

ApartTogether survey

PRELIMINARY OVERVIEW OF REFUGEES AND MIGRANTS
SELF-REPORTED IMPACT OF COVID-19



World Health
Organization

ApartTogether survey: preliminary overview of refugees and migrants self-reported impact of COVID-19

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World Health
Organization



Hand Sanitizer

This product is not for

COMPOSITION: Isopropyl alcohol (75%)

DIRECTIONS: Put a coin size of sanitizer on

CAUTION: Keep out of reach of children

contact with eyes, if irritates contact

Permission of Department

of Cox's Bazar

In association with

CONTENTS

Foreword	iv
Preface	v
Acknowledgements	vi
Executive summary	vii
Introduction	1
The ApartTogether survey	3
Sociodemographic characteristics	7
Self-reported health status, and seeking health care	11
Ability to follow preventive measures against COVID-19	14
Perceived impact of COVID-19 on mental health	16
Experiences of perceived discrimination	18
Perceived impact of COVID-19 on daily life	21
Conclusions and way forward	27
References	29

FOREWORD

Today we are seeing the largest population movements and displacement since the end of the Second World War. An estimated 1 billion people are on the move with more people than ever migrating or being displaced – about one in seven people worldwide.

Refugees and migrants contribute energy and ideas that drive economic and social development. However, the COVID-19 pandemic has had a disproportionately hard impact on these populations. They are often exposed to the virus with limited tools to protect themselves, and public health measures do not always reach them. Refugees and migrants may live highly insecure lives on the fringes of society, often in fear and without access to essential health and other services. Women may face the threat of violence and lack access to sexual and reproductive health services and social and financial protection. All these vulnerabilities may be further exacerbated by public health and social measures such as stay-at-home orders and border closures.

The pandemic has compromised the response capacities of health systems and highlighted existing inequities in access and utilization. Additionally, fear of the virus is exacerbating already high levels of xenophobia, racism and stigmatization and has even given rise to attacks against refugees and migrants. COVID-19 has entrenched restrictions on international movement and the curtailment of rights of people on the move.

To change this situation, it is vital that all countries include refugees and migrants in national health plans as part of their commitment to universal health coverage. Protecting the health of refugees and migrants is crucial in the context of the COVID-19 pandemic.

Health for all means just that: health for all, including refugees and migrants. Everyone should enjoy access to quality health services without facing financial hardship. This right must be supported by national health policies and legal and financial frameworks that see health as an integrating force in society.

If we exclude refugees and migrants, we will all bear the costs. That exclusion will undermine development and promote exclusionary and sometimes racist politics and sentiments. Throughout the COVID-19 pandemic, refugees and migrants have been key contributors to the response and will have a significant role to play in the recovery.

Global frameworks exist to improve the health and well-being of refugees and migrants, including WHO's Global Action Plan, Promoting the Health of Refugees and Migrants, alongside the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration.

These international commitments provide blueprints for governments, international organizations and other stakeholders to ensure that refugees and migrants, as well as host communities, get the support they need to meet the health needs of everyone during the COVID-19 emergency and beyond.

Yet beyond international agreements, there are many individual stories to be heard from refugees and migrants. We must learn from their varied and vivid experiences. This is the intention of this preliminary overview : to take stock of the real-life experiences of refugees and migrants, listen to their stories and understand first-hand the real challenges when associated with limited access to health care and with stigmatization and discrimination.

WHO is committed to working with countries towards a shared mission to promote health, keep the world safe and serve the vulnerable, including refugees and migrants. We shall continue this work alongside our many partners, including the International Organization for Migration, the Office of the United Nations High Commissioner for Human Rights and the United Nations High Commissioner for Refugees, and with many other international organizations and bodies to ensure that refugees and migrants are not left behind.



Dr Tedros Adhanom Ghebreyesus

WHO Director-General

PREFACE

The right to health as laid down in the WHO Constitution applies to every person, including refugees and migrants. Globally health has improved, yet there are profound differences and inequities. WHO's triple billion targets include 1 billion more people enjoying improved health and well-being. Here the key is that this improvement should be equitable and enjoyed by all people.

This report looks at the ways in which the pandemic has hit the lives of refugees and migrants. It takes the perspective of their own lived experiences during the COVID-19 crisis. There is clear evidence that even in more normal times their access to health and health services is often severely compromised, both by the organization of the health system and by the social setting in which they live. Women and children may be particularly severely affected. Ultimately, the survey reported in this publication is an inquiry into the right to health for refugees and migrants.

Understanding how refugees and migrants themselves experience and cope with the pandemic is crucial to shape inclusive and holistic policy responses. We wanted to give refugees and migrants a voice and to understand their specific challenges, such as when experiencing limited access to health care as well as their living and working conditions.

WHO is committed to the right to health for all, including refugees and migrants. The Thirteenth General Programme of Work concentrates on working towards universal health coverage and the achievement of the Sustainable Development Goals, which include inclusive health systems that put people at the centre. Ensuring the health and well-being of refugees and migrants is a key priority within this endeavour. The WHO Global Action Plan, Promoting the Health of Refugees and Migrants, aims to both protect refugee and migrant health and leave no one behind.

To move ahead and make a difference, WHO has now established the WHO Global Programme for Health and Migration. The Programme aims to provide and coordinate global leadership, policy, advocacy and research around health and migration; set norms and standards; promote tools and strategies; and generate evidence-based information to support decision-making. It will support Member States as well as other parts of WHO in addressing the public health challenges that are associated with human mobility, as well as promote global multilateral action and collaboration.

This ApartTogether survey report serves as a first inquiry into the social impact of the COVID-19 pandemic on refugees and migrants globally. It shows that, even though refugees and migrants face similar health threats as their host populations, the pandemic may have exacerbated their often precarious living and working conditions. The results underline the need and importance of including them in inclusive policy responses to COVID-19.

