CRISIS INFO #1: COVID-19 and People on the Move

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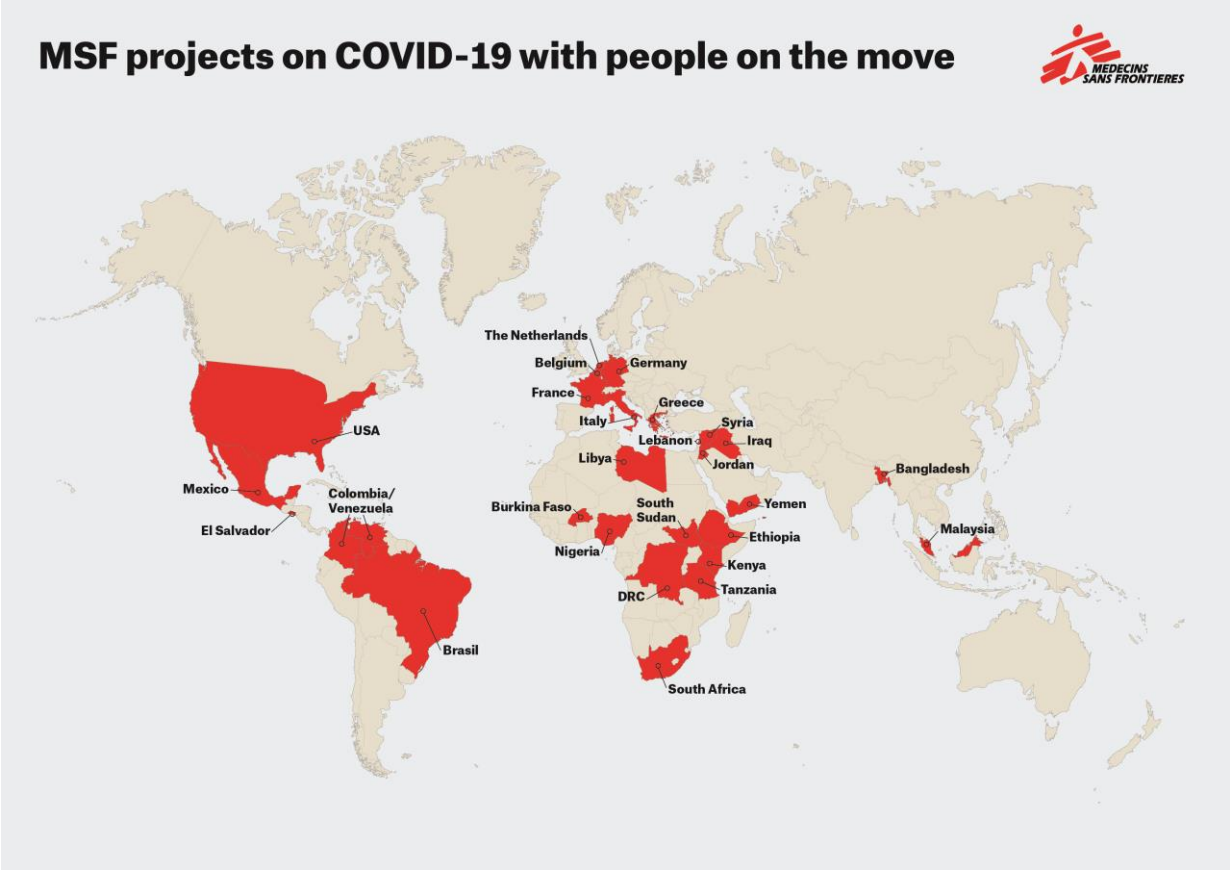

This crisis info focuses specifically on COVID-19 as it relates to people on the move (asylum seekers, refugees, internally displaced people (IDPs), and migrants) and the project updates look at those projects in which MSF is specifically working with these populations in the context of the pandemic.

KEY FACTS AND FIGURES (UNHCR)

- Some 70.8 million people around the world have been forced from home
- 25.9 million are refugees, 41.3 million are Internally Displaced Persons (IDPs) and 3.5 million are asylum seekers
- At least 167 states have fully or partially closed their borders to contain the spread, of which 57 make no exception for people seeking asylum
- 96 refugee-hosting countries have reported local transmission of COVID-19
- Nearly 80% and all IDPs are hosted in low- and middle income countries

KEY MESSAGES

A POPULATION PARTICULARLY EXPOSED TO COVID-19

- The COVID-19 pandemic is disproportionately impacting the world's most vulnerable populations. Among them are the world's more than 70 million forcibly displaced people – refugees, asylum seekers, internally displaced people (IDPs) as well as migrant workers, including undocumented migrants.

- Many of these men, women and children live in poor conditions all over the world, with lack of access to basic services such as clean water, food, sanitation or inadequate access to healthcare, as well as lack of legal status. The COVID-19 pandemic both exacerbates and is exacerbated by these living conditions.

