Health, Border and Mobility Management Framework

A Framework to Empower Governments and Communities to Prevent, Detect and Respond to Public Health Threats along the Mobility Continuum

2021 Edition
Health, Border and Mobility Management Framework

A Framework to Empower Governments and Communities to Prevent, Detect and Respond to Public Health Threats along the Mobility Continuum

2021 Edition
This document is the result of a collaborative venture involving several units within IOM’s Department of Migration Management and Department of Operations and Emergencies under the direction of the editors from the Migration Health Division. The editors are especially grateful to IOM’s senior leadership, colleagues from the Immigration and Border Management Division and from the Water, Sanitation and Hygiene Unit, and colleagues in country and regional offices who supported the drafting and reviewing process.
CONTENTS

LIST OF ACRONYMS ................................................................................................................................................................................... iv

1. INTRODUCTION ..................................................................................................................................................................................... 1

2. AIMS, SCOPE AND GUIDING PRINCIPLES ........................................................................................................................................ 7
   II.1 Aims ........................................................................................................................................................................................................7
   II.2 Scope ...................................................................................................................................................................................................10
   II.3 Guiding principles ...........................................................................................................................................................................12

3. STRATEGIC OBJECTIVES AND CORE ACTIVITIES .....................................................................................................................17
   III.1 Strategic Objectives and expected outcomes ..............................................................................................................................................18
   III.2 Core activities ..................................................................................................................................................................................18

   Strategic Objective 1: Enhance the evidence base on the human mobility dimensions of communicable disease to inform effective prevention, detection and response .......................................................18

   Strategic Objective 2: Build health system and border health capacity at points of entry and along the mobility continuum for communicable disease prevention, detection and response ....................................24

   Strategic Objective 3: Enhance community engagement and empower migrants, mobile populations and host communities in communicable disease prevention and response ........................................................................31

   Strategic Objective 4: Promote mobility-sensitive and inclusive policy, legal and strategic frameworks ........................................................................................................................................................................33

   Strategic Objective 5 (cross-cutting): Strengthen multisectoral partnerships and coordination, including cross-border coordination ...........................................................................................................35

REFERENCES ...................................................................................................................................................................................................41
### LIST OF ACRONYMS

<table>
<thead>
<tr>
<th>ACBC</th>
<th>African Capacity-Building Centre (of IOM)</th>
<th>MiGOF</th>
<th>Migration Governance Framework (of IOM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAP</td>
<td>accountability to affected populations</td>
<td>MoRRA</td>
<td>mobility-centred routine immunization approach</td>
</tr>
<tr>
<td>AWD</td>
<td>acute watery diarrhoea</td>
<td>MRC</td>
<td>Migration Response Centre</td>
</tr>
<tr>
<td>CCCM</td>
<td>camp coordination and camp management</td>
<td>NAPHS</td>
<td>National Action Plan for Health Security</td>
</tr>
<tr>
<td>CDC</td>
<td>(United States) Centers for Disease Control and Prevention</td>
<td>NCDC</td>
<td>(Libyan) National Centre for Disease Control</td>
</tr>
<tr>
<td>CEBS</td>
<td>community event-based surveillance</td>
<td>OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>COVID-19</td>
<td>(novel) coronavirus disease 2019</td>
<td>OCV</td>
<td>oral cholera vaccination</td>
</tr>
<tr>
<td>DTC</td>
<td>diarrhoea treatment centre</td>
<td>OSBP</td>
<td>one-stop border post</td>
</tr>
<tr>
<td>DTM</td>
<td>Displacement Tracking Matrix (of IOM)</td>
<td>PFA</td>
<td>psychological first aid</td>
</tr>
<tr>
<td>ePHR</td>
<td>Electronic Personal Health Record</td>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>EOC</td>
<td>emergency operations centre</td>
<td>PHEIC</td>
<td>public health emergency of international concern</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
<td>PHERP</td>
<td>public health emergency response plan</td>
</tr>
<tr>
<td>EVD</td>
<td>Ebola virus disease</td>
<td>PHIS</td>
<td>public health information services</td>
</tr>
<tr>
<td>FLoD</td>
<td>First Line of Defence (of the UN)</td>
<td>PMHAs</td>
<td>pre-migration health activities</td>
</tr>
<tr>
<td>GAP</td>
<td>Global Action Plan of WHO</td>
<td>PMMM</td>
<td>population mobility mapping</td>
</tr>
<tr>
<td>GBV</td>
<td>gender-based violence</td>
<td>PoC</td>
<td>point of control</td>
</tr>
<tr>
<td>GHAP</td>
<td>Global Health Assessment Programme</td>
<td>PoE</td>
<td>point of entry</td>
</tr>
<tr>
<td>IASC</td>
<td>Inter-Agency Standing Committee</td>
<td>PPE</td>
<td>personal protective equipment</td>
</tr>
<tr>
<td>IBM</td>
<td>Immigration and Border Management (of IOM)</td>
<td>RCCE</td>
<td>risk communication and community engagement</td>
</tr>
<tr>
<td>I/CBM</td>
<td>Integrated/Coordinated Border Management</td>
<td>SDGs</td>
<td>Sustainable Development Goals</td>
</tr>
<tr>
<td>IDP</td>
<td>internally displaced person</td>
<td>SEA</td>
<td>sexual exploitation and abuse</td>
</tr>
<tr>
<td>IDSR</td>
<td>Integrated Disease Surveillance and Response</td>
<td>SO</td>
<td>strategic objective</td>
</tr>
<tr>
<td>IEC</td>
<td>information, education and communication</td>
<td>SOP</td>
<td>standard operating procedure</td>
</tr>
<tr>
<td>IHR</td>
<td>International Health Regulations</td>
<td>SPRP</td>
<td>Strategic Preparedness and Response Plan</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
<td>UHC</td>
<td>universal health coverage</td>
</tr>
<tr>
<td>IPC</td>
<td>infection prevention and control</td>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>IT</td>
<td>information technology</td>
<td>UN</td>
<td>United Nations Department of Economic and Social Affairs</td>
</tr>
<tr>
<td>LGBTIQ+</td>
<td>lesbian, gay, bisexual, transgender, intersex and queer</td>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>MCOF</td>
<td>Migration Crisis Operational Framework (of IOM)</td>
<td>UNSG</td>
<td>United Nations Secretary-General</td>
</tr>
<tr>
<td>MHD</td>
<td>Migration Health Division (of IOM)</td>
<td>WASH</td>
<td>water, sanitation and hygiene</td>
</tr>
<tr>
<td>MHPSS</td>
<td>mental health and psychosocial support</td>
<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>MIDAS</td>
<td>Migration Information and Data Analysis System (of IOM)</td>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Caminantes have their injuries treated by IOM health workers along the road to Pamplona, Colombia. Their long journeys, often made in flip-flops or sneakers, result in many foot injuries. © IOM 2019/Muse MOHAMMED
The Migration Health Division (MHD) of the International Organization for Migration (IOM) initially conceived the Health, Border and Mobility Management (HBMM) Framework in the wake of the 2014–2016 Ebola virus disease (EVD) outbreak in West Africa. This revised version was drafted in 2020 and, as such, reflects IOM’s experiences in West Africa and subsequent communicable disease preparedness, prevention, detection and response efforts – notably the coronavirus 2019 (COVID-19) pandemic, ongoing at the time of publication, which mobilized an Organization-wide response. IOM will continue to learn lessons and refine best practices in integrating health, border and mobility management in the context of the pandemic and other public health preparedness and response efforts, and will continue to update the HBMM Framework going forward.
The scale of global migration has increased substantially, with more than 1 billion people on the move worldwide. There were 281 million international migrants globally in 2020 – over three times the number in 1970 – and approximately 763 million internal migrants within countries. Multiple factors have contributed to the growing volume and pace of migration, including acute events (such as political instability, economic crisis, environmental disaster or conflict), long-term trends (such as demographic changes, economic development and climate change) and population growth (with the percentage of international migrants in the global population increasing from 2.8 in 2000 to 3.6 in 2020). While the COVID-19 pandemic resulted in significant restrictions in movement, potentially altering future migration trends, international migration will nevertheless remain considerable, with migration dynamics varying by region and context (IOM, 2019a; UN DESA, 2021, 2013).

According to IOM, “migrant” is “an umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border; temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students” (IOM, 2019b, p. 132).

Thus, within this HBMM Framework, the term “migrant” is inclusive of short- and long-term migrant workers – both documented and undocumented, stranded migrants, returning migrants, smuggled migrants, victims of human trafficking and populations who are displaced across borders or within a State, including internally displaced persons (IDPs), asylum seekers and refugees. The Framework also prioritizes mobile populations who are not migrants, such as nomadic populations and travellers, as well as host communities.

Box 1: IOM’s definition of migrants and other populations of concern
The relationship between population mobility and health is dynamic and complex. The health of individual migrants is affected by the circumstances and challenges of the migration process along the mobility continuum, and population movements impact public health as mobile populations interact with host communities within and across borders on a larger scale. The transmission of communicable diseases is a critical dimension of population mobility and health. Today, a health threat in one location can eventually pose a health threat everywhere due to interconnectedness through travel and trade, the emergence and re-emergence of pathogens and unprepared public health and border management systems. At the same time, health care is not accessible for all, rendering uncovered, hidden, hard-to-reach populations – often including migrants and other mobile populations – vulnerable because of the absence of disease prevention, detection and control measures available to them. The volume, rapidity and ease of travel can pose unique challenges for communicable disease control, and well-coordinated, system-wide and multisectoral action is required to respond to public health threats (IOM, 2019a).

1 The mobility continuum refers to the complete pathway of population movement at points of origin, transit, destination and return, including the routes and congregation points along the way and the interconnectivity among them (see Box 6).
Meanwhile, during public health emergencies, migrants, including IDPs and refugees, along with other mobile populations are vulnerable to illness — with risks potentially heightened for example due to overcrowded and poor living and working conditions — as well as to loss of income and increased exploitation, discrimination and xenophobia. Health emergencies might also exacerbate mental health and psychosocial concerns relating to uncertainty about the future, lost livelihoods opportunities, financial hardship, loss of loved ones, stigma and so forth. Migrants might not be able to benefit from social protection schemes, or receive reliable information in a language they understand; they might be separated from their support networks and often have occupations in sectors most exposed to health risks, such as women migrant workers in the health sector (see section II.3 on guiding principles) — enhancing risk during and after an outbreak. In addition, migrants might be unable, or fear, to access health services, including mental health and psychosocial support (MHPSS), particularly if they have irregular migration status. Increases in stigma and xenophobia can furthermore result in exclusion from public health information programmes, testing, contact tracing and treatment, among other issues. In addition, these populations are also at higher risk than host populations of becoming stranded due to mobility and travel restrictions, or being forcibly returned to their country of origin without access to admission and stay support or protection services in transit/destination countries or the consular support of their countries of origin. Furthermore, refugees and other vulnerable populations might not be able to leave their countries or communities of origin, while humanitarian crises might be exacerbated (IOM, 2020c, 2020e, 2020f, 2019a, 2019c).

In this regard, IOM plays a key role in supporting governments and communities to build health and migration management systems that are responsive to migrants and mobile populations, and equipped to address public health concerns along the mobility continuum. IOM provides guidance and expertise on managing public health threats in a context of widespread human mobility, and ensuring that affected and at-risk populations and communities benefit from appropriate and timely assistance. IOM endeavors to build human mobility competent health systems, which provide equitable, accessible and culturally and linguistically appropriate health services to all people in need; are equipped to consider and address varying epidemiological profiles, cultural, language

---

2 For example, the United Nations Policy Brief COVID-19 and People on the Move specifically refers to the vulnerability of “migrants in irregular situations, migrant workers with precarious livelihoods, or working in the informal economy, victims of trafficking in persons as well as people fleeing their homes because of persecution, war, violence, human rights violations or disaster, whether within their own countries – IDPs – or across international borders – refugees and asylum-seekers” (UNSG, 2020).
and socioeconomic factors; and are responsive to the impact of the migration process and mobility on health, particularly at the primary health care (PHC) level. Through this work, IOM contributes to the attainment of the global health security agenda as well as to universal health coverage (UHC) by improving health outcomes for migrants, mobile populations and host communities, “leaving no one behind”. UHC is a fundamental dimension of both individual and collective health security and is an essential feature of resilient and sustainable health systems.