We hope that this report will inform political leaders and health managers and professionals about the possible heightened vulnerabilities of refugees and migrants during the pandemic and focus attention on this issue. We hope that this will lead to further research at global, regional, country and local levels on how address refugee and migrant health. National health policies, and supporting legislative and financial frameworks, should promote the right to health of refugees and migrants, see health as an integrating force in society and be gender sensitive.

We must recognize that the pandemic is bringing to the fore and exacerbating existing inequities in health system capacities and responses. We must commit to working with countries to build health system capacities and resilience in the face of the pandemic. We must take measures to identify and counter stigmatizing and discriminatory practices towards refugees and migrants in our COVID-19 responses. We must achieve equitable access to essential health services for refugees and migrants, remove financial and other barriers to COVID-19 testing and treatment services and introduce safety nets to mitigate the adverse social and economic impacts of the pandemic.

Above all we must leave none behind in our public health responses to the pandemic, using an inclusive approach that respects human rights.



Dr Zsuzsanna Jakab
WHO Deputy Director-General



Dr Santino Severoni
Director, Global Programme on
Health and Migration

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The ApartTogether Consortium includes Ghent University, Belgium (Anastasia Botsari, Saskia De Jonghe, Stéphanie De Maesschalck, Ilse Derluyn, Marina Rota, Eva Spiritus-Beerden, An Verelst, Robin Vandevoordt and Sara Willems), University of Copenhagen, Denmark (Signe Hviid Hansen, Nina Langer Primdahl, Rasmus Luca Lyager Brønholt, Morten Skovdal and Linnea Waade Biermann), Maynooth University, Ireland (Rebecca Murphy), University of South Florida, United States of America (Beatriz Padilla), Uppsala University, Sweden (Natalie Durbeej, Fatumo Osman and Anna Sarkadi), Sussex University, United Kingdom of Great Britain and Northern Ireland (Charles Watters), Lisbon University, Portugal (Adriano de Almeida, Catia Branquinho, Ana Cerqueira, Maria Emilia, Sandra Estevão, Susana Gaspar, Tania Gaspar, Margarida Gaspar de Matos, Fabio Guedes and Gina Tomé), University of Toulouse, France (Julia de Freitas Girardi, Yagmur Gökduman, Rachid Oulahal, Frédéric Rodriguez, Filipe Soto Galindo and Gésine Sturm), University of Sevilla, Spain (Rocio Garrido, Virginia Paloma), National and Kapodistrian University of Athens, Greece (Elisabeth Loannidi, Katerina Vasilikou), Azienda Unità Sanitaria Locale of Reggio Emilia, Italy

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EXECUTIVE SUMMARY

This paper is an advocacy brief based on a perception survey called ApartTogether that aims to identify how the new coronavirus SARS-CoV-2 (COVID-19) has impacted refugees and migrants around the world, as experienced and reported by them, especially for social and public health aspects; there were over 30 000 respondents from almost all Member States of WHO. The following highlights the initial findings of the survey.

Self-reported COVID-19 health status, history of testing and seeking health care

Among the respondents, refugees and migrants (the survey captured also those in irregular situation as “having no documents”), those living on the street or in insecure accommodation and those less likely to seek medical care in case of (suspected) COVID-19 symptoms. Lack of financial means, fear of deportation, lack of availability of health-care providers or uncertain entitlement to health care were the reasons cited most often for not seeking medical care in case of (suspected) COVID-19 infection. Of those who indicate not seeking health care, 35% of the survey respondents reported financial constraints as the reason, and a further 22% fear of deportation.

Public health social measures against COVID-19

Most refugees and migrants surveyed took precautions to avoid COVID-19 infections and followed government-initiated preventive public health social measures. Around 20% of respondents said that it was difficult to avoid public transport or avoid leaving the house. Younger respondents were less likely to follow risk reduction measures. Refugees and migrants relied on different sources of information about COVID-19, including from the news, from friends and family and from social media, and accessed information in both the home country and the host country. People living in more precarious housing situations (i.e. on the street, in insecure accommodation, in asylum centres or in refugee camps) had less sources of information on COVID-19. The survey found that nongovernmental and civil society organizations (NGOs), and other supporting organizations do play a key role regarding dissemination of accessible information on COVID-19 to refugees and migrants.

The impact of COVID-19 on mental health of refugees and migrants

At least 50% of the respondents across various parts of the world indicated that COVID-19 brought about greater feelings of depression, anxiety and loneliness and increased

worries. One in five respondents also increased drug- and alcohol use. Refugees and migrants living on the street, in insecure accommodation or in asylum centres are likely at high risk of experiencing mental health problems in the aftermath of the COVID-19 pandemic. Primary anxieties for respondents were uncertainty about their future, whether they or one of their family members or friends will get sick or whether they will suffer serious financial consequences.

Experiences of perceived discrimination

Respondents living in asylum centres, living on the streets, in insecure accommodation or in other precarious conditions (e.g. on unpaid work or sent home without pay) indicated being affected in terms of perceived discrimination – nearly 40% of those living on the streets or in insecure accommodation. Refugees and migrants, including those in an irregular situation or those living on the street or in insecure accommodation and in asylum centres, reported a relatively worsening situation of discrimination. Unemployed refugees and migrants reported greater discrimination than others who continued working.