- Many migrants, asylum seekers, refugees and IDPs live in formal and informal camps, reception centres, or in detention centres. Many others live on the streets in informal housing arrangements. In these settings, preventative measures are often not possible. How can we ask people to protect themselves when they don't have easy access to water or soap? Or to self-isolate when they live in cramped tents side by side with 10 other people? Physical distancing is very difficult, if not impossible, in overcrowded camps and dense urban settings, where people live side-by-side in small-congested shelters with many family members. Having to queue for water points and food increases the risks of viral transmission.

- COVID-19 related curfews and restrictions on freedom of movement also impact heavily on these groups, who are already excluded from most employment opportunities and who have even less access to assistance and protection.

- In many settings, displaced people live in insecurity and face the risk of arrest or abuse. They may be stigmatised as 'disease carriers' against a backdrop of increased xenophobia and have limited access to reliable information. Some populations are fully dependent on humanitarian aid. In many areas, such aid is limited.

- Others trapped in detention centres and camps in areas of ongoing conflict, violence or war not only face the threat of COVID-19 but also are exposed to indiscriminate attacks and shelling.

COVID-19 INCREASES THE NEEDS AND REDUCES ACCESS TO ASSISTANCE

- Lockdowns, travel bans, quarantine and border closures on public health grounds create challenges and disruptions for everyone – refugees, asylum seekers, IDPs and migrants are among the most vulnerable. In the context of the pandemic, it is to be expected that their needs for safe and dignified conditions, mental health services, adapted information and health promotion activities and specific pathways to detection and care will be exacerbated.

- Additionally, outbreak control and emergency measures are disrupting many essential services and humanitarian support that is provided by NGOs, volunteers and civic associations, including the provision of basic healthcare and food. The role of the police or military in enforcing emergency measures can also push people further underground and stop them from seeking medical care if they fear they will be harassed, arrested, detained or deported while walking in the street.

HARSHER BORDER MEASURES, ASYLUM RESTRICTIONS, CRIMINILISATION, XENOFOBIA AND STIGMATISATION

- While some border closures are understandable, we are seeing a disturbing conflation of COVID-19 outbreak control with politically motivated migration control measures. Measures such as medical screenings at borders or quarantine upon arrival can be put in place to preserve public health while still ensuring protection to refugees and asylum seekers. Yet in many places, the pandemic is being used as an excuse to punish people on the move, and those that seek to care for them.

- At least 167 states have fully or partially closed their borders to contain the spread of COVID-19 – of these, 57 make no exception for people seeking asylum (UNHCR). People seeking safety and shelter are being turned away at land and on the sea – often returned or transferred to countries where they may face serious threats to their life or freedom.

- No public health emergency should deny asylum seekers and refugees protection. Yet many states are purposely denying entry to asylum seekers or indirectly preventing their access under the guise of border closure measures in order to limit the spread of the outbreak. There is no evidence that a ban on asylum seekers or returning people would improve public health, indeed it is likely to be counterproductive. We know from our extensive humanitarian medical experience that when a person seeking refugee protection is refused it puts them at further risk.

- Several countries have announced restrictions to their asylum systems because of COVID-19. Some have suspended the registration of asylum claims which is denying asylum seekers access to legal status, reception and access to basic services including healthcare. Others have only suspended or limited the processing of claims. Additionally, many asylum seekers have been left to fend for themselves which asylum reception centres closing their doors to newly arrived.

- Several states have adopted concerning measures against refugees, asylum seekers and migrants in transit, such as targeted restriction of movements, forced relocation in camps, prohibition of transportation of migrants and mass arrests in parks.

KEY RECENT EXAMPLES:

US, Central and South America

- The US closed its border to all asylum seekers crossing through Mexico and put all asylum proceedings on hold, but deportations from the US to Mexico, Central America

and South America have continued. This is despite the fact that the US is right now the epicentre of the epidemic and is potentially exposing people to COVID-19 in detention centres before deporting them to countries with fragile health systems (Guatemala, Honduras, El Salvador or Haiti).

- Brazil has restricted the entry of foreigners at it land borders, including the Venezuelan border that hundreds of Venezuelan migrants and refugees used to cross daily.

Southeast Asia

- Since early May, Malaysia has conducted several immigration raids under the pretext of containing the spread of COVID-19. This has affected hundreds of migrants, including Rohingya refugees and children. While documented refugees are generally released after COVID-19 testing, undocumented migrants end up in detention.
- Boats carrying Rohingya refugees heading to Malaysia have been turned back. Most recently a boat carrying around 500 Rohingya was denied entry into Malaysia and up to 100 people on board are thought to have died before the boat was eventually allowed to make landfall in Bangladesh.