By bringing a deeper understanding of mobility dynamics, IOM facilitates better-targeted and evidence-informed approaches to communicable disease control, in line with the 2005 International Health Regulations (IHR) (see Box 2).

---

Box 2: The International Health Regulations (IHR)

The 2005 International Health Regulations comprise an international legal instrument governing the shared responsibility to stop infectious diseases and all health hazards before they become international emergencies, while minimizing interference with international travel and trade.

The IHR, agreed to by 196 countries, including all World Health Organization (WHO) Member States, aim to help the international community to prevent and respond to public health risks that have the potential to cross borders and threaten international health security. They define the rights and obligations of all countries in this regard, including the establishment of core capacities that each country must put in place to prevent, detect and respond to public health emergencies, and the requirement to report public health emergencies of international concern (PHEIC). It includes specific measures to be put in place at points of entry (PoEs) to limit the transmission of health threats across borders, and enable safe population mobility, without unwarranted travel and trade restrictions (WHO, 2005).

In the Report of the Review Committee on the Role of the International Health Regulations (2005) in the Ebola Outbreak and Response, the WHO Director-General called for international collaboration in supporting vulnerable countries to establish core capacities at and near borders, and specifically indicated that WHO should work with IOM and the UN High Commissioner for Refugees (UNHCR) to facilitate information exchange regarding migrant populations and undertake interventions to limit disease transmission (WHO, 2016, paragraph 9.3). This coordination was institutionalized in the WHO Global Action Plan (GAP) Promoting the Health of Migrants and Refugees (see Box 4).

Through efforts to build country capacities at borders and along the mobility continuum, HBMM contributes to helping Member States meet IHR requirements for public health emergency preparedness and response.

---

3 A PHEIC is defined in the IHR as an extraordinary event determined to constitute a public health risk to other States through the international spread of disease and to potentially require a coordinated international response.

4 A PoE is defined by the IHR as a “passage for international entry or exit of travellers, baggage, cargo, containers, conveyances, goods and postal parcels as well as agencies and areas providing services to them on entry or exit” (WHO, 2005). Under IHR, State Parties were expected to designate PoEs (all airports and ports, as well as some ground crossings) to strengthen the public health capacity of these locations in order to fulfil IHR objectives by 2012. Thus, as some ground crossings are not included, not all PoEs are IHR-designated PoEs.

5 The COVID-19 emergency – which spread rapidly across the globe after it was initially reported on 31 December 2019, leading WHO to declare it a PHEIC on 30 January 2020 and a pandemic on 11 March 2020 – was ongoing at the time of publication.
IOM supports stakeholders to understand the implications of human mobility for communicable disease preparedness and response within and across borders; contributes to the surveillance and management of disease outbreaks as part of a unified health and mobility management approach; and supports the long-term development of mobility-sensitive health systems. These interventions have been implemented in recent PHEIC – including Ebola virus disease (EVD) outbreaks in West Africa (2014–2016) and the Democratic Republic of the Congo (2018–2020), and the COVID-19 pandemic. IOM plays a key role in supporting preparedness for and response to health emergencies and has been well-recognized as a leading technical agency in border management and health security.
IOM’s Migration Health Division (MHD) played a critical role in the international effort to address the 2014–2016 EVD outbreak in West Africa, declared a PHEIC on 8 August 2014. Through a cooperative agreement with the United States Centers for Disease Control and Prevention (US CDC), IOM implemented a five-year regional project to build the core capacities of countries at PoEs to prevent, detect and respond to the outbreak. Interventions included developing standard operating procedures (SOPs) and public health emergency response plans (PHERPs), improving surveillance with an understanding of cross-border population mobility patterns including through population mobility mapping (PMM), convening multisectoral coordination mechanisms for border management and health security and establishing Emergency Operations Centres, among others.

During the tenth EVD outbreak in the Democratic Republic of the Congo (2018–2020), declared a PHEIC on 17 July 2019, IOM supported more than 100 PoEs and internal health screening points to screen travellers and strengthen the capacity of front-line workers to improve surveillance, contact tracing, flow monitoring and hygiene promotion, as part of the national response. IOM also supported displacement tracking to gather data on IDPs and people crossing the Congolese borders with Burundi, South Sudan, Rwanda and Uganda, including demographics, areas of origin, locations where they take refuge and where humanitarian assistance may be required. Moreover, IOM contributed to EVD preparedness efforts in neighbouring countries in East Africa, namely Burundi, South Sudan, Rwanda, Uganda and the United Republic of Tanzania, through interventions such as surveillance, screening and capacity-building at PoEs; PMM; elaboration of SOPs, manuals and training curricula; strengthening health facility capacity around border areas; and supporting cross-border coordination.

In response to the COVID-19 pandemic, IOM supported strengthening the capacity of countries to effectively prepare for and respond to minimize the impact of and contain the disease, using a mobility perspective. Interventions IOM supported included the following, among others: cross-border coordination; advocating to ensure migrants were included in national preparedness and public health planning as well as prioritization plans for vaccination, as appropriate, had access to health services and were reached with communication and messaging, regardless of their migration status; capacity-building at PoEs; strengthening surveillance, including at the community level; enhancing risk communication and community engagement (RCCE); providing water, sanitation and hygiene (WASH) services at PoEs, health facilities, transit centres and in camp and camp-like settings, along with other infection prevention and control (IPC) efforts; PMM; monitoring global travel restrictions; secondment of medical personnel; providing MHPSS to vulnerable migrants and communities, including those in quarantine, stranded and in displacement camps; and procuring and distributing critical supplies, including personal protective equipment (PPE), medical and hygiene supplies, food and non-food items.

IOM’s efforts contributed to IOM’s Global Strategic Preparedness and Response Plan (SPRP) – Coronavirus 2019, the WHO COVID-19 Global SPRP and the Global Humanitarian Response Plan for COVID-19, along with regional and national plans, and aligned with the 2020 World Health Assembly (WHA) Resolution 73.1 on COVID-19 response (IOM 2020c; UN OCHA 2020; WHO 2020a, 2020b).

---

6 An internal health screening point is a location, often along a strategic mobility corridor or pathway, where a person on the move is checked for symptoms of a disease and where other public health activities are carried out (e.g. risk communication and handwashing). These locations, previously referred to as points of control (PoCs) and still referred to as points de contrôle sanitaire in French, are typically chosen based on mobility trends, flows and dynamics, including connectivity to a communicable disease epicentre or outbreak-affected areas, and congregation of population.
IOM advocates for an approach wherein preparedness for, response to and resilient recovery from health crises must be multisectoral, responsive to population mobility and cross-border dynamics, well-coordinated with relevant partners and stakeholders and reflective of spaces of vulnerability along mobility pathways. These considerations are at the core of IOM’s Health, Border and Mobility Management (HBMM) Framework.

II.1 Aims

The HBMM Framework articulates IOM’s strategic role and objectives in the prevention, detection and response to communicable diseases in the context of widespread and multidirectional human mobility. It provides an operational action framework for IOM to undertake health, border and mobility management activities and serves as a reference for IOM Member States and partners to understand IOM’s role and contributions in this area of work. It is accompanied by an operational toolkit to support planning, design and implementation.7

The overarching aims of the HBMM Framework are as follows:

1) To support governments and communities to address the mobility dimensions of public health threats; and
2) To ensure that affected and at-risk populations benefit from appropriate and timely support.

7 Available in 2021.
Box 4: Global governance of migration and health

IOM’s approach to HBMM is guided by key global governance frameworks for migration and health, as well as IOM’s internal Strategic Vision and objectives for migration policy and practice.

Globally, IOM’s work in this area is governed by key international frameworks and agreements. Migration is a central feature in the 2030 Agenda for Sustainable Development, which provides the overarching vision to address the complex and dynamic relationship between migration and development. A guiding principle of the 2030 Agenda is inclusivity, with a pledge to “leave no one behind” – a goal that will not be achieved without due consideration of migrants (IOM, 2017a). Sustainable Development Goal (SDG) Target 10.7 calls on countries and partners to “facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies.” To achieve SDG 3 on good health and well-being, migrants’ health must be addressed. Of note is SDG Target 3.8 on UHC, including financial risk protection and access to health services, essential medicines and vaccines for all, which is inherently inclusive of migrants, and SDG Target 3.d, which calls for improved capacity for early warning, risk reduction and management of national and global health risks, in line with the IHR.

Further to these goals, United Nations Member States have adopted two global compacts to address migration and displacement: The Global Compact for Safe, Orderly and Regular Migration, and the Global Compact on Refugees (UN, 2018a, 2018b). The Global Compact for Migration, which expresses common goals in managing international migration at global, regional, national and local levels, features health as a cross-cutting priority. Key health-related objectives include Objective 15, on access to basic services for migrants, including health, which encourages States to include migrants in national and local policies and strategic plans, as well as Objective 7, which focuses on addressing and reducing vulnerabilities in migration (IOM, 2018).

In addition, HBMM is in line with the Sendai Framework for Disaster Risk Reduction (2015–2030), adopted by the UN in March 2015. The Sendai Framework prioritizes understanding disaster risk; strengthening disaster risk governance to manage disaster risk; investing in disaster risk reduction for resilience; and enhancing disaster preparedness for effective response – to “build back better” in recovery, rehabilitation and reconstruction. The global targets that measure progress in achieving the goals of the Sendai Framework align with the goal of mitigating health risks in cross-border areas.

HBMM also aligns with the principles of the 2016 Grand Bargain, an agreement among some of the largest donors and humanitarian organizations to improve the effectiveness and efficiency of humanitarian action, and accountability to affected populations (AAP) and communities (IASC, 2016).

More specifically related to migration and health, the WHO Global Action Plan (GAP) Promoting the Health of Migrants and Refugees (2019–2023) provides a framework of priorities and guiding principles to promote the health of refugees and migrants, contributing to the vision of the 2030 Agenda for Sustainable Development. The objective of the GAP is to promote the health of refugees and migrants in collaboration with IOM, UNHCR and other stakeholders. It builds on the 2017 World Health Assembly Resolution 70.15 and related Framework, as well as the 2008 WHA Resolution 61.17, which call for international cooperation to deal effectively with the impact of migration and displacement on health. The GAP also calls for supporting capacity to detect and respond to outbreaks, in line with the responsibilities and commitments related to the IHR (WHO, 2019, 2017, 2008).

Within IOM, the Organization’s Strategic Vision 2019–2023 prioritizes three pillars: resilience, mobility and governance. IOM’s work under the HBMM Framework contributes particularly to the pillars on resilience and mobility, by building capacities to prevent, detect and respond to communicable diseases in a context of widespread population movements, and providing tools to map and manage such movements. HBMM also contributes to IOM’s Institutional Strategy on Migration and Sustainable Development, particularly the outcomes
focusing on empowering migrants and their families as development actors (including the focus on upholding and protecting the rights of migrants including displaced populations), and improving the governance of migration. HBMM also aligns with the Migration Crisis Operational Framework (MCOF), which offers practical guidance to improve and systematize IOM’s support to better prepare for and respond to crises with migration dimensions, and the principles and objectives of IOM’s Migration Governance Framework (MiGOF). In particular, HBMM contributes to MiGOF Objective 2, to respond effectively to the mobility dimensions of crises — which includes health response in crisis situations, both health in humanitarian crises as well as public health emergencies — and ensuring countries are equipped to address influxes of crisis-affected populations and provide them with needed care and protection through humanitarian border management (HBM) (IOM 2020d, 2020g, 2015a, 2012b). (For more information on the relationship between HBMM and HBM, see Annex 1.)

Figure 1: Situating HBMM in global and institutional governing frameworks

Institutional
IOM Strategic Vision
Institutional Strategy on Migration and Sustainable Development
Migration Crisis Operational Framework
Migration Governance Framework

Global – migration in development and humanitarian contexts
Agenda 2030 and the SDGs
Global Compact for safe, orderly and regular Migration
Sendai Framework for Disaster Risk Reduction
The Grand Bargain

Global – migration health
WHO GAP Promoting the Health of Migrants and Refugees
WHA Resolution 70.15, Promoting the Health of Refugees and Migrants
WHA Resolution 61.17, Health of Migrants
IHR
II.2 Scope

HBMM is a public health framework that should be primarily applied and used by IOM to support governments and communities in the context of outbreak-prone communicable diseases including, but not limited to, those that result in a PHEIC declaration under the IHR (see Box 3). These can include, for example, yellow fever, cholera, plague, EVD, COVID-19 and other similar public health threats.