The perceived impact of COVID-19 on the daily lives of refugees and migrants

Refugees and migrants participating in the survey reported significant impact of COVID-19 on their access to work, safety and financial means. Respondents living in insecure accommodation and in asylum centres and irregular migrants suffered the worst impact of COVID-19 on their daily lives, making up around 60% of the respondents within the category. Refugees and migrants who participated in the survey and lived in the WHO Americas, European, South-east Asia and Western Pacific Regions reported greater impact than those in other regions. However, respondents said they were taking various measures to cope with such impacts. They identified staying in contact with family and friends, entertaining oneself, seeking information and meditating and praying as the most effective strategies.

Way forward

Self-reported quantitative and qualitative information provides important insights into the lives and livelihoods of the refugees and migrants who participated in the ApartTogether perception survey. This advocacy brief attempts to capture their perceptions regarding how they have been impacted in various ways by the pandemic and how they have been managing and coping with the psychosocial and other stresses. Additional complementary and more



in-depth analysis of these initial findings may give important information to the Global Programme on Health and Migration for future inputs to research initiatives aiming at strengthening evidence-informed norms and research for

effective policy formation and impactful programming.



INTRODUCTION

COVID-19 has swept across the world, with over 50 million confirmed cases and over 1.4 million deaths reported to WHO at the time of writing (1). In the face of this pandemic, all are vulnerable, including refugees and migrants.

“The virus has shown that it does not discriminate – but many refugees and migrants are at heightened risk” (4).

Today, every seventh person worldwide is estimated to be a migrant, with 272 million being international migrants (5) and 763 million internal migrants (6). Also, among them, by mid 2020, 80 million people were forcibly displaced because of persecution, conflict, violence, human rights violations or events seriously disturbing public order (7).

While refugees and migrants are resilient like rest of the humankind, they may often remain in difficult situation because of factors such as their migratory status, inadequate access to services including health and other entitlements and discrimination that they might face across the migration cycle.

Refugees and migrants enjoy the same human rights and the right to health as any other person in society, yet much evidence suggests that they may face difficulties in realizing such rights and have limited tools to protect themselves. The reasons may depend on poor living conditions, marginalization with respect to the reach of public health measures, limited access to health care, lack of financial protection and informal or precarious labour settings. They may

DEFINITIONS OF REFUGEE AND MIGRANT

Refugee

The 1951 Convention relating to the Status of Refugees and its 1967 Protocol (2) defines a refugee as “any person who ... owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.” The World Health Assembly Resolution A72/25 Rev.1 (Promoting the health of refugees and migrants: draft global action plan, 2019–2023) uses this definition (3).

Migrant

Resolution A72/25 Rev.1 also states that “There is no universally accepted definition of the term “migrant”. Migrants may be granted a different legal status in the country of their stay, which may have different interpretations regarding entitlement and access to essential health care services within a given national legislation, yet under international law such access remains universal for all in line with the 2030 Agenda for Sustainable Development, in particular with Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages)” (3). Migrants may remain in the home country or host country (settlers), move on to another country (transit migrants), or move back and forth between countries (circular migrants, such as seasonal workers).

Definitions in this document

While in some contexts such definitions may have important implications for entitlement of and access to health services, the definitions as applied in this document do not denote any particular legal status or entitlement. The entitlement of and access to health services for the various groups are determined by national regulations and legislation. In this document, the term migrant is used as an overarching category; the terms refugee and asylum seeker are included and applied in accordance with the 1951 Refugee Convention and as recommended by the International Organization for Migration and the Office of the United Nations High Commissioner for Refugees.



face additional stigmatization and discrimination as well as relative income instability (8–11). There are important differences among refugees and migrants depending on a wide range of factors such as their legal status, their integration in the hosting society, their educational background, country of origin and so on, all affecting their health status differently (11–13).

Evidence may indicate poor health outcomes among refugees and migrants. Migrant women are likely more exposed to sexual violence, abuse and trafficking, as well as risks related to pregnancy and childbirth. They may experience poor access to sexual and reproductive health services (12). Children may be affected by health risks and poor access to health services. Many refugees and migrants may be more prone to risk factors for noncommunicable diseases, such as exposure to tobacco, and often experience challenges in accessing health services when living with a chronic condition. Those affected by noncommunicable diseases may experience interruption in their care when they move without medicines or health records. Evidence also suggests that there are higher reported levels of mental distress among refugee and migrant populations, with increased risk for older people, people with underlying medical conditions, women and those who have experienced trauma; further risks are linked to lack of social support and increased stress after migration (11,12). Many of these problems might be intensified during the COVID-19 crisis. The negative

impact of COVID-19 on the health and living conditions of refugees and migrants may have impact on the families they have left behind in countries of origin (8–10,14–18).

The plight of refugees and migrants during the COVID-19 crisis has been highlighted in the media, and by online stories, blogs, reports and posts, often with regional or national focus and not reported by refugees and migrants themselves. It is vital to better understand how refugees and migrants themselves experience the pandemic and its consequences. The ApartTogether survey aimed to collect data from refugees and migrants globally on how they perceived the pandemic has impacted them. The results presented here could provide insight into potential actions, including indicating where more data might need to be collected systematically, to address the concerns faced by refugees and migrants.

The survey gave refugees and migrants a platform to self-report the perceived impact of COVID-19 on their lives including the preventive measures recommended. It also provides an opportunity to better understand their situation and specific difficulties they face. This is not a systematic survey of the incidence of COVID-19 among refugees and migrants nor an assessment of the prevalence of symptoms or immunity. This advocacy brief captures a preliminary analysis and findings based on the collected self-reported data and observations.

THE APARTTOGETHER SURVEY

The survey aimed to capture whether refugees and migrants understand the information related to COVID-19, whether their living situations are hampered following certain regulations, what current daily stressors they may face (e.g. insecure income or limited housing), whether they have experienced discrimination during the pandemic, and what impact the current measures of physical distancing have had on their social support networks. This survey used convenience sampling combined with snow-ball sampling.