Europe

- We are seeing humanitarian efforts being blocked in the name of COVID-19 – for example civilian search and rescue efforts are being blocked as states use discriminatory and disproportionate application of public health control measures. Germany asked NGOs to cease search and rescue activities, while Italy and Malta closed their ports to rescued people, implementing a system of "floating quarantine vessels" suspensive of people's right to disembark in a place of safety.
- France continue to pushback refugees, asylum seekers and migrants to Italy.
- Belgium, Denmark, Italy and Greece have suspended or limited the processing of claims, such as of interviews.

North Africa:

- In Libya, the detention centre in Kufra expelled nearly 900 men and women from April 11 to 15, taking them by truck or bus across hundreds of miles of sand and leaving them either in a remote town in Chad or at a Sahara border post in Sudan.

Africa:

- Uganda has also closed its borders and announced the temporary suspension of refugee law for emergency reasons.
- In the midst of the COVID-19 crisis, deportations of Ethiopian migrants from Saudi Arabia were halted briefly in March and resumed in early April. However, around 3,000 people were deported in about ten days in April, amid calls from the UN and MSF to stop deportations or space them out. Deportations are now again on hold. Arriving migrants are sent to a quarantine centre at a university in Addis Ababa.

KEY MSF CALLS

PROTECTION OF VULNERABLE REFUGEES, ASYLUM SEEKERS AND MIGRANTS: Refugees, asylum seekers and migrants should not be stigmatised or painted as a "threat" during times of

COVID-19. The virus has no borders and all humans are potentially at risk. Everyone must be equally included in the outbreak response for the response to be efficient. They must not be discriminated against through exclusion, criminalisation and discrimination by authorities - this is counterproductive to the efforts to stop the outbreak. States should also take adapted measures that are responsive to the specific needs of these particularly vulnerable groups of population.

ACCESS TO HEALTHCARE MUST BE ENSURED: Refugees, asylum seekers, IDPs and migrants must be assured access to healthcare. COVID-19 control measures should not come at the cost of access to urgently needed healthcare. This means border closures must not stop urgently needed medical and humanitarian supplies, as well as medical and humanitarian staff, from coming into countries and governments must ensure restrictions in camp, detention or reception settings do not block people from accessing healthcare. In Cox's Bazar, travel restrictions introduced in response to COVID-19 are affecting access to healthcare for both local Bangladeshis and the Rohingya. It is much harder for people with 'invisible' illnesses to prove they are sick and eligible to travel to facilities for treatment, and face interruptions and a possible deterioration in their conditions. It is important that any government restrictions on asylum systems must not result in denying asylum seekers access to legal status, reception and access to basic services including healthcare. All refugees, asylum seekers, IDPs and migrants need to have access to health information (in their own language) on prevention, isolation and treatment measures.

COVID-19 MUST NOT BE USED AS AN EXCUSE TO ENFORCE DEADLY MIGRATION CONTROL POLICIES: Governments must not use COVID-19 as an excuse to enforce further restrictive migration control policies and evade international obligations towards refugees, asylum seekers and migrants. Governments must not cynically leverage this public health emergency in order to shut the door to those in desperate need of protection. This includes decisions to suspend all possibilities to claim asylum, deliberate targeting of migrants of asylum seekers with a negative effect and complete closures of borders with no exceptions for entry to asylum seekers or to indirectly prevent their access to territory. As an emergency medical humanitarian organisation responding to the pandemic globally, MSF understands the serious challenges presented by COVID-19. However, safeguarding the wellbeing of those in your own country and upholding your international obligations towards refugees, asylum seekers and migrants are not mutually exclusive principles.

Governments must continue to allow people to follow legal processes to request asylum, providing for non-discriminatory screening and referral to health facilities as necessary. Reception centres must be organised and managed in such a way to limit the risks related to the virus (no overcrowding, ensuring access to water and medical care etc). More than ever the detention of people because of their migration status should be avoided and alternatives to detention should be sought, to protect people's ability to practice physical distancing and be given the right to apply for asylum.

THE RIGHTS OF MIGRANTS AND REFUGEES MUST BE RESPECTED IN THE TIME OF COVID-19: Governments must not use COVID-19 emergency public health measures to directly target refugees, asylum seekers and migrants. All restrictions on rights must be strictly necessary, based on scientific evidence and neither arbitrary nor discriminatory in application. They must

be also be of limited duration, respectful of human dignity, subject to review, and proportionate to achieve the stated objective. Further, no limitations and restrictions can apply to certain human rights such as the right to life or the right to be protected from torture. These concepts of proportionality and necessity are open to interpretation by states. In contexts where states already restrict access to certain rights to a minimum – such as the right to seek asylum – there is a real risk that these rights are further eroded.

LOCKDOWNS AND MASS QUARANTINING CANNOT BE CUT-AND-PASTED OR DISCRIMINATORILY APPLIED Given the rapid spread of COVID-19, along with evidence of asymptomatic transmission, mass lockdown and other restrictive measures have public health justifications. Measures that are the least intrusive or restrictive to rights should be privileged and should not be discriminatory. Clear ethical and public health principles, as well as domestic and international legal frameworks (most notably, the Siracusa Principles[1]) must guide any restrictions imposed on personal freedoms.