Certain activities of the HBMM Framework, such as those that aim to improve the understanding of population mobility patterns in relation to disease spread, may also be applied in other contexts of communicable disease transmission across borders, such as in the case of elimination efforts for malaria, polio and measles, where population mobility may result in the reintroduction of previously eliminated diseases in host communities (see Box 5).8

Box 5. Application of HBMM in the context of malaria elimination in Paraguay

In Paraguay, IOM supported the Ministry of Health and Social Welfare in strengthening the National Strategy for the Prevention of the Reintroduction of Malaria through a Global Fund-supported project beginning in January 2016. Paraguay was certified as free of malaria by WHO in 2018.

Paraguay had no autochthonous malaria cases since 2012; identified cases thereafter were detected in people who had come from endemic countries or areas where local diagnoses of the disease were still recorded.9 IOM emphasized disease prevention, identification of potential cases, accurate diagnosis, treatment and enhancement of resources and skills in the 18 health regions of the country. IOM focused on strengthening disease surveillance measures and ensuring appropriate local responses, particularly in the country’s border regions, which were characterized by high levels of population movement. IOM also strengthened the capacity of health officials, including physicians, biochemists, nurses and so forth, thereby improving health and laboratory services and supporting an enabling policy environment. Through the project, 5,000 volunteers in the country’s most remote areas established malaria diagnosis units along with systems to report cases within 24 hours; initiated timely treatment and closely monitored individual cases; and conducted investigations and monitoring of the outbreak location.

In all contexts, the HBMM Framework emphasizes equity and inclusiveness for migrants along the entire mobility continuum – that is, through origin, transit, destination and return. In other words, it is not only focused on communicable disease threats at physical or regulated borders or points of entry (including airports, ports and ground crossings) or entities welcoming migrants for admission and stay-related procedures (including external providers, embassies and consulates). HBMM also includes locations where informal cross-border movements take place, travel routes and spaces of vulnerability where the risk of disease transmission may be high, and public health interventions would be necessary (see Box 6). Spaces of vulnerability are geographical areas and locations where migrants and mobile populations interact with stationary, local communities, such as where these populations live, work, transit and originate. These locations represent an environment that is conducive to increased health vulnerabilities, such as outbreaks. Examples of spaces of vulnerability include PoEs, mobility corridors, points of congregation or population gathering sites (see Figure 2), key hubs including urban spaces, towns and villages and displacement camps and camp-like settings. An analysis of human behaviour and mobility in the setting informs how the HBMM Framework is applied on the ground.

---

8 Elements of HBMM might also have some applicability to prevention, detection and response to public health emergencies in other hazard scenarios, such as those triggered by climate change or other environmental disasters where population mobility may challenge health systems in similar ways. However, the HBMM Framework does not supersede or circumvent established internal and external frameworks and mechanisms that should be applied in such contexts.

9 In general, populations travelling from an area with high malaria burden can potentially reintroduce malaria into low-transmission or malaria-free areas. The combination of social and economic inequalities and discriminatory policies in all sectors, such as health, immigration, labour and social protection, often limit migrants’ access to appropriate malaria prevention, diagnostics, treatment and care services. This can perpetuate the disease cycle among migrants and host communities (IOM, 2020b).
The mobility continuum encompasses the complete pathway of movement, temporary or long-term, within or across borders: points of origin, transit, destination and return; routes through various modes of travel; and congregation points along the way. Each space along this pathway can present specific health risks, vulnerabilities and opportunities to reach and empower people, based on the scale of mobility flows, interactions between mobile populations and host communities, and potential occurrence of public health threats such as communicable disease outbreaks. Through a thorough understanding of these pathways, their flows and associated vulnerabilities, the HBMM Framework facilitates a more comprehensive and effective response to health threats. Figure 2 depicts this mobility continuum and its links with communicable disease prevention, detection and response:

- **Green** | Cross-border travel, from points of origin (pre-departure) to destination (post-arrival), is undertaken through various means, i.e. by land (formal or informal ground crossings), air or sea, presenting distinct characteristics and vulnerabilities, including pre- and post-travel procedures.

- **Yellow** and **black** | Along the way, mobile populations interact with host communities in congregation points (e.g. workplaces, schools, places of worship, temporary residence, marketplaces, health facilities). These congregation points are spaces of vulnerability for the spread of communicable diseases or other public health threats.

- **Red** | A health event detected at any of these points would activate a public health response (e.g. disease surveillance and/or quarantine, health screenings, referrals to health services, case detection and management), coordinated among national and local governments on both sides of the border, with the active engagement of border communities.
II.3 Guiding principles

Working with Member States and partners, IOM strives to ensure that the core activities of the HBMM Framework – as described in the following sections – are mainstreamed and sustained within its overall response to communicable diseases and other public health emergencies. The HBMM Framework should also be used in complementarity with relevant existing technical and operational guidance related to such emergencies, including guidance issued by WHO, the Global Health Cluster, national Health Clusters and the principles of the UN Inter-Agency Standing Committee (IASC) for humanitarian coordination, alongside IOM’s internal guidance and policies, including MCOF and MiGOF (see Box 4).

Further, all activities of the HBMM Framework must be implemented with adherence to international principles of good practice related to migration and health, and utilizing, adapting and building on scientific evidence to understand human mobility and health through multidisciplinary, mixed-method research approaches. The WHO GAP 2019–2023 sets out cross-cutting guiding principles to promote the health of refugees and migrants (WHO, 2019), which provide a reference for the implementation of all HBMM-related activities:

1. Right to the enjoyment of the highest attainable standard of physical and mental health;
2. Equality and non-discrimination;
3. Equitable access to services;
4. People-centred, refugee-, migrant- and gender-sensitive health systems;
5. Non-restrictive health practices based on health conditions;
6. Whole-of-government and whole-of-society approaches;
7. Participation and social inclusion of refugees and migrants; and
8. Partnerships and cooperation.

IOM recognizes that marginalized groups, such as people with disabilities and older people, could experience barriers to accessing information, care and support, and thus be at higher risk of exposure to outbreak-prone communicable diseases and the
secondary impacts. Furthermore, entrenched gender inequality can serve to prevent women and girls from accessing adequate information and services. Therefore, IOM is committed to mainstreaming protection, gender equality, age and disability considerations throughout its HBMM programming, while targeting at-risk groups, to ensure that its approach is gender/vulnerability-responsive and inclusive.

In Lebanon, Syrian refugees undergo a COVID-19 PCR test with IOM health staff ahead of their resettlement to Europe. © IOM 2020/Muse MOHAMMED
Figure 3: Commitments to gender responsiveness, accountability to AAP and protection mainstreaming

### Gender responsiveness and equality

- In line with the 2015 IOM Gender Equality Policy, IOM has endeavoured to achieve gender mainstreaming and parity in all programming globally. Emergencies and crises, including public health emergencies, affect people of different genders, including women, men, girls and boys, in very different ways, and all programming, including HBMM programming, must take these differences into account (IOM, 2015b).

- For example, the gendered impacts of the COVID-19 pandemic included the following, among others: women experienced high caregiving burden and potential increased exposure as they comprised the majority of front-line health workers and household caregivers; in some sociopolitical contexts, women faced barriers to accessing accurate information as well as health and related services; and movement restrictions and related measures contributed to increases in gender-based violence (GBV), heightening risk for women and lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) individuals (IASC, 2020).

- HBMM programming that is gender-responsive and mainstreams gender – i.e. recognizes, understands and responds to the different needs, capacities and priorities of people of all genders – aims to reduce gender-based inequalities and contribute to gender equality.

### Accountability to affected populations (AAP)

- AAP is an active commitment by humanitarian actors to use power responsibly by taking account of, giving account to, and being held to account by the people they seek to assist. IOM’s commitments to AAP affirm the rights of affected populations and communities to be informed and involved in the decision-making processes that affect them, and enable IOM to ensure that affected people are placed at the core of its programming. APP commitments centre on: (a) leadership; (b) information-sharing and transparency; (c) participation; (d) complaints and feedback mechanisms; and (e) partner coordination.

- IOM’s 2020 AAP Framework establishes IOM’s common approach for implementing and mainstreaming AAP throughout its crisis-related work. In addition to helping ensure quality, safe and responsive programming in line with the evolving needs of affected populations and communities, it reinforces the Organization’s zero tolerance against sexual exploitation and abuse (SEA) and other forms of misconduct (IOM, 2020i).

- The commitments of the AAP Framework were developed in line with the IASC commitments to AAP and adapted to meet IOM’s operational realities. In implementing HBMM, IOM strives to demonstrate its commitment to AAP.

### Protection mainstreaming

- Public health emergencies can exacerbate pre-existing vulnerabilities and risks of violence and discrimination, which can intersect with other factors such as gender, age, disability, nationality, status and/or ethnic origin.

- IOM is committed to ensuring that the protection of migrants including displaced persons and other vulnerable populations remains at the centre of its interventions, including HBMM interventions. Thus, IOM supports the continuum of critical protection mechanisms and responses during public health and other emergencies, including across borders, in order to provide urgent protection services or referrals to appropriate services to those most in need. Such populations include stranded migrants, displaced populations, affected communities and other persons in vulnerable situations or in need of specific care and protection, such as women and girls at risk of or survivors of GBV, persons with disabilities, children including unaccompanied and separated children, elderly persons and so forth.

- Protection services might consist of emergency shelter, alternative care, family tracing and reunification, access to other health services including but not limited to MHPSS, accessible information, case management and livelihoods support, among others.
HBMM also aligns with the ministerial statement on commitments at the Global Consultation on Migrant Health (IOM, 2017b). IOM, WHO and the Government of Spain organized a Global Consultation on the Health of Migrants in 2010, which resulted in four key priorities: developing systems and sharing good practices related to monitoring migrant health through research and data; implementing inclusive policy and legal frameworks across sectors and borders; creating migration-sensitive and responsive health systems; and fostering partnerships and multi-country frameworks. In 2017, IOM, WHO and the Government of Sri Lanka jointly organized the second Global Consultation on Migrant Health to offer Member States and partners a meaningful platform for multisectoral dialogue. The consultation resulted in the Colombo Statement, reflecting political commitment to enhance the health of migrants, including implementation of WHA 61.17 and other relevant WHA Resolutions (see Box 4); mainstreaming the migration health agenda in national, regional and international fora, in varied domains including migration and development, disease control, global health, health security, occupational safety, disaster risk reduction, climate and environmental change and foreign policy; and promoting the principles and agreements reached at the second Global Consultation in future global initiatives and intergovernmental consultations.

Finally, HBMM aligns with the guiding principles of the aforementioned Global Compact for Safe, Orderly and Regular Migration, as follows: human rights, people-centred, international cooperation, national sovereignty, rule of law and due process, sustainable development, gender-responsive, child-sensitive, whole-of-government and whole-of-society approach.
IOM Afghanistan’s Mobile Health Clinic in Shahrak Sabz IDP settlement (Herat) offers health services such as vaccinations, reproductive, maternal and child health, and health education. © IOM 2021/Muse MOHAMMED
This section presents the strategic objectives, expected outcomes and core activities of the HBMM Framework, summarized in Figure 4.