It is expected that the results of this perception-based survey may provide information for policy makers to address the specific challenges of refugees and migrant and to inform the health systems, preparedness and inclusiveness.

Participation in the survey

Over 30 000 refugees and migrants from around the world participated in the ApartTogether survey.¹ After cleaning responses for inconsistencies, this report is based on responses from 28 853 refugees and migrants from around the world who have shared their perspectives on how COVID-19 has impacted their lives. There were 5764 migrants who completed the survey while residing in their country of birth; they represented a diverse group that included children of migrants, internally displaced people and returnees. Survey respondents lived in 170 countries and originated from 159 countries.

The survey aimed to capture refugees and migrants older than 16 years of age.

Participation in the survey was voluntary and the participants could withdraw their participation from the survey at any point without providing any reasons or skip any questions that they did not want to answer. Consequently, not every question was answered by all participants. How many participants answered each question is clearly indicated under each figure. The voluntary nature of participating in the survey, and aim of the survey and other relevant information was indicated in the informed consent form for those wishing to participate in the survey. Participants

could also contact WHO, in addition to consulting the WHO website on COVID-19 for which a link was provided.

Methodology

Information presented in this report was derived from a brief non-systematic cross-sectional survey called ApartTogether administered online to allow speedy completion using phones or other hand-held devices. The survey was intended to be completed by refugees and migrants themselves through online access. However, it cannot be guaranteed that this was the case in all instances. However, based on the reports received from partners such as NGOs and academic institutions involved in facilitating the participation of refugees and migrants in the survey, this was largely ensured. Questions were in 37 languages and the 30 questions were organized around five categories.

- Sociodemographic characteristics of the participants: gender, age, education, country of residence, country of origin, time living in the current country of residence, residence status (citizen, permanent documents, temporary documents, no documents/without legal documents, other), housing situation (house or apartment, asylum centre, refugee camp, on the street/in insecure accommodation, other), family composition and family size in the household, and work situation.
- COVID-19: self-reported health status related to COVID-19, understanding of measures (physical distancing, handwashing, masks, gloves, coughing in elbow, etc.) and the ability to follow preventive measures.
- Daily stressors: impact of COVID-19 and related measures on daily living, including income, food, housing sense of safety and access to medical care.
- Psychological well-being: symptoms of anxiety and depression, loneliness and anger; reminders, physical reactions, feelings of irritation and hopelessness; sleep problems, substance use and other worries.

The website for the survey offered the possibility for participants to voluntarily add their stories to enlarge on the

¹ The survey protocol, questionnaire and informed consent form were approved by the WHO Ethics Review Committee. Ethics approval for the study was also granted by the Ethics Committee of the Faculty of Psychology and Educational Sciences of Ghent University.



survey. All stories contained in this report have been anonymized to protect the identity of respondents.

In the initial phase, April-July 2020, the survey was pilot tested by ApartTogether consortium partners led by Ghent University, Belgium, and Copenhagen University, Denmark. Although pilot testing was limited to Europe and the USA, it captured refugees and migrants coming from all around the world, allowing for further minor revisions of the survey instrument. Since the revisions made to the survey instrument were minor, data collected from pilot testing could be combined with the final dataset. The pilot testing also indicated the need to adopt additional strategies such as contacting key stakeholders such as NGOs and academic institutions to disseminate the survey and to promote active participation of the target population groups.

The survey was subsequently rolled out globally by the Global Programme on Health and Migration, WHO

headquarters in Geneva, through the WHO network of regional and country offices as well as other research and collaborating centres. To increase the uptake of the survey, targeted campaigns were conducted in countries across WHO African, Americas, Eastern Mediterranean, European, South East Asia and Western Pacific Regions.

This enhanced participation of refugees, and migrants themselves through various network groups: United Nations agencies dealing with refugees and migrants, NGOs, grassroots organizations, national organizations working with refugees and migrants, academics, international organizations and institutions, as well as WHO regional and country offices (listed in the acknowledgments).

Additionally, an intensive social media campaign was rolled out. The Facebook pages of ApartTogether and the twitter account of ApartTogether and those of WHO were used to reach out to the wider public, organizations, policy-makers and

formal and informal groups of refugees and migrants. A Facebook advertisement and other proactive social media and network outreach approaches were used to contact organizations working with refugees and migrants communities in and from focus countries that might be outside the primary networks. The survey was closed on 31 October 2020.

The report focuses on descriptive analyses. A frequency analysis was performed to get an overall sense of the variables combined with cross tabulations to indicate any relationship between variables.

Challenges in data collection and methodological limitations

The survey findings give a brief overview of the situation for refugees and migrants who answered the survey and not a generalized picture of refugees and migrants globally. There were a number of reasons for this, particularly related to the extraneous circumstances around the pandemic and difficulties in collecting data from hard-to-reach population groups. However the survey did capture information on the situation of refugees and migrants living in 170 countries. Please note that this does not indicate the situation in the 170 countries were systematically surveyed.

The urgent nature of the COVID-19 pandemic called for the very rapid development and distribution of the survey. COVID-19 also hampered traditional methods of survey outreach.

The strategy to disseminate the online survey widely among people, organizations and within social media groups and communities, and that allowed respondents to complete the survey on their own devices, worked well in some groups but was less successful for other groups, possibly missing some groupings of refugees and migrants. This also led to unintended bias such as unequal distribution of participation rate across regions, as well age groups. Limited access to devices and the Internet, among other reasons such a low literacy, made it difficult to achieve uniform access to all population groups and this was aggravated by heightened financial stress, insecurity and rising unemployment due to COVID-19. Any cross-regional and other comparisons are therefore for illustration purposes only and should not be used to infer causality or other associations.