MSF is calling for quarantine and lockdown measures to apply equally to all without discrimination; for those who are quarantined to be provided with healthcare, social and psychosocial support, and basic needs such as food, water and other essentials; for mass quarantine to be avoided and; where possible for the immediate transfer of asylum seekers to places where all the preventive measures can be applied. Forcing people to live in overcrowded and unhygienic camps was always irresponsible but now more than ever due to the COVID-19 threat. Furthermore, states must not criminalise undocumented populations. People cannot be sanctioned for not respecting emergency measures when they have no means to do so. Outbreak responses only work with the trust of communities, with the inclusion and participation of all in the population. Measures intended to stigmatise and criminalise and push people underground are counterproductive and only increase the vulnerability of those they target.

DISPLACED PEOPLE AT RISK SHOULD BE EVACUATED WHENEVER POSSIBLE: Viruses thrive in poor living conditions, without adequate water or sanitation. Refugees, asylum seekers, IDPs and migrants living in overcrowded conditions, on the streets, in makeshift camps, in reception or detention centres or substandard housing are at particular risk. European prevention methods cannot be simply applied to refugee camp or reception or detention settings. We have to find other ways to help people keep themselves protected such as mass distributions of soap, water, building water and handwashing stations and delivery of food and other essential items.

While it is not possible in every setting (for example in refugee and IDP settings in Tanzania and South Sudan where there are tens or hundreds of thousands of people), where possible, MSF is calling for the relocation or evacuation of vulnerable refugees, asylum seekers and migrants. For example, in Greece on the island hotspots MSF is calling for the evacuation of people the most at risk (people above 60 years and those with respiratory conditions, diabetes, or other health complications) as well as the continuation of efforts to decongest the camps, including the agreed relocation to other EU member states of unaccompanied minors and sick children. In Libya MSF is calling for the international community and the European governments to put in place direct humanitarian evacuation corridors for the most vulnerable refugees, migrants and

[1] The Siracusa Principles stipulate that coercion is unethical and that at a minimum, provisions for people under enforced quarantine include basic needs (food, water, soap, fuel, medicine, means of communication).

asylum seekers exposed to the most imminent life-threatening risks, including those trapped in detention centres across Libya and other places of captivity.

MSF COVID-19 OPERATIONS: REFUGEES, ASYLUM SEEKERS, IDPS & MIGRANTS

NOTE: This includes only those projects where we have a COVID-19 response where we are working with people on the move (asylum seekers, refugees, internally displaced people (IDPs), and migrants).

Europe

BELGIUM: MSF's intervention for COVID-19 is currently focusing on nursing homes in addition to supporting people who are homeless and vulnerable migrants. Support for vulnerable groups such as homeless people and migrants is focused on an isolation medical unit in Brussels where so far 119 patients received care and 88 were discharged. An outreach team is also assisting other centres where vulnerable people are living in collective centres providing information on infection prevention and control (IPC) and testing. So far, this team has supported about 35 structures and reached out to more than 3,300 people.

FRANCE: MSF is providing medical care to vulnerable people confined in emergency shelters or still living on the streets or in makeshift camps in Paris and the suburbs. MSF teams in mobile clinics have visited six emergency shelters to provide medical support, evaluate health status and identify potential COVID-19 cases. Additionally, a new hotline has been set up with MSF nurses to provide advice to managers of these facilities and flag the most concerning situation to medical mobile teams. We also provide general consultations near food distribution sites five days a week and medical assistance in two "COVID-19 centres" set up to isolate and accommodate migrants and homeless population infected by COVID-19 south and north of Paris (Châtenay-Malabry and Aulnay-sous-Bois).

GERMANY: An MSF team is supporting the authorities in the federal state of Saxony-Anhalt in a centre for asylum seekers in the city of Halberstadt, in which hundreds of people are under quarantine and where some were already infected with COVID-19. Our teams are carrying out health education activities, including infection prevention and control (IPC) and providing psychological support in the centre. In addition, in different parts of Germany, MSF is advising organisations, volunteer groups and state institutions working with the homeless, migrants and other vulnerable groups on IPC measures, to enable them to continue their services. Those we are supporting include a network of volunteer organisations distributing food to the homeless in Berlin, and a variety of social support provided by the Protestant Church of Germany.

