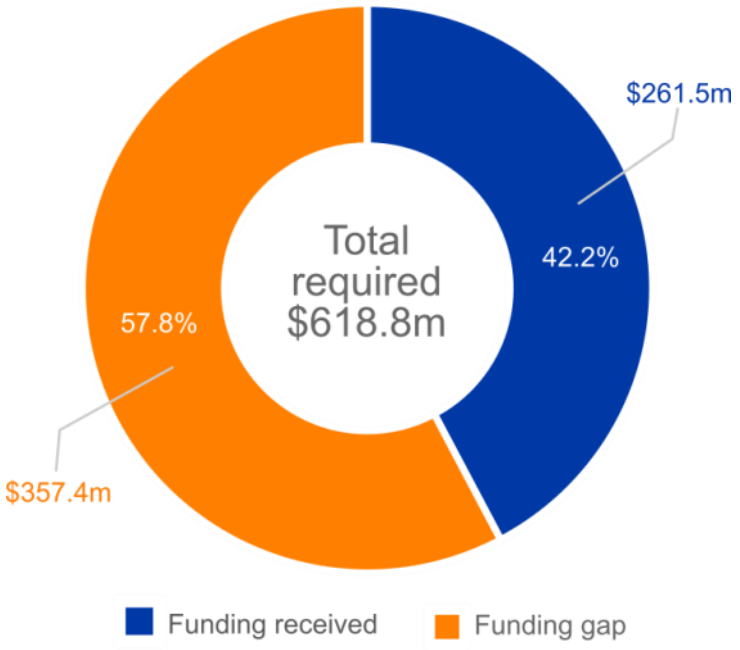
Movement restrictions have also affected the ability to carry out preparedness efforts and provide services in already complex humanitarian crises. This is due to the reduced movement of aid workers, stemming from a **sharp reduction in surge deployments** to support front-line operations as well as a **limited access to locations in need**. In addition, due to various levels of movement restrictions across and within borders, the conduction of on-site needs assessments for evidence-based programming and effective preparedness and response efforts has been hindered. **Lockdowns and restricted access to camps** in places such as Iraq and Uganda have also meant that the provision of goods and services to IDP populations has been reduced. In many countries, movement restrictions also prohibit IDPs' capacity to access livelihood opportunities, putting further pressures on their ability to supplement the stretched aid supply. Furthermore, restrictions on movement of goods and people have also resulted in **supply chain disruptions and delays in delivery of essential supplies** related not only to COVID-19, such as testing kits and PPE, but also to other essential supplies and commodities. Cross-border coordination for contact tracing and other elements of the health response also remains challenging in some contexts due to the ongoing mobility restrictions.

Due to the significant impact of COVID-19 on the movement of people, airline operations, public health and border controls and restrictions, non-urgent IOM **movement operations for resettlement and relocation were temporarily placed on hold as of 17 March**. The temporary hold was the first of its kind in the history of resettlement though necessary given the closure of borders, grounding of airlines, lock downs and health considerations. The hold **delayed the departures of some 10,000 refugees** to resettlement countries. However, throughout this period, IOM, alongside UNHCR and other partners, continued to process and counsel refugees and resettled scores of urgent cases. In addition, numerous resettlement countries established or expanded their capacities to apply flexible processing modalities, to adapt and ensure the continuity of their resettlement in unpredictable circumstances. On 18 June, IOM and UNHCR announced the resumption of resettlement departures for refugees, allowing movement operations to move forward where feasible. Though this type of operations has been severely impacted by the current crisis, resettlement movements have resumed with departures on the rise.