Figure 4: The Health, Border and Mobility Management Framework

<table>
<thead>
<tr>
<th>Strategic objectives</th>
<th>Core activities</th>
<th>Expected outcomes</th>
<th>Impact</th>
</tr>
</thead>
</table>
| **SO1**: Enhance the evidence base on the human mobility dimensions of communicable disease to inform effective prevention, detection and response | • Needs assessment and risk analyses  
• Population mobility mapping (PMM)  
• Disease surveillance, including community event-based surveillance (CEBS)  
• Operational research  
• Reporting and information-sharing | Public health response informed by an understanding of population mobility  
Mobility-sensitive and inclusive health, including border health, systems and services  
Improved population awareness, trust, behavioural change and community engagement in response to communicable disease threats | Governments and communities are better capacitated to respond to the mobility dimensions of communicable disease control |
| **SO2**: Build health system and border health capacity at points of entry and along the mobility continuum for communicable disease prevention, detection and response | • Standard operating procedures (SOPs), plans and guidelines  
• Screening and referral  
• Capacity-building of health, border and other front-line workers  
• Infection prevention and control (IPC)  
• Vaccination  
• Clinical case management  
• Laboratory and testing  
• Provision of infrastructure and supplies | | |
| **SO3**: Enhance community engagement and empower migrants, mobile populations and host communities in communicable disease prevention and response | • Mobility-sensitive risk communication and community engagement (RCCE)  
• Social and behaviour change communication  
• Mental health and psychosocial support (MHPSS) | | |
| **SO4**: Promote mobility-sensitive and inclusive policy, legal and strategic frameworks | • Advocacy for mobility-sensitive and inclusive policies, strategies and legal frameworks  
• Technical support to develop and implement such frameworks | | |
| **SO5** (Cross-cutting): Strengthen multisectoral partnerships and coordination, including cross-border coordination | • Multisectoral coordination within countries  
• Multisectoral coordination across borders  
• Inter-agency coordination  
• Internal IOM coordination to leverage Organization-wide response capacity | Enhanced multisectoral and cross-border collaboration for communicable disease preparedness, prevention, detection and response | Affectcd and at-risk populations benefit from needed services – “leaving no one behind” |
III.1 Strategic Objectives and expected outcomes

The HBMM Framework is organized around five Strategic Objectives:

- **Strategic Objective 1**: Enhance the evidence base on the human mobility dimensions of communicable disease to inform effective prevention, detection and response.
- **Strategic Objective 2**: Build health system and border health capacity at points of entry and along the mobility continuum for communicable disease prevention, detection and response.
- **Strategic Objective 3**: Enhance community engagement and empower migrants, mobile populations and host communities in communicable disease prevention and response.
- **Strategic Objective 4**: Promote mobility-sensitive and inclusive policy, legal and strategic frameworks.
- **Strategic Objective 5 (cross-cutting)**: Strengthen multisectoral partnerships and coordination, including cross-border coordination.

By implementing these objectives and associated core activities, the HBMM Framework will contribute to the following expected outcomes:

1. Evidence-based public health responses to communicable diseases that are informed by an understanding of population mobility.
2. Mobility-sensitive and inclusive health, including border health, systems and services.
3. Improved population awareness, trust, behavioural change and community engagement in response to communicable disease threats.
4. Conducive policy, legal and strategic frameworks to protect and promote the rights of migrants, mobile populations and communities near borders and in migrant-dense areas, along with public health.
5. Enhanced multisectoral and cross-border collaboration for communicable disease preparedness, prevention, detection and response.

III.2 Core activities

The five Strategic Objectives of the HBMM Framework are operationalized through a set of core activities that are further described in detail below. Although some of these core activities can be implemented independently, they are ultimately interrelated and mutually supportive in realizing the expected outcomes of HBMM. All core activities need not be implemented simultaneously; rather, they should be implemented according to the context, such as the stage of a communicable disease outbreak (see Box 10), national and humanitarian capacity, contributions of partners and other factors.

However, activities must be planned and delivered as part of a comprehensive and sustainable approach that ultimately aims to build long-term and sustained national capacities for public health preparedness and response, in compliance with the IHR. The core activities under each Strategic Objective are defined below.

**Strategic Objective 1: Enhance the evidence base on the human mobility dimensions of communicable disease to inform effective prevention, detection and response**

This objective refers to building the evidence base for an effective public health response to communicable diseases. Such responses that are inclusive of migrants and sensitive to human mobility dynamics require the adoption/adaptation of rigorous evidence-based research, forecasting and monitoring approaches.

The objective comprises of various methods and modalities to gather information on mobility patterns and related vulnerabilities, assess national and local capacities, contribute to disease surveillance and support joint analyses of mobility and disease transmission data.
This Strategic Objective includes the following core activities:

1.1 Needs assessment and risk analyses: This essential step includes approaches and activities to collect and analyse information on subnational, national and cross-border capacities for preparedness and response to communicable disease outbreaks, including knowledge, skills, resources, coordination and infrastructure. These interventions serve to identify gaps and risks, and define priorities. This activity area includes assessments of broader health system preparedness as well as specific assessments on core capacities of PoEs in relation to the requirements under the IHR. Given the linkages between health and mobility, IOM proposes that PoE assessments should cover health-related services as well as other areas pertinent to PoEs, such as immigration, customs and revenue, law enforcement, protection and so forth. IOM also supports Member States to conduct various types of risk assessments, such as public health risk assessments, and supports countries in meeting their IHR commitments for developing national risk assessment capacity.\(^\text{11}\) IOM may engage in both primary data collection and secondary data review. IOM missions are encouraged to review available secondary data when conducting a situational analysis prior to planning interventions. Existing data from previous needs assessments, public health information services (PHIS), risk assessments and other available relevant information should be considered as a part of this activity before rolling out further data collection exercises.

IOM’s routine primary data collection activities include directly conducting or supporting new assessments, which can contribute to an analysis of capacities and needs to inform public health interventions to prevent, detect and respond to communicable disease outbreaks. For example, in Liberia, IOM supported capacity assessments in officially designated PoEs as part of the 2014–2016 EVD response, which formed the basis upon which SOPs and the PHERP were subsequently developed. IOM has also performed PoE assessments in other outbreaks, including in the Democratic Republic of the Congo and for preparedness in neighbouring

---

\(^{10}\) Figure 5 illustrates the three layers of data and information that comprise the HBMM data landscape: (1) mapping capacities and gaps for preparedness and response at national and subnational levels, using needs assessments and risk analyses; (2) mapping human mobility through PMM and flow monitoring; and (3) epidemiological/disease mapping, via surveillance for the detection and notification of events of public health concern, screening at PoEs and other health screening points, etc. The horizontal arrow encompasses the diversity of approaches and methods taken to produce each map, while the vertical arrow indicates that the three layers can be superimposed to make sense of the landscape.

\(^{11}\) Risk analyses are also a standard component of IOM’s project implementation cycle, through which factors that could have a negative effect on a project are identified and a strategy to mitigate these risks is defined (IOM, 2012a).
countries including South Sudan and Uganda during the 2018–2020 EVD outbreak, and in various countries around the world for COVID-19. Also during COVID-19, IOM developed a questionnaire for in-depth assessments at PoEs, based on WHO’s assessment tool for core capacity requirements. The assessment, conducted in conjunction with relevant national authorities and partners, aims to understand resources and capacities as well as needs; it comprises a multisectoral baseline assessment, followed by thematic modules on public health, WASH, immigration and border management, including trade. In South Sudan, IOM produced in collaboration with WHO a joint analysis of health-care access for IDPs and returnees, which provided a country-wide summary of gaps in access to functional health facilities.

It should also be noted that other forms of data can inform needs assessment, surveillance and other data collection exercises. For example, at PoEs, data from IOM’s border management information system, the Migration Information and Data Analysis System (MIDAS) – which produces anonymized statistical reports on cross-border movements – could be used, where available and appropriate. In Paraguay, in the context of the aforementioned malaria-related efforts (see Box 5), IOM MHD linked with the Immigration and Border Management (IBM) Division to create a system of alerts within MIDAS, which had associated SOPs, to guide officials during instances of travellers arriving from endemic areas.

1.2 Population mobility mapping (PMM): IOM conducts participatory mapping exercises to help understand population mobility dynamics and characteristics and identify priority communities and locations that may be vulnerable to infectious disease outbreaks and other health threats. PMM includes three components:

1) Participatory mapping exercises, facilitated group discussions in which key informants share their knowledge on a specific geographical area of interest, including information related to public health and population mobility, using a base map and complementary tools;

2) Site evaluation, field visits carried out at the priority sites identified during the participatory mapping exercises to verify and collect supplementary information;

3) Population flow monitoring, traveller surveys carried out at specific points determined from the results of participatory mapping exercises, or agreed in collaboration with government and/or partners, with the objective of collecting data on population flows, public health events and mobility characteristics.

These exercises gather valuable quantitative and qualitative information on mobility patterns and vulnerabilities at national and subnational levels as well as points of entry and locations where informal border crossings take place, to inform public health preparedness and response efforts.

IOM has experience conducting these exercises in response to disease outbreaks, such as in Guinea-Bissau, Guinea and elsewhere during the 2014–2016 EVD outbreak and in the Democratic Republic of the Congo and neighbouring countries in 2018–2020. These exercises were beneficial to Member States as they served as a basis for prioritization of efforts and resource allocation, both in responding to and preparing for a disease outbreak. PMM exercises can also be used in the context of a natural disaster to help prepare for a potential outbreak, such as an example from Kenya, where in 2018 following severe flooding that displaced more than 300,000 people, IOM conducted PMM to help identify priority locations vulnerable to cholera and other communicable diseases and understand mobility dynamics to inform preparedness efforts. During the COVID-19 pandemic, IOM engaged in PMM to anticipate preparedness measures to be implemented in a strategic and prioritized manner in coordination with multiple additional Member States, including Cameroon, Mali, Mongolia, Nepal, Rwanda, the United Republic of Tanzania and other countries.

1.3 Disease surveillance: IOM contributes to the development and strengthening of disease surveillance capacities, in particular at borders, among border communities and in migrant-dense areas. This activity area includes IOM’s contributions to national community event-based surveillance (CEBS) for the detection and notification of events of public health concern, contact tracing and screening at PoEs and other health screening points (see activity 2.2, screening and referral). It is critical that disease surveillance activities within HBMM contribute to
national Integrated Disease Surveillance and Response (IDSR) systems to support the provision of early detection of public health threats, timely surveillance during outbreaks and efficient monitoring of the response.

IOM activities in this area also include building capacity for cross-border surveillance of public health threats, including training of border officials and community leaders and volunteers. Cross-border surveillance aims to prevent and/or manage the international transmission of diseases, vectors and other health hazards; detect changes in trends of public health events at PoEs; inform competent authorities at PoEs and the health system; and assist them in adopting preventive measures, investigation, management and follow-up of events.

IOM’s community disease surveillance efforts aim to engage migrants and mobile populations, as well as host communities residing along borders and in migrant-dense areas, in ways that are culturally appropriate, non-stigmatizing and rights-based, as a more sustainable approach. For example, IOM has provided support for the integration of CEBS into the national surveillance system in Burundi, Ghana, Guinea, Guinea-Bissau, Liberia, Panama, Sierra Leone and elsewhere. Engaging with the community and building trust is a key component of HBMM and important in supporting the strengthening of community-based surveillance. In Mozambique in 2020, for example, IOM reached thousands of returning migrant workers and their families with community contact tracing and household tracing, along with awareness-raising campaigns, with the support of community health workers, local leaders and community networks. IOM Libya undertook event-based community surveillance for migrants, wherein data is collected on a daily basis by IOM Displacement Tracking Matrix (DTM) enumerators, following training by IOM MHD, WHO and Libya’s National Centre for Disease Control (NCDC) medical staff. Syndromic surveillance took place both at flow monitoring points at and around PoEs with substantial cross-border flows, as well as in migrant communities in locations near borders with neighbouring countries. Enumerators maintained strong ties with migrant community leaders to facilitate data collection, and data fed directly into the NCDC surveillance system.

HBMM aims to broaden understanding of how health and mobility are interlinked. DTM is IOM’s system
to track and monitor displacement and population mobility over time and can be used to support enhanced disease surveillance during outbreaks. For example, in Chad and multiple locations, DTM surveys were used to collect disease surveillance data linked to COVID-19, including access to health services and awareness of the virus and related mitigation measures. Additionally, together with the US CDC, IOM rolled out the DHIS2-COVID-19 software for data collection and contact tracing at PoEs in Guinea-Bissau, while IOM Guinea set up a disease surveillance system (including SOPs) at PoEs with Côte d’Ivoire, Liberia and Mali. In these ways, IOM plays a key role in linking an understanding of population mobility with disease surveillance.