GREECE: MSF is providing support to the asylum seekers in Moira camp on the island of Lesbos, as well as Vathy refugee camp on the island of Samos. There are currently no reported cases of COVID-19 in either camps, yet the overcrowded and horrific living conditions in all the camps - or hotspots - on the Greek islands provide the perfect storm for a COVID-19 outbreak. Given the lack of adequate sanitation services and the severely limited medical care, the risk of the virus spreading amongst the inhabitants of the camps is extremely high once they have been exposed. In both Lesbos and Samos MSF is carrying out health promotion and supporting referrals of patients presenting symptoms related to COVID-19. At the same time, we have adapted our facilities and procedures in order to ensure the safety of our patients and our staff, increased the provision of water and sanitation services in the camps and are scaling up our operations with the recruitment of extra medical, paramedical, support staff and the medical equipment. MSF is now in the process of finalising a 40-bed isolation facility in proximity of Moria Camp, with a centralised COVID-19 triage system with other organisations now operational.

ITALY: In Rome, the first emergency intervention launched at Selam Palace, a building hosting more than 500 refugees, mostly coming from the Horn of Africa, became a wider project covering several informal settlements and reception centres in south-east suburbs of the city, in cooperation with local health authorities and Medecins du Monde. Activities include health promotion, monitoring and a dedicated telephone line managed by a doctor and intercultural mediator to facilitate medical counselling and assistance.

THE NETHERLANDS: We are monitoring the situation for homeless people across the Netherlands (including asylum seekers living on the streets following rejected claims), ready to support if needed.

AMERICAS

BRAZIL: In Boa Vista, Roraima state, MSF teams are undertaking health promotion activities (providing hygiene and physical distancing guidance) for Venezuelan migrants via mobile clinic at informal shelters, and gathering places such as the local bus station. The team has also assisted in expanding access to safe water in formal and informal shelters and has distributed hygiene kits. COVID cases are increasing (about 80 new cases a day in Roraima) and the health structure is very weak, with only 10 ICU and 60 intermediate care beds in the main city´s hospital. There have been delays in opening a field hospital with larger capacity due to a lack of HR and equipment.

COLOMBIA: Due to the pandemic, primary health care, mental health care and sexual and reproductive healthcare projects for Venezuelan migrants in border areas of Colombia had to be modified in response to the social distancing norms dictated by the national government and to activities supporting the public health system. Thus, we continued to provide care with appointments for sexual and reproductive health, family planning, IVE and mental health. We follow up the patients with chronic diseases to whom we have advanced the medicines they require. The pandemic has adversely affected migrants, who have been left without income-generating alternatives due to the application of compulsory isolation in the country. Migrants in vulnerable situations (in settlement contexts, living in unhygienic conditions in marginal neighbourhoods) are at risk of contracting the disease if they face difficulties in implementing preventive measures (hand-washing, social distancing, quarantine when ill) and obstacles in accessing medical care. This is the reality of many migrants in our intervention contexts. As a consequence, hundreds have undertaken the return to their country, most of the times in risky conditions and without the pertinent sanitary controls. Despite the fact that humanitarian corridors are being set up spontaneously by civil society the management in many cases has not been adequate and health controls are not carried out on those leaving the country.

EL SALVADOR: El Salvador has officially entered in the community transmission phase. With both the USA and Mexico sending migrant deportation flights to the country, there is a big challenge in terms of organising quarantine and isolation measures. In El Salvador, teams have expanded the emergency services (ambulances) to collaborate with transfers for unrelated medical emergencies COVID-19. We keep working in neighbourhoods affected by gang violence and we have started providing mental health care for deported people, who are kept in quarantine in Contention Centres for a month after getting to the country.

MEXICO: MSF increased medical activities in Matamoros camp on the US/Mexico border where around 2,000 asylum seekers live. With a lack of comprehensive care inside the camp and COVID-19 in the country we are providing physical and mental health services, and health promotion activities in a precarious environment. So far, COVID-19 patients have not been detected. Also in the US/Mexico border, MSF continue its intervention in Nuevo Laredo by assessing and

implementing IPC in all migrant shelters where more than 200 persons are staying in confinement. Psychosocial support is provided to shelter's host, staff and also sometimes to members of the surrounded communities. MSF continue to monitor the constant flow of Mexicans repatriated by US authorities and deported non-Mexican migrants.

In Tenosique (Tabasco), based in La 72 shelter, MSF continues to offer comprehensive primary healthcare (medical and psychological support) to the migrants of Tenosique. MSF team supported to La 72 shelter in implementing the IPC protocols and get prepared if a COVID case would be reported inside the shelter. In Mexico, the CAI (a specialised centre for those who have suffered torture or extreme violence) continues to integrate new cases referred by our partners from Mexico City, in addition to the patients who were already following the program before the confinement. MSF assessed and implemented IPC in migrant shelters across Mexico City. In Mexico City and in Tijuana, we have visited different health structures to prepare a coordinated response with the health authorities to respond to high numbers of patients affected by COVID19. In Tijuana, bordering San Diego (US) and a city traditionally linked to migrants and asylum seekers, MSF teams have started working with moderate COVID-19 patients in the Zonkies basketball court (refurbished as an auxiliary hospital). Teams also have set up a telephone line where specialised psychologists offer free and confidential psychological consultations, remotely to both migrants and victims of violence in the state of Guerrero.