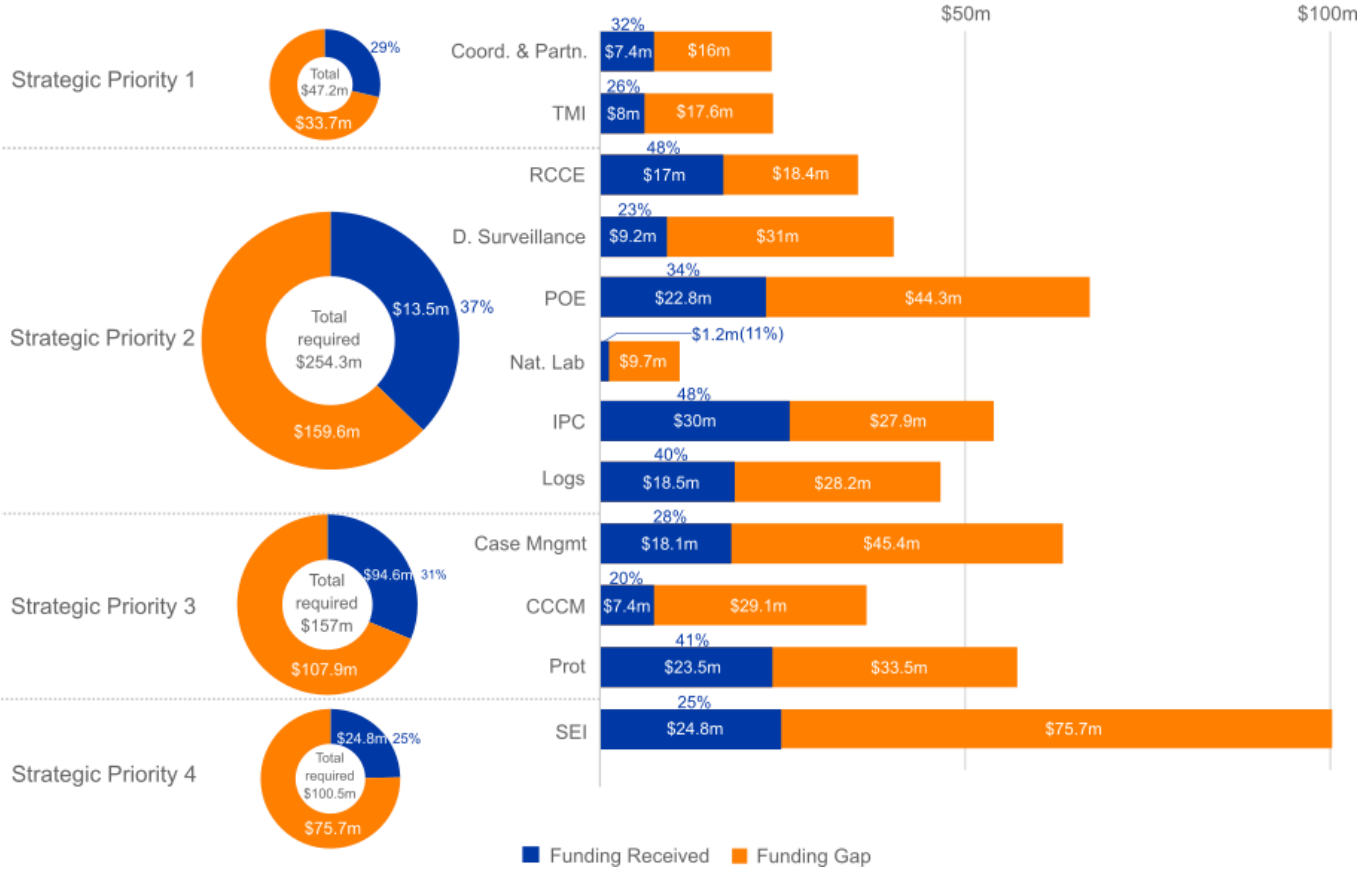
IOM had also to **temporarily scale back its pre-migration health activities** to guarantee the safety of migrants as well as staff. As of end of August, the Global Health Assessment Programmes (HAP) is gradually resuming its operations and the caseload has now reached 50 per cent of the caseload for the same period in 2019. Likewise, IOM's immigration and visa processing programmes have reduced activities, in adherence with health and local government directives. As of 2 September, there are no centres operating and assisting migrants at regular capacity, 53 per cent have temporarily reduced operations and 47 per cent remain temporarily closed.

RESOURCE MOBILIZATION AND FUNDING GAPS[1]

FUNDING RECEIVED AND GAPS[2]



FUNDING ANALYSIS PER STRATEGIC PRIORITY[3]



1 Funding analysis includes both new (202.2 million) and reprogrammed (59.3 million) contributions.

2 The total funding received does not include the CERF allocation for IOM's support to NGO life-saving assistance for COVID-19 [USD 25,074,550].

3 Financial contributions to the First Line of Defence and CERF-funded IOM's support to NGO life-saving assistance project have not been taken into consideration for this analysis.

FUNDING RECEIVED BY DONOR[3]

Donor	Total Funding Received (USD)
United States of America	105,229,786
European Union	30,810,390
Germany	27,631,278
United Kingdom of Great Britain and Northern Ireland	15,742,350
UN Department of Operational Support	13,653,460
Italy	7,603,042
Canada	6,595,350
Japan	6,452,889
World Bank	6,107,245
Australia	5,433,933
Country Based Pool Funds (CBPF)	5,359,570
Switzerland	3,804,954
Central Emergency Response Fund (CERF)	3,461,800
UN COVID-19 Response and Recovery MPTF	3,170,911
Sweden	2,940,687
Denmark	2,452,951
UN Post-Conflict Multi-Partner Trust Fund for Colombia	2,047,489
Norway	1,639,919
Netherlands	1,490,782
United Nations Children's Fund (UNICEF)	1,394,119
New Zealand	1,300,000
Livelihoods and Food Security Fund (LIFT)	1,028,934
Republic of Korea	955,197
IOM Internal Funds	788,986
State of Kuwait	700,000
Peacebuilding Fund (PBF)	517,020
Global Fund to Fight AIDS, Tuberculosis and Malaria	377,035
Finland	362,049
United Nations Development Programme (UNDP)	348,862
World Health Organization (WHO)	330,000
United Nations Human Settlements Programme (UN-Habitat)	277,000
Portugal	271,444
Qatar Charity	250,000
TradeMark East Africa	226,160
Chile	111,000
United Way Worldwide	109,476
Estonia	108,578
International Rescue Committee (IRC)	102,234
Spain	58,499
United Nations Trust Fund for Human Security	56,000
Joint Programme for Peace (JPP)	52,411
Kuwait Projects Company (KIPCO)	32,363
Bulgaria	27,594
Luxembourg	22,075
Czech Republic	12,000
Joint United Nations Programme on HIV and AIDS (UNAIDS)	7,137
Office of UN Resident Coordinator - United Nations in Ukraine	5,400
Stichting AFEW International	3,600
Private Donation	3,063
Total funding received for COVID-19 programming	$ 261,467,022

[3] CERF funding represented in this table does not include the CERF allocation for IOM's support to NGO life-saving assistance for COVID-19 [USD 25,074,550].

International Organization for Migration (IOM)

The UN Migration Agency