1.4 Operational research: This activity includes IOM support for enhancing research on various aspects of the bidirectional relationship between migration and health at individual and population levels. In addition to ground-level research to inform public health interventions – such as health capacity assessments of one-stop Border Posts (OSPBs) in East Africa – IOM engages in and disseminates other analyses. One such example is a bibliometric analysis on COVID-19 and migration health, which contributed to a better understanding of the essential information to be considered in designing mobility-inclusive interventions to support effective COVID-19 response.13 Previously, during the 2009 H1N1 – also known as swine flu – pandemic, IOM in collaboration with McGill University conducted a study regarding influenza knowledge among migrants in Thailand, which informed public health recommendations to increase prevention. In 2018, IOM led a collaborative research project and paper, Missing: Where Are the Migrants in Pandemic Influenza Preparedness Plans?, which assessed the extent to which migrants were included within pandemic preparedness plans in low-to-middle-income countries in the Asia and Pacific Region (Wickramage et al., 2018). This activity area also includes continued advocacy for mainstreaming data collection on internal and international migration as part of routine national health management information systems. For example, in the European Union (EU), IOM has supported the development and implementation of the electronic personal health record (ePHR) to promote access and integration of migrants including refugees into the health system. The ePHR facilitates data entry, analysis and transfer within and between EU Member States, which is based on the experience of IOM in health assessment and medical data management (see SO 2, activity 2.6, case management). It serves to enhance knowledge about the health needs of migrants; ensure that migrant health assessment records are available at transit and destination countries; and strengthen national and cross-border disease surveillance and response capacities.

Around the world, IOM has supported the inclusion of indicators related to migration in census, demographic and health surveys and national disease surveys, as well as for routine reporting in health information systems where relevant and appropriate. The strategic information generated from such inclusion supports mainstreaming migrants in health systems – critical to achieving universal health coverage – and efficient and effective planning and allocation of health – including emergency health – services and programming among government and other stakeholders.

Moreover, ongoing monitoring and evaluation of the HBMM approach and interventions is also necessary to understand the effectiveness and impact, and inform improvements and decisions about future programming.

1.5 Reporting and information-sharing: This activity area includes information-sharing for coordination purposes, and providing data and analysis on mobility and public health collected through SO 1 activities 1.1-1.4, among others (see SO 5 on coordination). It also includes the joint analyses of mobility patterns and disease surveillance data, and sharing information with concerned stakeholders (including government agencies, health facilities, other partners/agencies, communities and so forth) in order to identify spaces

---

12 OSBP promotes a coordinated and integrated approach to facilitating trade and movement of people, and improving security. They eliminate the need for travellers and goods to stop on both sides of a border, implementing joint controls to minimize routine activities and duplications – thereby reducing clearance time.

13 The IOM Migration Health Division also launched the Migration Health Evidence Portal for COVID-19, an open-source, searchable repository of research publications on COVID-19 in relation to migrants and human mobility based on the quantitative analysis of the thematic trends of relevant publications.
of vulnerability and target the response accordingly. IOM also engages in reporting surveillance data on public health emergencies of international concern as part of the IHR and promoting information exchange, including across borders and between agencies.

For example, during the 2014–2016 EVD outbreak, IOM supported the development of memorandums of understanding to establish systems for cross-border collaboration among Guinea, Liberia and Sierra Leone, to improve information exchange and regional coordination for disease surveillance. During COVID-19, IOM DTM created and disseminated a database among partners, the public and other stakeholders to monitor, analyse and report on international travel restrictions implemented around the world to provide an overview of the impact of COVID-19 on human mobility at the global, regional and country levels. Additionally, when the Zika virus disease was declared a PHEIC in 2016, the IOM Regional Office for North America, Central America and the Caribbean elaborated a series of maps depicting Zika virus incidence and mobility patterns of international migrants to identify potential risk areas and hotspots for the disease Zika, along with a series of recommendations to support health and migration authorities and other stakeholders in the region to develop a coordinated, effective response inclusive of migrants.
Strategic Objective 2: Build health system and border health capacity at points of entry and along the mobility continuum for communicable disease prevention, detection and response

This objective comprises a range of activities to enhance the technical and operational capacity of health systems to deliver mobility-sensitive health services, along with border health capacity, including improving the health-sensitivity of border management systems. It includes the direct delivery of health services during a public health emergency (in particular at points of entry and along the mobility pathway), as well as activities to build longer-term readiness and capacity, which are critical for sustainability. Specifically, this Strategic Objective includes the following core activities:

2.1 Standard operating procedures, plans and guidelines: This activity area includes the development of various SOPs, guidelines, plans and tools for the management of communicable diseases, including for detection, notification, isolation, management and referral at borders. It also includes the development of emergency response plans at PoEs. Public health guidance at borders should be anchored within broader border management procedures and structures, including the integration of IHR into integrated/coordinated border management strategies and OSBP procedural guides. As part of continuity of response, border coordination mechanisms between health and non-health actors should be strengthened, including specific guidance for circumstances where health authorities are not present.

In West Africa, following the 2014–2016 EVD outbreak, for instance, IOM supported the development of SOPs, tools and public health emergency response plans for public health emergencies at the main international airports and selected seaports in six countries. In Uganda, IOM spearheaded development and finalization of a national taskforce toolkit for PoEs, which included SOPs for surveillance and PoE assessment tools, and supported training and rollout to PoEs nationwide. This toolkit was subsequently adapted for use in the COVID-19 pandemic. As part of COVID-19 response, IOM supported the development of PoE-specific SOPs in multiple locations, including but not limited to Afghanistan, Bangladesh, Belize, Burundi, the Democratic Republic of the Congo, Ethiopia, Guinea-Bissau, Jordan, the Lao People’s Democratic Republic, the Marshall Islands, Mauritania, the Federal States of Micronesia, the Republic of Moldova, Mozambique, Myanmar; Senegal, South Sudan, the United Republic of Tanzania, Thailand, Viet Nam, Zambia and Zimbabwe. In Ethiopia, IOM supported the Government to develop SOPs on the management of returnees from PoEs to their places of origin.

2.2 Screening and referral: IOM aids in establishing and conducting health screening and referral at borders and other spaces of vulnerability where disease transmission risks related to population mobility may be high, when this public health measure is included in national planning to prepare for and respond to a health threat. Health screening procedures are adapted to the specific characteristics of an individual disease or health threat, and linked with a competent referral system connected to the national response. Health screening posts can also serve as locations for surge data collection on mobility, which can, in turn, strengthen the response to health threats. For example, during the 2018–2020 EVD outbreak, IOM established a network of flow monitoring points alongside health screening posts in transit and congregation hubs and cross-border areas in the Democratic Republic of the Congo, Burundi, South Sudan and Uganda.

Additionally, IOM supported the implementation of early detection and referral of cases at PoEs through primary and secondary screenings. For example, IOM set up and managed more than 100 PoE and health screening points alongside health screening posts in transit and congregation hubs and cross-border areas in the Democratic Republic of the Congo, where travellers washed their hands; over 170 million screenings for Ebola symptoms were conducted. During the COVID-19 pandemic, IOM supported health screening for travellers including

---

14 As mentioned under activity 1.2, flow monitoring aims to derive quantitative estimates of the flow of individuals through specific locations and to collect information about the profile, intentions and needs of the people moving.

15 Primary screening includes observing travellers for symptoms of illness, measuring temperature and collecting exposure information, while secondary screening includes having a medical or public health professional conduct further public health assessment of individuals with symptoms or potential exposure, e.g. due to travel history.
Between 1 September 2014 and 4 February 2016, 166,242 persons underwent screening for EVD at Freetown International Airport in Sierra Leone. Primary and secondary screening was undertaken by airport staff trained by a joint residential training programme led by the Ministry of Health and IOM with support from the CDC and WHO.

Screening steps for travellers included the following: notification to travellers of entry and exit screening and that any person who meets risk criteria for EVD infection or exposure could be denied entry into, or exit from, Sierra Leone; distribution of a health declaration form to all prospective travellers to assist primary screeners to determine if the traveller meets the risk criteria; and traveller screening, with the risk criteria consisting of elevated temperature as measured with a non-contact thermometer, potential for exposure (e.g. caring for ill persons, attending the funeral for a person with possible EVD) and self-reported or observed signs and symptoms (fever, vomiting, diarrhoea, headache, red eyes, extreme fatigue, muscle/joint pain, abdominal pain, difficulty breathing and/or unexplained bleeding). Any positive response to those criteria led to secondary screening undertaken in an isolation room with qualified medical personnel (Wickramage, 2019).

Box 7: Example of health screening at an airport in Sierra Leone during the West Africa EVD outbreak

Between 1 September 2014 and 4 February 2016, 166,242 persons underwent screening for EVD at Freetown International Airport in Sierra Leone. Primary and secondary screening was undertaken by airport staff trained by a joint residential training programme led by the Ministry of Health and IOM with support from the CDC and WHO.

Screening steps for travellers included the following: notification to travellers of entry and exit screening and that any person who meets risk criteria for EVD infection or exposure could be denied entry into, or exit from, Sierra Leone; distribution of a health declaration form to all prospective travellers to assist primary screeners to determine if the traveller meets the risk criteria; and traveller screening, with the risk criteria consisting of elevated temperature as measured with a non-contact thermometer, potential for exposure (e.g. caring for ill persons, attending the funeral for a person with possible EVD) and self-reported or observed signs and symptoms (fever, vomiting, diarrhoea, headache, red eyes, extreme fatigue, muscle/joint pain, abdominal pain, difficulty breathing and/or unexplained bleeding). Any positive response to those criteria led to secondary screening undertaken in an isolation room with qualified medical personnel (Wickramage, 2019).
2.3 Capacity-building of health, border and other front-line workers: IOM provides support to develop curricula and train health and non-health personnel – such as immigration, customs and revenue and other law enforcement personnel – to detect and respond to communicable disease, including management of ill travellers and best practices on IPC, in accordance with established procedures. This activity area can also include the organization of field simulation exercises at PoEs for preparedness as well as the general sensitization of health and non-health personnel to the needs and vulnerabilities of mobile populations.

During the EVD outbreak in West Africa, for instance, IOM supported the training of national and international health personnel and hygienists, including in clinical management, IPC and PPE use for front-line Ebola and non-Ebola medical practitioners through the National Ebola Training Academy in Sierra Leone. IOM also deployed mobile training teams to remote areas, and supported the organization of trainings for border, immigration and customs officials and volunteers on the SOPs and emergency response plans, and developed training materials, posters and various other job aids. Also in Sierra Leone, IOM supported the development of an updated roster of health screeners and a rapid recruitment and deployment plan for surge capacity at the international airport, to improve readiness in case of a public health emergency.

As part of COVID-19 response, IOM strengthened the capacity of front-line officials in a range of disciplines – including health, immigration, customs, police and so forth – in Afghanistan, Bangladesh, Cambodia, the Democratic Republic of the Congo, the Marshall Islands, the Lao People’s Democratic Republic, Mali, the Marshall Islands, Mauritania, the Federated States of Micronesia, the Republic of Moldova, Myanmar, Portugal, Rwanda, Senegal, Somalia, South Sudan, Thailand, Viet Nam, Uganda, Zambia and elsewhere. IOM also strengthened the capacity of health professionals and other stakeholders; in Ethiopia, for example, IOM supported the Government in conducting simulation exercises in quarantine facilities to prepare for migrant returns.

In North Africa, in 2018 through 2019, in a cross-border preparedness effort, IOM partnered with stakeholders in Algeria, Libya, the Niger and Tunisia to enhance the capacities of governments along the Central Mediterranean Route to better counter hazards and health security issues in the context of mixed migratory flows. IOM contributed to improved understanding of border and data management and health security concepts through trainings, workshops and applied learning through practical exercises such as field border health assessments; and provided a platform for governments to further communicate and coordinate responses to migration and health security-related challenges.

In addition, IOM has contributed to preparedness in Europe with training initiatives through multiple regional projects targeting front-line health, police and other professionals, reaching thousands of participants in countries including Bulgaria, Croatia, France, Germany, Greece, Italy, Malta, Norway, Portugal, Serbia, Slovenia and Spain, among others, since 2013. Included among the topics were prevention and control of infectious diseases; familiarization with IHR and the role of early warning systems and alert mechanisms; and rapid risk assessment at PoEs and reception centres.

2.4 Infection prevention and control: In order to prevent disease transmission, IOM undertakes IPC measures such as providing basic equipment including disinfectants and PPE – which, depending on the disease, might include surgical masks, gloves and gowns, eye protection, hazmat suits, aprons, boots and so forth – to front-line staff. IOM also implements WASH interventions, including installing handwashing facilities at PoEs, health facilities, transit centres, quarantine facilities and displacement camps, and other vulnerable areas. IOM further supports the development and implementation of protocols for handwashing, disinfection, waste disposal and other relevant issues, which are responsive to the needs of migrants including displaced populations.
and related communities. Interventions target health personnel, non-health personnel (including immigration and law enforcement officials), community leaders/members and travellers at PoEs, border communities, transit centres and other spaces of vulnerability. These activities also serve to build longer-term readiness capacity for managing communicable disease outbreaks.