USA: MSF teams are working in key sites around the country with local authorities and partner organisations serving vulnerable communities who often lack access to healthcare, including migrants and homeless people. Partnering with local organisations, MSF is working to improve infection prevention and control (IPC) measures in facilities serving people who are homeless or housing insecure. We have donated over 80 handwashing stations to places like soup kitchens and supportive housing facilities. In addition, MSF has opened a temporary shower trailer in Manhattan, offering free showers to people who currently lack access to such facilities. We have also sent teams to assess the local needs in several other locations where people lack equitable access to pandemic response services, including in Puerto Rico, Florida and Native American communities in the southwest of the country. In Immokalee, Florida, where some 10,000 to 20,000 migrant farmworkers have continued to labour during the pandemic with minimal access to health care and testing, we are working with the Coalition of Immokalee Workers, the Department of Health, and local organisations and health care providers to implement a multifaceted COVID-19 response. MSF is running a public health education campaign and mobile "virtual" clinics, which provide COVID-19 testing and remote medical consultations for COVID-19 and other health issues.

MENA

IRAQ: In Iraq, MSF activities in Baghdad and Mosul target the local population and among them some internal displaced people and returnees coming from different parts of the country. In Baghdad, MSF is supporting Ibn El Khateeb Hospital, a MoH hospital in Baghdad, identified as one of the three main hospitals for COVID-19 in the city, with technical training on patient triage and infection protection and control. In Mosul, MSF has donated beds to furnish a 50-room building (run by the MoH) in Al Salam hospital complex, for the isolation of patients. Another hospital, Al Shifaa, is located in this same complex. The new Al Shifaa was built by MSF in 2019 and is now used as the main referral point for suspected COVID-19 patients in the Ninawa province. MSF is supporting Al Shifaa by setting up 40 isolation rooms and 30 beds for mild and moderate cases in its centre for post-operative care. 26 isolation rooms are already in use for the isolation of suspect cases. MSF works jointly with local health authorities to facilitate their treatment. MSF has also been helping local health facilities in Erbil by providing technical support, logistic support and training for their staff on infection prevention and control (IPC).

In Laylan IDPs camp in Kikruk, triage of COIVD-19 has started and MSF has implemented a surveillance system, as well as training for drivers and other non-medical staff on PPE and sterilisation. Moreover, one COVID-19 caravan is being built with a 10-bed capacity. This will be pre-positioned for a potential COVID-19 intervention to treat mild cases. MSF's existing projects in Ninawa, Diyala, Kirkuk and Baghdad have also been reinforcing their capacity to triage, support infection and prevention control, and refer cases to Ministry of Health (MoH) hospitals; according to the protocol established by health authorities. MSF will continue monitoring the situation and discussing support possibilities with the MoH.

JORDAN: We have carried and assessment of the needs in Zaatari camp and started preparing a case management facility in the camp should the needs and a response to COVID-19 arise.

LEBANON: In Lebanon MSF responds to the needs of the most vulnerable who struggle to get adequate access to healthcare. Among them there are many refugees coming from Syria or Palestine and other undocumented migrants. Our activities target them together to the most vulnerable parts of the Lebanese population. In Zahle, we conduct regular paediatric activities in Elias Hraoui Governmental Hospital through a two-flow emergency room in tents set up outside the premises. Children have been admitted in the in-patient department and in the intensive care unit, but no COVID-19 positive cases so far. Confirmed cases, if any, will be managed in the emergency room of the COVID zone and referred for hospitalisation or home isolation. The thalassemia unit was moved to a separate area to protect thalassemia affected children from becoming exposed to COVID-19.

In Bar Elias, MSF's elective surgeries hospital, usually handling elective surgeries and wound-care activities, was being prepared to host potential influx of COVID-19 patients. MSF had temporarily suspended the elective surgeries but wound care activities were still running. COVID-19 activities planned in Bar Elias are now on stand-by and elective surgeries should resume soon. We've also been in contact with several governmental hospitals (in Hermel, Saida, and Tripoli) to support them with different logistic services and medical supplies and increasing their medical capacities through training staff members. MSF also deployed a medical team to UNRWA's Siblin training centre (near Saida), which has been turned into an isolation site. Our team trained the staff there on IPC and biosafety. The activities target patients as well as vulnerable communities living in the four corners of Lebanon.

In Dora, a northern suburb of Beirut, MSF has created a medical helpline in partnership with a local organisation called Anti-Racism Movement, in order to provide medical support and assistance to the migrant communities and especially women domestic workers during the lockdown. Awareness campaigns have been conducted by the MSF teams from Akkar to Tripoli, South Beirut, Bekaa. We are engaging with community leaders and partner NGOs to spread awareness about general protective measures especially in crowded refugee camps and informal tented settlements.