In some countries, the survey outreach was further constrained by national restrictions on specific social media outlets, combined with incompatibility between local networks and the electronic survey. To overcome this and to reach harder-to-reach population groups, a more strategic

recruitment strategy was implemented in several countries in various parts of the world in an attempt to cover most of the major migration routes and population concentrations. Local promoters of the survey, listed above, identified respondents and facilitated survey completion. Such efforts not only increased the survey responses from these countries but also increased the representation of respondents in other countries where they had migrated. However, as indicated in Figs 1-3 below, the survey respondents do not fully represent the diversity of the refugee and migration population globally and regionally. Hence, the regional comparisons are for illustrative purposes and does not indicate causality or associations in terms of the geographical location of refugees and migrants.

Added to this, physical distancing and other public health social measures, travel bans and other restrictions imposed to control the spread of the pandemic, were clear challenges to overcome to have a representative sample of the various population groups targeted and presented in this report. Such limitations are documented in this report as a caution regarding further interpretation and generalization of the findings captured in this advocacy brief.

Such challenges, however, do not diminish the global information the survey collected. Despite the issues described, the survey results provide a global overview of the impacts of COVID-19 pandemic experienced by refugees and migrants. Although the pandemic impacted all from around the world, refugees and many migrants, especially if in an irregular situation, find themselves in a difficult situation because of socioeconomic situations and precarious living and working conditions. The survey aimed to capture the concerns of such populations groups and to highlight the level of impact the pandemic brought about to them.

The survey findings also may provide valuable information to the Global Programme on Health and Migration and WHO on how to design effective policies and impactful programming including for refugees and migrants. Lessons learned from the survey can be important insights for the Programme on how to overcome future challenges on data collection and information gathering.



SOCIODEMOGRAPHIC CHARACTERISTICS

Fig. 1 shows the age and gender distribution of the respondents. As the respondents were at least 16 years of age to participate and due to the method of online data collection used in the survey described above, give rise to a skewed distribution towards a younger age group. The survey also captured 27 respondents who identified themselves as transgender or non-binary.

Fig. 2 shows movements of survey respondents across various WHO regions as well as gender distribution of refugees and migrants for these regions. The majority of the participants were living in high-income countries (Fig. 3a) and originated from lower-middle or low-income countries (Fig. 3b).

Various epidemiological studies have shown a higher prevalence and mortality burden for COVID-19 among older age groups, particularly those older than 60 years. However, this group is underrepresented among the survey participants.

Most of the survey respondents had some form of education, with a majority having higher education (Fig. 4), although 10% had primary or no education whatsoever. The majority of the participants were employed with the remaining being unemployed, with or without unemployment allowance, students, homemakers, pensioners and parental leave.

FIG. 1. Age and gender profile of the survey respondents

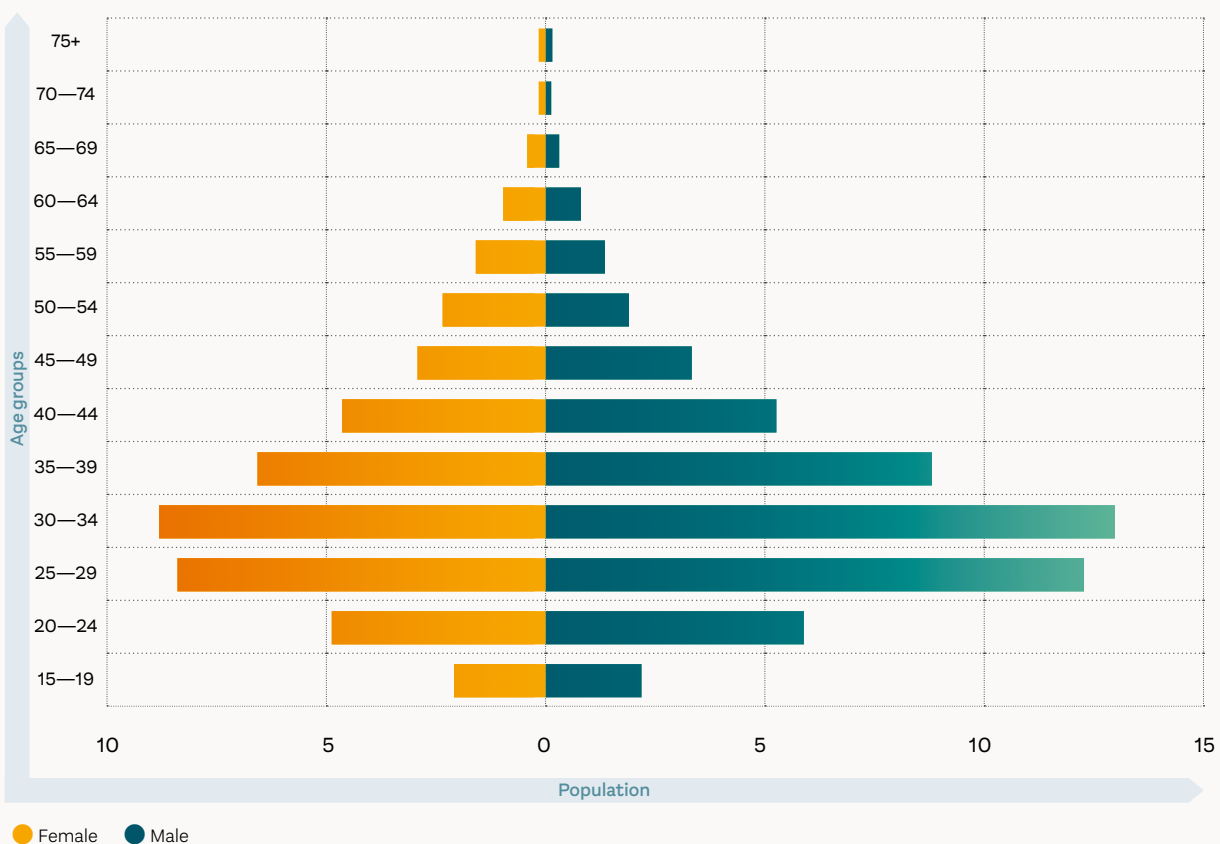


FIG. 2. Summary of the regions of birth (origin) and regions of residence for respondents indicating migration flows