For example, in the context of the 2018–2020 EVD outbreak in the Democratic Republic of the Congo, IOM South Sudan maintained basic WASH facilities at PoE screening sites, including handwashing facilities, pit latrines, waste disposal pits and rehabilitation of water points. IOM also supported targeted PoEs and health facilities with essential IPC supplies, such as disinfectants (chlorine, hand sanitizers), soap, water containers, sprays for vector control and PPE, as well as incinerators for proper disposal of medical waste, in order to ensure that travellers and users of the health facilities adjacent to PoEs had access to the minimum measures to prevent spread of or exposure to EVD and other diseases. During COVID-19, among other IPC and WASH interventions, IOM provided IPC training to health and/or border officials in many countries, and constructed handwashing facilities in camp and community settings in Cambodia, Cox’s Bazar in Bangladesh, Indonesia, the Federated States of Micronesia, Mozambique, Myanmar, Nigeria, Somalia, South Sudan, the Sudan, the Syrian Arab Republic, Yemen and elsewhere.

2.5 Vaccination: IOM supports vaccination activities in preparedness for, management of and response to vaccine-preventable disease outbreaks, such as measles, cholera and polio. This activity area can include:

- Direct provision of vaccination;
- Identifying “zero-dose populations” (i.e. those who have not benefited from any vaccines) and their needs;
- Provision of technical support to ensure reliable documentation and communication, for example regarding proof of vaccination, including across borders – potentially through IT support;
- Advocacy to ensure prioritization plans for vaccines for preventable, outbreak-prone diseases are inclusive of migrants and mobile populations, depending on local epidemiology, health system capacities and migration profiles (see SO 4 for more on advocacy);
- Engaging in and providing guidance to ensure that community engagement activities regarding vaccination address potential misinformation and misconceptions and build trust, and that information is provided in languages understood by migrant and mobile populations in a culturally adequate manner (see activity 3.1, RCCE); and
- Trainings and building capacity of vaccination systems, including strengthening cold chain management, data management and surveillance.

For example, IOM has engaged in a partnership with Nexleaf, a private startup that received funding from the Gates Foundation and Gavi, The Vaccine Alliance, to improve cold chain systems in low- and middle-income countries. IOM has helped expand this initiative to cover remote areas in regions where refugees reside, including refugee camps in Kenya and the United Republic of Tanzania.

During humanitarian and public health emergencies, IOM has used rapid response mechanisms to conduct mass vaccination campaigns, focusing on vulnerable, hard-to-reach populations, such as IDPs, refugees (including urban refugees) and other migrants (see Box 8). For example, during a cholera outbreak in South Sudan from June 2016 to February 2018, which resulted in more than 20,000 cholera cases and 436 deaths, IOM deployed 12 rapid response teams to conduct oral cholera vaccination (OCV) campaigns in various parts of the country, including sites for IDPs, reaching over 683,000 people with two OCV doses.

In 2017 in Cox’s Bazar, Bangladesh, as part of a multi-agency effort, IOM supported a mass OCV operation, going house-to-house to reach Rohingya refugees, which reached more than 700,000 people in total. In Mozambique, in response to a cholera outbreak following following two devastating cyclones in 2019, DTM data was used to inform mass campaign microplanning and ensure that displaced populations were adequately reached. IOM has also led measles vaccination campaigns in South Sudan and other locations throughout the world, and has furthermore engaged in polio vaccination efforts targeting migrants including refugees and other displaced populations in recent years in Egypt, Jordan and other countries. In 2019, more than 380,000 children under 5 were vaccinated against polio and/or measles in emergency settings by IOM.
IOM’s Global Migration Health Assessment Programme (GHAP) also delivers vaccines in some 65 countries as part of its pre-migration health activities (PMHAs), reaching 181,350 migrants and refugees in the process of migration with more than 445,800 vaccination doses in 2019. Migration health assessments are conducted worldwide by IOM health professionals (see activity 2.6, clinical case management), and include provision of vaccines to improve the health of migrants including refugees as well as host communities by increasing key vaccine coverage, especially for those not covered by traditional immunization programmes, and to reduce the risk of arrival of migrants in destination countries with vaccine-preventable diseases. Providing vaccines at the pre-departure phase also improves integration into new communities upon arrival by ensuring that the migrants, including refugees, are healthy and can immediately enter school or jobs that require mandatory vaccines. Migrants including refugees are counselled on the benefits and risks of vaccines and provided with health education, which improves uptake of immunization before and after the migration process.

2.6 Clinical case management: IOM supports delivery of critical health services that complement health screening and referral, which can include assessment, testing, diagnosis, health education, isolation, treatment, monitoring and so forth. Guided by formal protocols such as those developed by WHO and national authorities, IOM supports direct clinical case management during the acute phase of a disease outbreak, in particular at borders and migrant-dense areas or other areas where gaps may be present. Such activities also help to build longer-term capacity of the health system to deliver mobility-sensitive services. For example, during the acute phase of the 2014–2016 EVD response, IOM intervened directly to set up and operate emergency treatment units in Liberia and emergency operations centres in Guinea, trained rapid response teams and provided transport capacity to transfer patients to health facilities, even across borders when necessary.

In response to a diphtheria outbreak in Cox’s Bazar, Bangladesh, in 2017, IOM established specialist isolation and treatment wards at IOM medical centres to provide inpatient care to diphtheria patients, in addition to training health promoters on outreach activities and contact tracing, and supporting the government-launched diphtheria vaccination campaign. In 2018, IOM supported the management of an outbreak of acute watery diarrhoea (AWD) in Djibouti. Migrants, who often moved through

---

16 IOM provides vaccines for diphtheria, hepatitis A, hepatitis B, human papillomavirus, influenza, Japanese encephalitis, measles, meningitis, mumps, pertussis, pneumococcal infection, polio, rotavirus, rubella, tetanus, varicella and yellow fever, among others.

17 Delivering vaccination services in many settings where IOM works – particularly in remote locations or in countries with weak infrastructure – requires a robust system of vaccine distribution and storage. IOM ensures that all of its migration health centres have cold chain equipment, such as cold boxes, ice-lined refrigerators, digital thermometers, temperature data loggers and generators. Temperature monitoring and alert systems are in place in case of power outages. IOM staff are provided with ongoing training to deliver vaccinations in line with international standards; staff are trained on vaccine handling, administration, management of adverse effects, maintenance of cold chain, vaccination-related health education and other topics.
country on foot to and from the East and the Horn of Africa and Yemen, faced increased vulnerability due to poor access to safe drinking water and sanitation, as well as health services, along the route. IOM established a diarrhoea treatment centre (DTC) at its Migration Response Centre (MRC) in Obock to triage and treat patients. In Yemen, IOM has operated multiple DTCs across the country, and supported hospitals and health centres to provide oral rehydration points as the first AWD treatment point. In addition, extensive support was provided in the context of COVID-19, with IOM providing direct assistance to migrant beneficiaries, including PHC, emergency care, health education, health screening and triage, health promotion and dispensing of PPE and hand sanitizer to protect vulnerable migrants from transmission.

Relatedly, during public health emergencies, IOM supports continuation of essential services (e.g. PHC, maternal and child health services, MHPSS — see activity 3.3) — for migrants and other populations in vulnerable situations, including continuity of ongoing treatments, for example for chronic illnesses such as tuberculosis and HIV, particularly in contexts with pre-existing humanitarian needs. For example, during the COVID-19 pandemic, in addition to training health workers on COVID-19 prevention and management and establishing an isolation and treatment centre inclusive of an intensive care unit in Yemen, IOM provided access to health services more broadly through IOM-supported health facilities and mobile health teams. In Afghanistan, IOM’s mobile health teams provided basic health services to tens of thousands of individuals in IDP camps, and thousands of returning undocumented migrants were screened for tuberculosis in IOM transit centres. IOM also provided post-arrival humanitarian assistance to undocumented Afghans at the transit centres, including unaccompanied migrant children, persons with medical conditions, single-parent families, persons with disabilities and unaccompanied elderly persons.

[MRCs provide essential services to migrants on the migratory route (including food, non-food items, temporary shelter, health including MHPSS services and return assistance).]
Furthermore, within GHAP programming, IOM provides PMHAs for migrants including refugees. PMHAs are an array of procedures that are undertaken in the context of regular migration at the request of destination country governments, and aim to achieve at least one of the following: identification of health conditions of public health importance (communicable and non-communicable conditions) in relation to specific country legislation and the IHR; provision of continuity of care, linking pre-departure, travel, transit and post-arrival phases; establishment of fitness to travel to another country; improvement of the health of migrants before departure to another country through the provision of preventative or curative care; and/or minimization or mitigation of public health risks related to mobility. PMHAs may entail any number of screening, diagnostic, treatment or preventive services, as well as health-related travel assistance.

IOM provides migrants with PMHAs for the purpose of assisting them with resettlement, international employment, enrolment in specific migrant assistance programmes, obtaining a temporary or permanent visa or during post-emergency relocation and reintegration. While the vast majority of these activities occur prior to migration, in some cases, activities may extend to the post-arrival phase, generally associated with the renewal of visa status. Health-related travel assistance serves to address individual health and safety and to manage conditions of public health concern as individuals move across geographical, health system and epidemiological boundaries, through pre-embarkation checks to assess fitness to travel, stabilization treatment and pre-departure care, special travel arrangements including medical escorts and facilitating continuity of care upon arrival. Related services include referral, counselling, health education and public health interventions including but not limited to surveillance, outbreak response and vaccinations (see activity 2.5, vaccination); this includes, for example, public health surveillance and outbreak management in camps, transit centres and other temporary settlements.

2.7 Laboratory and testing: With its global network of laboratories, IOM supports enhanced national capacity for detection during public health emergencies. This activity area can include provision of trainings and operational support for the packaging and transfer of laboratory samples, including cross-border support to transport samples for laboratory confirmation; provision of trainings on laboratory biosafety and appropriate use of PPE; and provision of assistance with testing when appropriate and feasible.

Through GHAP programming, IOM carries out extensive tuberculosis testing in its laboratories in Nepal and elsewhere to facilitate migration by treating individuals and minimizing the risk of transmission to other persons before, during and after migration. As part of the COVID-19 response, IOM Afghanistan, in coordination with the Public Provincial Health Directorates, seconded laboratory technicians and information management staff to increase capacity at four laboratories in border provinces. In Cox’s Bazar, Bangladesh, IOM, in partnership with WHO, organized a training for medical staff (including medical officers, nurses, medical assistants and laboratory technicians) on COVID-19 sample collection and transport, to build capacity among front-line responders to facilitate COVID-19 testing and improve their understanding of the scale and impact of the illness on the ground. In Kenya, IOM facilitated COVID-19 testing for thousands of truck drivers, including at the border with Uganda to ease the backlog of trucks stopped there and at the port in Mombasa, thereby releasing millions of dollars in essential trade.

2.8 Provision of infrastructure and supplies: IOM contributes its logistics and field operations expertise to emergency response efforts, and engages with governments and partners to support the procurement, storage and distribution of critical supplies. IOM can also support supply management systems and contingency stockpiling during the recovery phase, as well as the rehabilitation of physical border infrastructure at PoEs and PHC facilities at PoEs and in border communities and other spaces of vulnerability.

For example, throughout the 2014–2016 West Africa EVD response, IOM established observation/isolation rooms at border health screening posts and procured, distributed and administered health and infrastructure supplies at emergency treatment units, EOCs and health screening posts. IOM has also built over 40 border-crossing points in nine countries in West and Central Africa over the last five years, which
are equipped with immigration booths protected by a glass, public toilets, water and, usually, an office for health services. As part of the COVID-19 response, around the world, IOM provided needed supplies – including medical, WASH and IT equipment, tents, solar panels, thermal scanners – for PoEs, health facilities, transit centres and isolation, quarantine and triage stations. The Organization also supported the safe return of migrants to their communities of origin with transportation support in the Plurinational State of Bolivia, Guatemala, Malawi, the Philippines and other countries. IOM supported infrastructure development at PoEs and elsewhere; for example, in the Bolivarian Republic of Venezuela, IOM rehabilitated and equipped temporary shelters for vulnerable returnees. IOM furthermore provided PPE to front-line health and border officials in many countries around the world.