LIBYA: MSF activities in Libya have been severely impacted by the restrictions imposed by the COVID-19 response and the escalation of armed conflict, while these same factors increase humanitarian needs in the country. In Tripoli (OCA), MSF continues providing medical and humanitarian assistance to migrants and refugees in one detention centre, while other facilities have been emptied or closed under COVID19 outbreak threat and escalating conflict circumstances. While curfew and lockdown measures had severe impact on migrants and refugees access to basic services, MSF participated in interagency food distributions, offering medical and humanitarian assistance to migrants and refugees living in urban settings. Beyond Tripoli, MSF continues working in three detention centres (in Khoms, Zliten, Zintan), providing primary healthcare and referrals to migrants in Bani Walid and running a tuberculosis (TB) programme (16-bed TB unit + lab support) in Misrata. We are also providing COVID-19 related

trainings to medical staff in Tripoli, Zliten, Misrata, Khoms, Yefren and Bani Wali, as well as and reinforcing IPC and prevention measures in detention centres (handwashing points, distribution of soaps and cloth masks, health promotion with migrants and refugees arbitrarily detained and guards).

NORTHEAST SYRIA: Across northeast Syria, MSF takes part in the COVID-19 humanitarian taskforce, chaired by the local health authorities. We are providing training and preparedness measures in Al Hassakeh National Hospital and in Al Hol camp, where some 68,000 people reside. In the camp, where 94 percent of inhabitants are women and children, we continue to run an inpatient nutrition centre and a tent-based wound care programme for those who cannot reach the clinics, while also providing water and sanitation support. We have also started mapping vulnerable people who are more likely to develop severe illnesses as a result of COVID-19. We share targeted health awareness messages and hygiene kits accordingly. We are preparing to use the inpatient therapeutic feeding centre (ITFC) for case management - if needed - in the camp. In the past week, MSF has flown two charter flights landing in Erbil International Airport, Iraq. The two charter flights have brought in 46 tonnes of essential medical supplies and fourteen MSF staff to support medical activities and the Covid-19 response in northeast Syria. The medical supplies have been shipped across the border and the team, made up of medics, water and sanitation experts, logisticians and coordinators, will travel into northeast Syria after respecting 14 days of quarantine in Erbil.

NORTHWEST SYRIA: MSF responds to the needs of local population affected by the conflict and among them a great part of internally displaced people coming from other areas of Syria. Since the beginning of the COVID-19 pandemic, we have been reviewing the triage systems and patient flow in the hospitals and health centres that we support in Idlib governorate to ensure fast detection of potential COVID-19 patients. This measure is taken to put symptomatic patients under observation until they are tested. We have also set-up Hygiene Committees and reinforced them with additional staff. Additionally, to keep our activities running in our burn unit in Atmeh, we have also organized the triage and screening of burn patients and implemented infection prevention and control measures, trained the medical and the logistics staff and prepared a COVID-19 isolation ward in the hospital.

In the camps, we have adapted the triage system of our mobile clinics to protect the patients and the medical staff and we have implemented social distancing measures during NFI distributions. We are also spreading awareness and health promotion messages about the means of prevention and how to react in case of symptoms and are continuing distributions of hygiene kits to thousands of displaced families in camps while we evaluate water distribution systems and standards in order to be able to reinforce them in case of need.

YEMEN: Health Promotion activities are ongoing in the community, working with the Yemeni Red Crescent, and in IDP camps, working with the Danish Refugee Council. In Abs, we are also working with communities, including holding focus group discussions in Al Khudish camp, to understand more about perceptions and knowledge of COVID-19 within the community, including exploration of first impressions and considerations around 'shielding' measures (concept of moving vulnerable people to be together in a 'green zone' to 'shield' them from potential infection).

Southeast Asia

BANGLADESH: Regular activities in the Rohingya refugee camp in Cox's Bazaar and in the capital Dhaka are ongoing. MSF has created isolation wards in all our medical facilities in Cox's Bazar and is preparing two dedicated treatment centres. In total, we have made 260 isolation beds

available, but this is just a fraction of the capacity necessary if there is widespread outbreak within the Rohingya community. Our clinics in the refugee camps are not able to treat severe cases given the lack of ventilators and limited availability of concentrated oxygen. Additional challenges include the very high population density which means the ability to self-isolate is near impossible, coupled with limited access to water and a huge population dependent on humanitarian assistance, making Rohingya refugees particularly vulnerable to the spread of COVID-19.

MALAYSIA: In Penang, we are providing COVID-19 health education in different languages, including Rohingya and Burmese, and translations in hospitals. We've had to suspend mobile clinics, but patients can reach us through our phone hotline. We have donated food supplements to 100 vulnerable families. We issued a call to the Malaysian government to repeal a circular, obliging public health facilities to report irregular migrants, including refugees and asylum seekers. We also published an open letter stating that MSF was ready to support the government of Malaysia with safe disembarkation of persons in distress at sea, and urging the Malaysian authorities not to use COVID-19 at the expense of Malaysia fulfilling its humanitarian obligations under international law towards people in distress at sea.