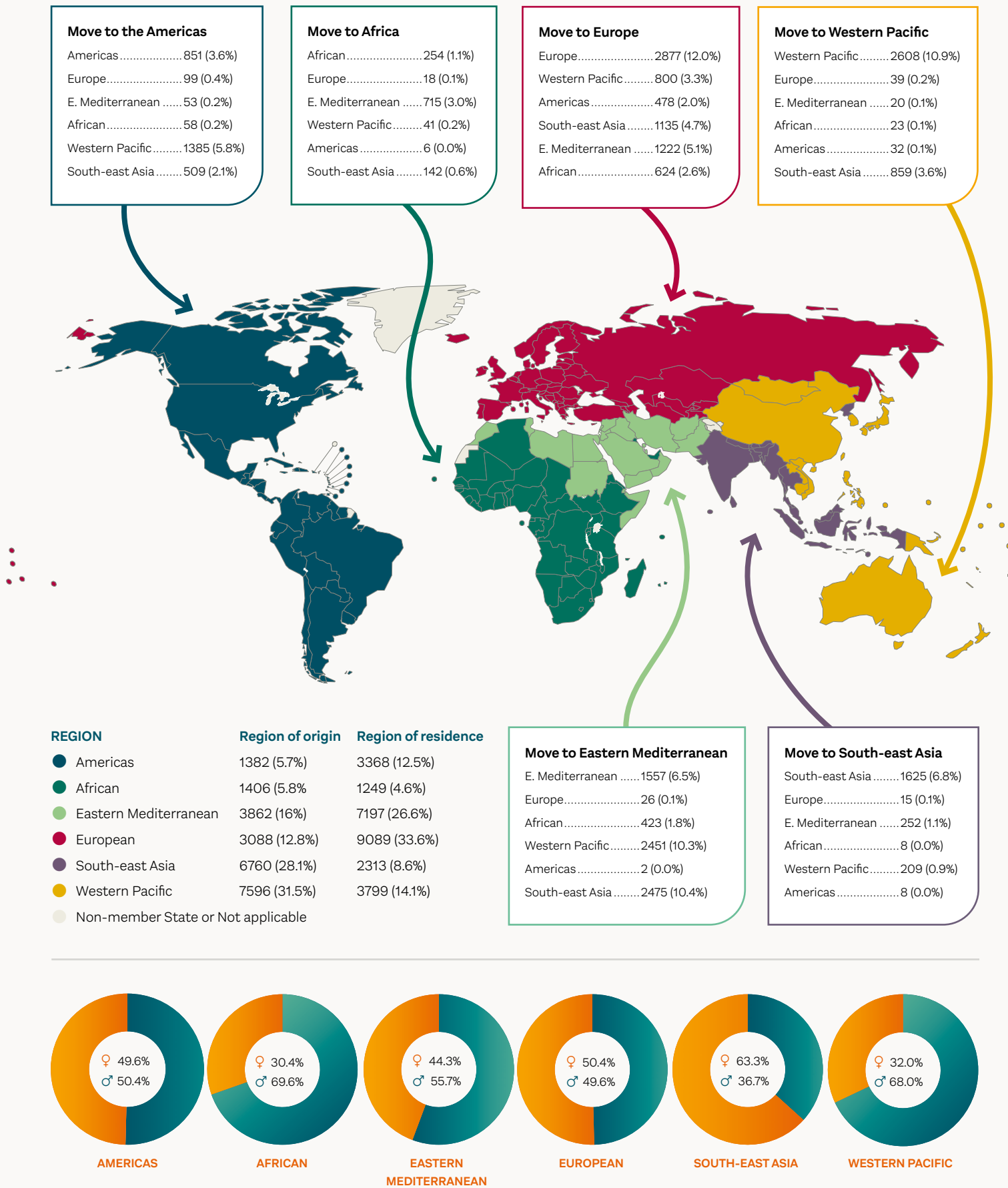
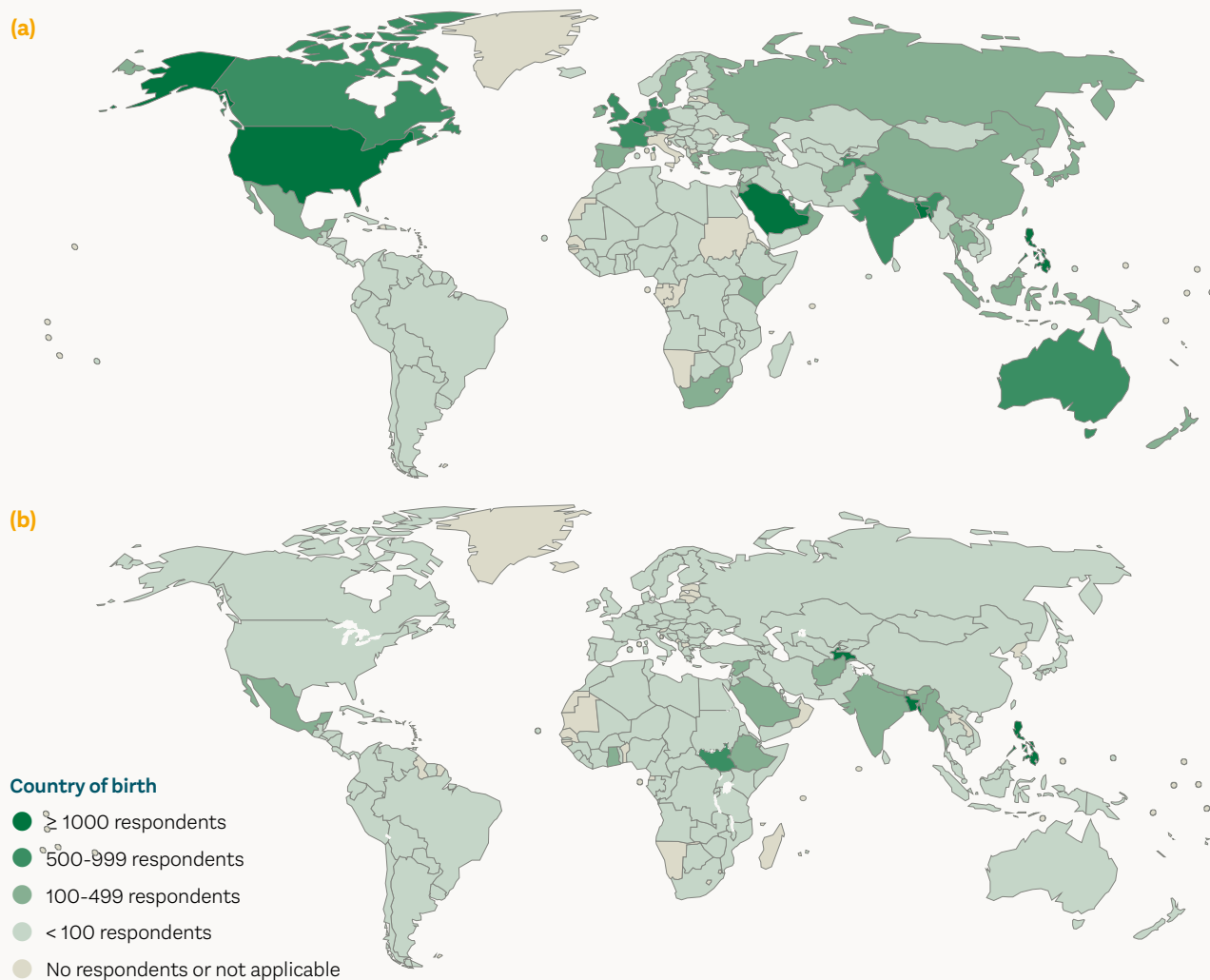
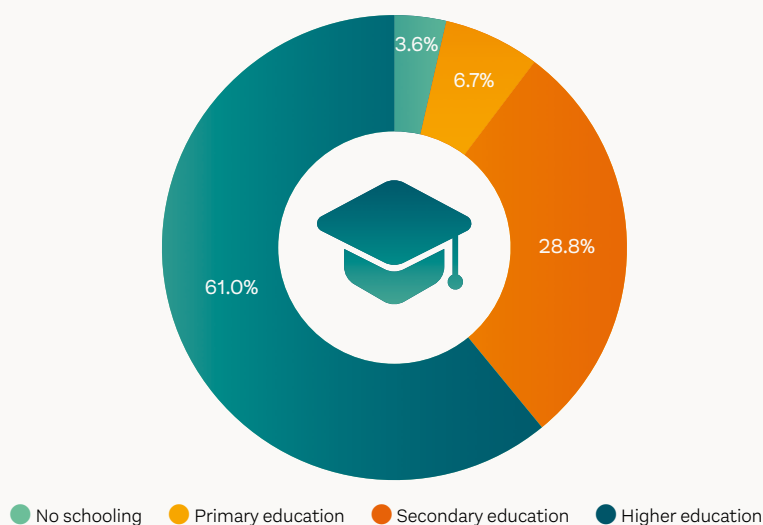