Box 9: IOM’s provision of essential health services for UN staff during the COVID-19 pandemic

As part of the UN’s First Line of Defence framework, IOM became a key partner in the UN’s network of clinics to ensure that UN personnel and their dependents could access high quality, reliable health services in contexts where health-care systems may be overwhelmed, and minimize the need for medical evacuations. This contributed to ensure the UN could continue to deliver essential services in line with its mandate throughout the pandemic. Services provided varied from one context to another, but included the following: (1) laboratory services, including testing for COVID-19 in various countries including Burundi, Cambodia, Egypt, Ethiopia, Ghana, Kenya, Nepal, Nigeria, the Philippines, Rwanda, South Africa, Thailand and Uganda; (2) clinical services, including management of COVID-19 patients, isolation facilities, primary care for other conditions, MHPSS, paediatrics, radiology and referral; (3) telehealth, including in-home monitoring and treatment of COVID-19 patients and patients with other medical conditions, and specialist consultations; and (4) medical movement support, including assisting COVID-19 patients to the airport and provision of medical escorts for non-COVID-19 patients.

Strategic Objective 3: Enhance community engagement and empower migrants, mobile populations and host communities in communicable disease prevention and response

This Strategic Objective comprises activities to engage mobile populations and host communities in the response to communicable diseases. They aim to strengthen community awareness and participation, build trust and resilience, engage communities in monitoring mobility and risks in their surroundings, support their health needs including MHPSS and bring about positive behaviour change. Specifically, it includes the following activities:

3.1 Mobility-sensitive risk communication and community engagement (RCCE): IOM engages in community-based preparedness and response activities with the goal of ensuring that populations at risk are well-informed on how to avoid infection, prevent further transmission and seek care. IOM also works to ensure that mobility is considered in public health messaging, and that migrants and mobile communities have access to timely, appropriate, context-specific and correct information in languages and forms that they can understand. This activity area can entail communication with communities and cross-border community-level awareness-raising and feedback along mobility corridors, PoEs and other spaces of vulnerability. It can also include development, translation and dissemination of tailored information, education and communication (IEC) materials; health education and hygiene promotion; rumour tracking; and outreach to migrants, for example in schools and communities, including via posters and leaflets, traditional media (radio, television, printed press) and social media platforms. This area also includes providing technical guidance and tools to ensure risk communication messages are culturally and linguistically tailored and that migrants are included in outreach campaigns to avoid stigmatization.

For example, in response to COVID-19, among extensive RCCE efforts globally, in Thailand, IOM conducted a nationwide survey to understand challenges, needs and concerns for migrant populations, which revealed misconceptions about prevention and
treatment of the disease. In response, IOM developed IEC materials to address the misconceptions. IOM also worked closely with the UN Country Team to develop a “Solidarity Against COVID-19” campaign targeting the general public, policymakers, the private sector and vulnerable populations and rolled out via SMS, mainstream media and social media, including through partnerships with popular platforms, such as LINE and Twitter. In the Gambia, IOM mentored community health volunteers in border communities, identifying RCCE best practices and challenges, ran messages on COVID-19 stigma and discrimination on television and radio stations, trained journalists virtually on migration reporting and its relationship with COVID-19 and engaged Gambian returnee migrants in developing videos and other content in the #StayHomeChallenge RCCE effort. In Central America and the Caribbean, IOM provided communication and prevention messages through multiple avenues including videos, a network of information hubs and MigApp, IOM’s global app for migrants. MigApp highlighted official health recommendations, border restrictions and COVID-19 hotlines, and also included small surveys regarding COVID-19, enabling IOM to better understand issues impacting migrants. Information hubs, located in eight Mesoamerica and Caribbean countries, provided safe and accurate information about migration procedures, services for migrants and risks of irregular migration. In Nepal, IOM launched an awareness campaign using video and radio on stigma, discrimination and fear against returnee migrants, health workers and COVID-19-infected persons, and mobilized civil society organizations sheltering vulnerable women returnee migrants to promote the campaign.

As part of the EVD response in the Democratic Republic of the Congo, IOM implemented a community-based RCCE strategy, involving transport associations (including car-taxi, motorcycle taxi and maritime transporters) and agency managers in passenger surveillance activities. IOM sensitized the local population living near PoEs and internal health screening points to foster their commitment and ownership of surveillance activities and to ensure their involvement in the design, implementation and monitoring of surveillance activities; and established interpersonal communication activities and traveller feedback mechanisms. IOM strengthened RCCE at the PoEs/screening points through mass communication including community radio, pre-recorded audio messages, posters and leaflets, as well as through interpersonal (and small group) communicators, social mobilization, theater and community meetings.

3.2 Social and behaviour change communication:
Social and behaviour change communication approaches use strategic communication approaches to influence knowledge, attitudes, practices and social norms, and ultimately to influence behaviour. In public health emergencies, it is critical to combat rumours, misinformation, discrimination and stigma; provide correct information; and calm fears. This activity area includes support for social mobilization efforts to raise awareness and promote healthy practices among border and mobile communities. For example, during the West Africa EVD response, IOM carried out large social mobilization initiatives to build community knowledge at building community knowledge and participation in curbing the spread of the disease, including adoption of safe burial practices, safe meal preparation, notification of suspect cases, contact tracing and self-quarantine. To address avian influenza in Nigeria in 2007, IOM conducted awareness campaigns among bird sellers and mobile populations, who were initially excluded from a national avian influenza plan despite their key role in combatting the disease, following a national sensitization exercise with key stakeholders including government, UN and other development partners.

3.3 Mental health and psychosocial support (MHPSS):
IOM’s MHPSS response aims to address emotional and social suffering and prevent long-term consequences on health, social and economic systems, while ensuring that vulnerable migrants including refugees, other displaced populations and returnees have equitable access to services and supports at all stages of the migration process, including return and reintegration. MHPSS is a critical part of the HBMM framework as IOM aims to provide support to migrant and mobile populations, their families and communities to address the mental health and psychosocial impacts along the mobility continuum, including fears of illness or death, isolation, social exclusion and discrimination against persons who are from, or perceived to be from, affected areas. IOM provides services directly, including through deployment of psychosocial mobile teams, linguistically and culturally capable of serving
vulnerable migrants, without barriers. Interventions can be offered remotely, for instance online or via telephone. They are context-specific and can include the establishment of community-based and community-run response mechanisms, including volunteers who check in with older persons and other vulnerable populations, basic psychosocial skills training for leaders and activists and peer support. IOM also provides training to front-line health, immigration and other workers on MHPSS in epidemics, for instance on psychological first aid (PFA) and anti-stigmatization, to increase sensitivity to the psychosocial needs of vulnerable populations. IOM strives to integrate such mental health and psychosocial considerations into preparedness, response and recovery plans.

During the COVID-19 pandemic, in Burundi, IOM’s psychosocial mobile team provided PFA training and remote supervision to community health workers, focal points and local authorities, who subsequently offered MHPSS services in communities, including door-to-door sensitization, while respecting physical distancing measures. In many countries, IOM engaged in remote MHPSS services including counselling initiatives for migrants and vulnerable populations, including those stranded and in reception and transit centres, quarantine, displacement sites and so forth. In Bangladesh, IOM’s protection team reached tens of thousands of people with COVID-19 and protection messages and trained isolation and treatment centre staff on protection principles, GBV, counter-trafficking, PFA, safe referrals and protection from SEA, and IOM also trained community members and leaders on mental health, well-being and COVID-19 prevention.

Strategic Objective 4: Promote mobility-sensitive and inclusive policy, legal and strategic frameworks

This Strategic Objective comprises of advocacy and technical support to ensure that local, national and regional policies, legislative frameworks, regulations and strategies are in place to support mobility-sensitive health systems and responses that are inclusive of migrants, mobile populations and migration-affected communities – including health frameworks as well as integration of health into migration frameworks. IOM mainstreams advocacy on migrants’ rights and better management of migration challenges in all of its programming, including its work as part of the HBMM Framework.

Inclusive policy, strategic and legal frameworks are the foundation of public health preparedness, response and recovery. By fostering an enabling environment for mobility-sensitive public health action, they
increase the effectiveness of measures to prevent, detect and respond to health threats at local, national, regional and international levels. Moreover, they contribute to realizing universal health coverage in law and practice, through equal access to health services for migrants and mobile populations, irrespective of their legal status, provide social protection; promote policy coherence across different sectors in relation to health and migration issues; and build sustainable national capacities to develop and implement inclusive health policies.

The main activities under this Strategic Objective include the following:

4.1 Advocacy: To foster an enabling environment for mobility-sensitive health systems that support UHC and contribute to global health security, IOM engages in advocacy with policymakers, decision makers and influencers, including multilateral, bilateral and national partners, to promote migrant-inclusive and responsive policy, legal and strategic frameworks in the context of cross-border mobility and disease transmission. This activity area includes the following:

- Efforts to raise awareness on the importance of mobility-sensitive and migrant-inclusive policies and frameworks from the perspectives of public health and human rights to generate support from the public, government and other stakeholders;
- Sharing data, research and experiences to support advocacy efforts;
- Sensitizing policymakers, lawmakers, law enforcement personnel and other key stakeholders on such policies when they are in place; and
- Promoting policy coherence among relevant sectors, such as health and immigration.

IOM also advocates to ensure that health and other relevant preparedness and response plans are inclusive of migrants and responsive to mobility, while minimizing stigma. For example, in Tunisia and elsewhere, IOM’s advocacy successfully resulted in the inclusion of migrants in the national COVID-19 response strategies, including the establishment of a multilingual hotline for migrants to access information, and the provision of free testing for migrants and other relevant services such as MHPSS. Furthermore, IOM works with governments and partners to ensure a conducive policy environment for continuity of essential health services including in camps and camp-like settings, and access to emergency health care for irregular migrants, including identifying temporary legal solutions for access to medical care and coordinated temporary measures regarding visas and consular support.

4.2 Technical support: IOM provides direct technical assistance to Member States and partners to develop and implement mobility-sensitive and inclusive policy, legal and strategic frameworks. This includes direct support to review, develop and revise policies and strategies related to public health emergency preparedness and response – for instance a National Action Plan for Health Security (NAPHS) – that are non-discriminatory on the basis of a person’s migration status, coherent with international guidance, responsive to mobility and inclusive of migrants as a vulnerable group. This can also include specific legal or regulatory support, such as for the establishment of conducive immigration and health protocols for the transfer of patients, biological specimens, equipment and human resources for cross-border responses to public health threats. IOM also engages and supports governmental and inter-agency efforts to develop and implement national and regional health emergency and other relevant preparedness and response plans through contingency planning processes, to ensure that they are responsive to mobility and inclusive of migrants, such as mobility-sensitive, rights-based health and border management strategies and interventions.

During COVID-19, for instance, IOM supported the development of community action plans in The Gambia and elsewhere, and PHERPs at PoEs in Timor-Leste, Uganda and Zimbabwe, among other countries. PHERPs are multisectoral coordination plans to prevent communicable disease transmission, required by the IHR to be in place at designated PoEs. In addition, in Burkina Faso, Mali, the Niger and elsewhere, IOM provided support to its Member States developing national contingency plans for cross-border crisis response, looking at all possible scenarios, including pandemic. The plans were used during the COVID-19 response, including additional fund allocation at the regional level, adaptation of the chain of command with a more predominant role for health authorities and an integrated response inclusive of all border management
authorities. IOM also supported the development of the strategy on cross-border management of the outbreak in East and Southern Africa, which responded to the need to prevent, control and suppress cross-border transmission of COVID-19 and increasing cases among truck drivers. To this end, the strategy presented 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. In Costa Rica, IOM in close coordination with the General Directorate of Migration (DGME) and the Pan American Health Organization/WHO prepared a contingency plan for a transit centre for vulnerable migrants at the Nicaraguan border, including protocols for management, triage, hygiene and isolation of possible COVID-19 cases.

In Sri Lanka, IOM supported the Ministry of Health (Directorate of Quarantine) to formulate a new national border health strategy in 2013. IOM provided technical guidance and financial assistance to formulate and implement the approach, which was based on the following: (a) updates to legislation to address new and emergent border health issues and threats, and enabling meaningful statutory and regulatory functions for border health officials; (b) system changes through new SOPs for border health officials and key stakeholders at PoEs to guide the operations/practice according to IHR and a multi-hazard emergency preparedness and response plan; (c) training and simulations for frontline officials; and (d) the development of a National Border Health Information System to enable real time health surveillance.