Africa

BURKINA FASO: We are adapting triage and infection prevention control measures on our projects of Titao, Djibo, Kaya and Barsalogho (not yet affected by COVID-19), and train staff, as concerns are high with the number of displaced people in Northern, Central and Eastern part of the country. We have set up isolation units and trained staff, as concerns are high with the number of displaced people in the northern, central and eastern parts of the country. In the Eastern area, where we have seen recent influxes of displaced populations into the city of Fada, we have rehabilitated a provisional isolation site at the regional health centre in Fada. We also continue to train health staff in Fada regional health centre and Gayeri (which currently has 5,400 IDPs in the city) medical centre on COVID-19 prevention measures, identify isolation sites and adapt patient circuit and triage at the structures we support, as well as implemented WASH activities i to minimise the risk of infection. A mental health strategy has been finalised.

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DRC: In Ituri Province, where MSF works with indigenous and IDPs, we are building isolation rooms for the potential COVID-19 cases in structures where we are already present. We also continue to raise awareness among communities in all IDP sites to COVID-19 and to improve hygiene conditions.

ETHIOPIA: In Ethiopia, MSF is engaging with the authorities to provide medical and mental health support to arriving migrants in a quarantine centre at a university in Addis Ababa, as well as providing COVID-19 advice and training in terms infection prevention measures and other aspects. At least 139,000 migrants, most of them Ethiopians, crossed from the Horn of Africa to Yemen aiming to reach Saudi Arabia or other Gulf countries in 2019, in what is an extremely dangerous migration route (IOM). In parallel, 10,000 Ethiopian migrants have been deported on average every month from Jeddah to Addis Ababa since March 2017. In the midst of the COVID-19 crisis, deportations of Ethiopian migrants from Saudi Arabia were halted briefly in March and resumed in early April. Around 3,000 people were deported in about ten days in April, amid calls from the UN and MSF to stop deportations or space them out. Deportations are now again on hold. Arriving migrants are sent to a quarantine centre at a university in Addis.

KENYA: In Dagahaley camp, in Dadaab, Kenya's largest refugee camp, MSF has set up an isolation unit with 10 beds for COVID-19 positive patients. Unit has a capacity to expand up to 40 beds.

NIGERIA: Across the seven states where MSF works in Nigeria, we are providing technical support to the Ministry of Health and Nigeria Centre for Disease Control as they set up isolation centres for patients who may present symptoms of COVID-19, as well as undertaking community-based health promotion activities, and setting up hand washing points and isolation areas in local communities and IDP camps. Ongoing community engagement in Anka and Benue in displaced persons' camps including discussing with the community about what they would like to do with their most vulnerable members, including possibility of setting up shielding options. Ongoing activities include installing water points for IDPs.

SOUTH AFRICA: Interventions for vulnerable asylum seekers and elderly homeless are active in Tshwane to mitigate the impact of the national 21-day lockdown, as well as an explo mission among vulnerable populations in Johannesburg.

SOUTH SUDAN: MSF is working on preparedness for COVID-19 in all project locations across the country, as well as on preventive measures, to be able to isolate and treat suspected patients of COVID-19 who may eventually approach our health facilities. This includes in the Protection of Civilian (PoC) sites in Bentiu – which has now a confirmed COVID patient being treated in the MSF hospital – and Malakal which together house over 145,000 IDPs, in Yei which continues to be affected by ongoing violence with many displaced people, as well as in Doro camp in Maban which hosts 60,000 refugees. These measures include setting up additional washing points equipped with either chlorinated water or soap and reinforcing the existing ones, training staff on triage and infection prevention and control (including the use of PPE), identifying and establishing isolation areas for suspected COVID-19 patients and conducting health promotion and awareness sessions with patients and the local community. We have also conducted explorations in Mangateen and Gumbo IDP camps in Juba,and have started community engagement and training of healthcare workers there.

TANZANIA: MSF is the sole healthcare provider in Nduta refugee camp, which hosts 75,000 Burundian refugees. In preparation for a COVID-19 outbreak in the camp, we built four triage/isolation areas in each of the health clinics where we work in the camp. We completed preparation for a main isolation centre at the MSF hospital, where suspect cases of COVID-19 will be referred. Currently we have 10 beds with the possibility to connect 10 oxygen concentrators. We are in the process of constructing an additional 50 beds, with the possibility to scale up to 100 beds, if needed. 116 MSF staff have so far been trained for COVID-19 response, with a focus on case definition, triage, screening, infection prevention and control, as well as case management. Training is ongoing in our hospital in Nduta refugee camp. Meanwhile, our health promotion team in Nduta camp are working to sensitise and educate the community on hygiene and best health practices, to improve preparedness for COVID-19 within the camp