FIG. 3. Respondents to the survey by (a) their country of residence and (b) their country of birth



Note: (a) data from 23 739 respondents from WHO Member States and 1189 from non-Member States and territories for those residing in 170 countries or territories; (b) data from 18 412 respondents from WHO Member States and 945 from non-Member States and territories by country of birth among 159 countries or territories.

FIG. 4. Distribution of educational background for respondents



Note: data from 22 618 respondents for education (806 no schooling, 1521 primary education, 6504 secondary education, 13 787 higher education).



SELF-REPORTED HEALTH STATUS, AND SEEKING HEALTH CARE

The ApartTogether survey enquired about COVID-19 symptoms, testing, taking precautions, receiving information and seeking health care. Refugees and migrants also added their own personal experiences, which provide more information outlined in the boxes.

Symptoms and testing

Respondents were asked whether they thought they had or have had symptoms of COVID-19, with 2595 (12%) saying that they currently suffered from symptoms they thought were linked to COVID-19. A positive answer did not necessarily imply they were infected with the virus nor that

they had the COVID-19 disease. It merely indicated that they thought they currently had symptoms they attributed to COVID-19. The actual prevalence of COVID-19 for the respondents to the survey or for the entire population of refugees and migrants could not be concluded from the answers to these questions.

Respondents were also asked whether they had tested positive themselves or had someone close to them (survey categorized them as “a loved one”) who tested positive.

Story of Mohib



Mohib, a Rohingya refugee in his forties stays at a refugee camp in Cox’s Bazar District of Bangladesh, which is one of the world’s largest refugee camps. Mohib and his family left Rohingya State of Myanmar after their village was burnt. Many people were tortured and killed. Many women were raped, and children were stampeded to death. Mohib and his family members, along with several thousand men, women, children, toddlers and infants who had lived in their homes for years, fled their villages, crossed the perilous border and came to Bangladesh to save their lives. Mohib now runs a small business inside the Rohingya camp. He and his family members live on whatever he makes from the business and the inadequate but important help they get from the camp.