**Strategic Objective 5 (cross-cutting): Strengthen multisectoral partnerships and coordination, including cross-border coordination**

This objective cuts across the four Strategic Objectives above and is integral to the design and implementation of all other core activities.

5.1 Multisectoral coordination within countries: To be effective, HBMM needs to be anchored in a well-coordinated multisectoral approach, which brings together relevant sectors such as health, border management, immigration, labour, transport (civil aviation, maritime, among others), trade and so forth. IOM facilitates dialogue and coordination within countries – including various ministries, local municipalities, national agencies present at PoEs, UN agencies, NGOs and so forth, depending on the context – including provision of technical support to coordination mechanisms for response to public health emergencies. During the EVD response in West Africa and later in the Democratic Republic of the Congo and neighbouring countries, for example, IOM played a critical role in supporting national authorities to establish multisectoral and multi-stakeholder coordination forums and technical working groups related to health security at PoEs. IOM also ensured that SOPs and emergency response plans were developed with the participation of multiple stakeholders. During the COVID-19 pandemic, in many countries around the world, IOM led or co-led inter-agency PoE taskforces and technical working groups, within which IOM facilitated multisectoral coordination (such as health, immigration and protection), for effective prevention and response measures at borders.

Strengthening health components in the Integrated/Coordinated Border Management (I/CBM) approach, which often guides immigration and border authorities, is crucial for public health crisis preparedness and response and also as a standard multisectoral approach beyond crisis settings, as articulated in IOM’s policy paper, *Cross-Border Human Mobility amid and after COVID-19* (IOM, 2020h). IOM assists immigration and border authorities to enhance cooperation with health authorities and incorporate health concerns into immigration and border management processes through promoting a mutual understanding of key concepts and procedures. At the operational level, this could include the facilitation and creation of national multi-agency crisis management teams, nested within a “steering committee” needed for the implementation of the I/CBM model. IHR PoE core capacities could also routinely be integrated into border and migration management assessment tools often adopted by immigration and border authorities.

5.2 Multisectoral coordination across borders: IOM also facilitates multisectoral dialogue and coordination across borders, including among national authorities communicating with their counterparts at multi-country and regional levels, and coordination
mechanisms including regional economic communities. These interventions also fully align with cross-border coordination by health and non-health authorities, as promoted in the I/CBM approach. For example, during the EVD outbreak in West Africa, IOM supported the Governments of Guinea and Sierra Leone to sign a memorandum of understanding to establish a cross-border coordination group and regular meetings with multiple stakeholders, including national authorities, IOM, WHO, the US CDC, local and community leaders, civil society organizations and the media. During the 2018–2020 EVD outbreak, IOM in Burundi and Democratic Republic of the Congo implemented cross-border programming engaging government stakeholders and IHR focal points to enhance collaboration between the two countries, including cross-border assessments, capacity-building and SOP development, along with a cross-border simulation exercise on SOP implementation. During the COVID-19 response, in the Asia and Pacific region, the IOM Regional Office convened a Technical Working Group on Migrants, Refugees and COVID-19 for Asia Pacific, with regular participation by the International Federation of Red Cross and Red Crescent Societies, the International Labour Organization, the Office of the United Nations High Commissioner for Human Rights, the UN Office for the Coordination of Humanitarian Affairs (OCHA), the UN for Disaster Risk Reduction, UNHCR, UN-Women, WHO and international NGOs. IOM also served as the lead/co-lead agency for the Points of Entry Pillar as part of the inter-agency Regional Partners Coordination Platform for Preparedness and Response to COVID-19 for East, Horn and Southern Africa as well as for West and Central Africa (chaired by WHO).

To ensure the safety of returning migrants in the context of COVID-19, IOM facilitated strong coordination between origin and destination countries around the world before return and reintegration to ensure that movement took place in accordance with public health recommendations. IOM also coordinated with IOM Country Offices and relevant State agencies (see 5.1 on multisectoral coordination within countries) to provide facilities where returning migrants could safely stay while adhering to required self-isolation or quarantine measures. For example, in Myanmar, IOM chaired a UN Core Group on Returning Migrants to coordinate the UN’s response in support of the government to assist returnees, while in Colombia, IOM held coordination meetings with local authorities and other actors to ensure assistance, psychosocial support and information on IPC measures were provided to migrants in temporary shelters and transit centres.
5.3 Inter-agency coordination: IOM coordinates with key agencies for preparedness and response to public health emergencies. IOM is a member of the Strategic Advisory Group of the IASC Global Health Cluster; as well as a member of the Global Outbreak Alert and Response Network. IOM is also the global co-lead on Camp Coordination and Camp Management (CCCM). IOM coordinates within these and related mechanisms at global and national levels. Additionally, as Coordinator and Secretariat of the UN Migration Network, IOM works closely with WHO and other member agencies and partners to ensure the integration of migration health concerns across the United Nations system.

As a member of the IASC, IOM supported the humanitarian system’s COVID-19 outbreak readiness and response, contributing to joint guidance and operational approaches to minimize impacts in humanitarian contexts. IOM also worked with OCHA to meet the additional needs stemming from the pandemic while sustaining ongoing humanitarian operations and life-saving programmes responding to pre-existing needs. The UN Migration Network released statements against stigmatization of migrants and for their inclusion in COVID-19 vaccination campaigns, among other key issues.

IOM also co-convened the Regional Task Force on COVID-19 and Migration/Mobility in the Middle East and North Africa, which promoted a coordinated approach, including with other task forces as well as other thematic interventions; supported field operations as a community of practitioners to enhance coordination at the country and regional levels among UN agencies and response actors; promoted migration/mobility-related data and information-sharing among agencies and disseminated good practices and lessons learned; explored programme synergies in country operations through a One-UN, whole-of-government and whole-of-society approach; and provided policy advice to the governments through policy briefs, online sessions and regular coordination and interaction at the country level. Similarly, as mentioned above, IOM convened a Regional Thematic Working Group on Migrants, Refugees and COVID-19 for Asia and the Pacific, bringing together UN and NGO partners.

5.4 Internal IOM coordination to leverage Organization-wide response capacity: Within IOM, this Strategic Objective ensures that HBMM-related activities are well-coordinated with internal areas of work related to emergencies, and leverages IOM’s multisectoral response capacity. This includes MHD (including emergency health, MHPSS and GHAP programming) engaging and working with teams focused for example on WASH, DTM, IBM, CCCM, shelter/non-food items, protection and GBV prevention and mitigation.

Building on IOM’s vast expertise in the various aspects of human mobility, health and humanitarian emergency response helps to deepen the understanding of migration health issues in all their complexity, and enhances the effectiveness and efficiency of IOM’s support for communicable disease prevention, detection and response efforts. For example, as part of its Organization-wide response to COVID-19, IOM convened a Headquarters-level PoE Working Group co-chaired by MHD and IBM, and comprised of multiple other IOM divisions, which was replicated by some IOM Regional Offices. The PoE Working Group aimed to promote multisectoral programming and support national and regional-level COVID-19 responses through the provision of guidance for IOM’s technical and operational engagement in the PoE space, where IOM is a recognized technical lead in public health emergencies. The working group was responsible for mapping, developing, reviewing and endorsing guidance materials; providing technical guidance to IOM programming at country, regional and global levels; and supporting PoE-related coordination at all levels of the Organization. In addition, MHD has collaborated with DTM on adding “Public Health Measures at Points of Entry: Public Health Module for IOM’s Global Survey”, wherein MHD is involved in the development of data capture form, guide and training module for enumerators.

Moreover, this area of work includes leveraging existing IOM resources to strengthen HBMM interventions. This includes, for example, IOM’s African Capacity-Building Centre (ACBC) in the United Republic of Tanzania, which responds to requests from IOM Members States in Africa to
strengthen capacity in migration management across the continent. Utilizing ACBC to conduct trainings, for instance, institutionalizes the trainings, contributing to sustainability and ensuring further use and strengthened capacity of a variety of key government stakeholders across Africa and around the world.

**Box 10: Tailoring HBMM activities along the continuum of prevention, detection and response**

The operationalization of the core activities can be influenced by the stage of the communicable disease outbreak and response. Activities therefore need to be tailored to the specificities of the pathogen and the epidemic curve, and adapted along the continuum of prevention, detection and response. Figure 6 below provides an illustration of how activities may be identified and tailored along this continuum.

**Figure 6: Examples of core activities along the continuum of prevention, detection and response**

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Detection</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1: Enhance the evidence base on the human mobility dimensions of communicable disease to inform effective prevention, detection and response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assess PoE capacity and needs in relation to IHR requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Map population mobility, including congregation hotspots and transmission risk venues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Build capacity for cross-border and community surveillance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Enhance health surveillance in border areas, including participation of communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Establish border data management systems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Improve infrastructure and technology for cross-border health data collection and sharing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Analyse and share disease surveillance and mobility data with national and cross-border designated parties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Link data to national and regional surveillance systems and report under IHR mechanism</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SO2: Build health system and border health capacity at points of entry and along the mobility continuum for communicable disease prevention, detection and response**

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Detection</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase awareness on communicable diseases and IPC among front-line personnel (e.g. health, immigration, law enforcement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Equip PoEs and health facilities with basic equipment (e.g. sanitation, PPE, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Develop SOPs, guidelines, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advocate for equitable use and distribution of vaccines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Establish well-trained screening and surveillance teams at PoEs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Build capacity of front-line officials to identify outbreak-prone communicable diseases and apply agreed SOPs and protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Strengthen laboratory capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support activation and implementation of public health emergency plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support management of observation and isolation rooms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support trained rapid response teams and referral systems</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SO3: Enhance community engagement and empower migrants, mobile populations and host communities in communicable disease prevention and response**

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Detection</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase awareness and promote preventive healthy practices among border and mobile communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Engage community leaders for cross-border information and to counter stigmatization and build trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Disseminate tailored RCCE messages and information, e.g. on prevention, symptoms, referral and health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support community-based MHPSS, e.g. peer support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support mobile and border communities to have access to health information and services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Support contextualized and appropriate MHPSS service provision</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SO4: Promote mobility-sensitive and inclusive policy, legal and strategic frameworks

| • Advocate on the importance of inclusive policy, legal and strategic frameworks, and raise awareness among immigration, law enforcement, health and key stakeholders regarding existing inclusive frameworks |
| • Strengthen policies, laws, regulations and strategies to improve disease detection and data management in the context of cross-border mobility, in compliance with the IHR |
| • Establish inclusive response plans and conducive immigration and health protocols for transfer of patients, specimens, equipment and human resources |
| • Review relevant policy and legislative frameworks to ensure that case management within a cross-border system is existing, adequate and coherent with relevant strategies and IPC principles |

## SO5 (Cross-cutting): Strengthen multisectoral partnerships and coordination, including cross-border coordination

| • Establish multisectoral communication mechanisms among key governmental and inter-agency stakeholders with clearly defined roles and responsibilities |
| • Engage with local authorities, leaders and media for harmonized cross-border prevention and information campaigns and interventions |
| • Establish internal, multisectoral collaboration mechanisms, e.g. the PoE working group, to ensure IOM is prepared to leverage Organization-wide capacity |
| • Establish mechanisms for cross-border information-sharing, contact tracing and case management |
| • Identify and establish mechanisms for engagement with local health systems and national networks of social mobilization for effective surveillance and early alert |
| • Facilitate partnerships between Ministries of Health, Immigration, Foreign Affairs and others on occurring health and border issues |
| • Establish intersectoral and multi-country procedures for cross-border coordination and information-sharing |
IOM’s rapid response team collects samples for COVID-19 testing in Herat, Afghanistan, for returnees and internally displaced persons. © IOM 2021/Muse MOHAMMED
REFERENCES

Inter-Agency Standing Committee (IASC)


International Organization for Migration (IOM)
2012a IOM Project Handbook. IOM, Geneva. (Please note there is an updated version, but it is not available publicly.)


United Nations (UN)


United Nations Department of Economic and Social Affairs (UN DESA)


United Nations Office for the Coordination of Humanitarian Affairs (OCHA)


United Nations Secretary General (UNSG)


Wickramage, K.


World Health Organization (WHO)