“Life was extremely hard here, but it became harder after the COVID-19 outbreak,” Mohib says. “Thousands of Rohingyas stay in a small area. The first COVID-19 positive case was identified in May and the first Rohingya in the camp died from COVID-19 in June. The sale of my business has dropped significantly after the outbreak. My family and I passed some days without a full meal.”

But Mohib praises the NGOs and the Bangladeshi Government agencies for their help and mentioned that his family got timely medical services during COVID-19. Requests for physical distancing and masks are not followed properly. People roam around freely without masks or other protection. Mohib says: “Local NGOs used to provide us reminders about physical distancing and national health guidelines provided by Bangladeshi Government agencies, but now-a-days, the rate of publicity and awareness has decreased. We were so conscious of the corona situation that we used to wear masks and take other precautions. But now it is a totally different scenario. People’s consciousness decreased and we are leading quite a normal life.” He further says: “I am concerned that most of the people did not follow physical distancing and social gathering was quite a common scenario here. They were not interested in this “Corona Virus” topic. Though the health-care centre is open from 8am to 4pm, people here are not interested to get tested though they have symptoms.” Mohib goes on to say, “Lifestyle got changed. It’s getting impossible for us to sustain in this environment. I have a large family. With several children and we cannot maintain physical distancing in this camp. I got sick in June, but isolation can’t be followed here. I didn’t go for the test cause if I get tested positive then I cannot run my business.”

Story of Jamy



Jamy is originally from Sierra Leone, now based in Gambia in West Africa with his wife and four children. He has been living in Gambia for more than 20 years. He is a medical practitioner working in a private clinic, and through his profession he faces the challenges of COVID-19 daily when meeting his patients. When Jamy is watching the news, he also becomes aware that all over the world medical care workers are dying from the virus, and that causes fear. Since he is more exposed to people who could potentially be infected by COVID-19, Jamy is afraid of a higher risk of transmission. Jamy explains how the limited access to quick tests for COVID-19 makes the situation stressful for medical professionals like himself: "You don't have the facility where you can test yourself regularly. We have rapid test for malaria. We have rapid test for HIV now, here in Africa, within a few minutes you can have the result. So, this is quite contrasting when it comes to COVID-19. Because it is something new, so we don't have the facility. So, these are some of the challenges that we have."

Story of Bibinoz



Bibinoz, a woman in her fifties, was unemployed and left Tajikistan for the Russian Federation before the COVID-19 pandemic. She supports six children. She is a single mother and a clinical laboratory physician by profession. But it is very difficult to get a job in her speciality in the Russian Federation. Her two eldest sons graduated from school and received higher education in Dushanbe, but their diplomas are not recognized in the Russian Federation. They have to study and get their diplomas again. Bibinoz received a temporary residence permit and applied for citizenship. She purchased a plot of land to build a house, through selling her house in Tajikistan. She works as a nanny and does everything to ensure that her children receive a proper education. They had been ill with COVID-19 but had access to medical care when needed. Fortunately, her efforts to maintain hygiene in the apartment were not in vain. She and her eldest son do not use public transport. They avoid public places and try to shop early in the morning and at night or on Sunday afternoons.

Seeking health care

The lower the educational level, the less likely refugees and migrants were to seek health care when they or a family member had symptoms (Fig. 5).

The primary reasons for not seeking medical care were financial, fear of deportation, lack of availability of health care or no entitlement (Fig. 6). Such reasons may not necessarily be specific for COVID-19 but may reflect more the day to day challenges faced by refugees and migrants to seek care.

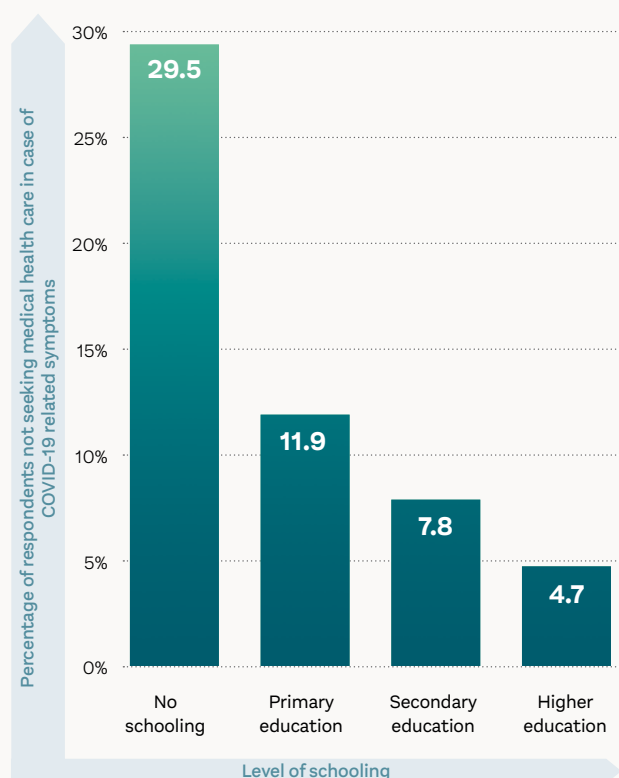
Residence status was also found to be a factor that impacted willingness to seek medical care for themselves or for their family members or friends even when they developed COVID-symptoms (Fig. 7). One out of six migrants (290 (18.6%)) without any documentation would not seek medical care for COVID-symptoms; this was much less common among respondents having citizenship or permanent documents in the country in which they lived (363 (5.9%) and 228 (4.1%), respectively).

Story of Sanjib



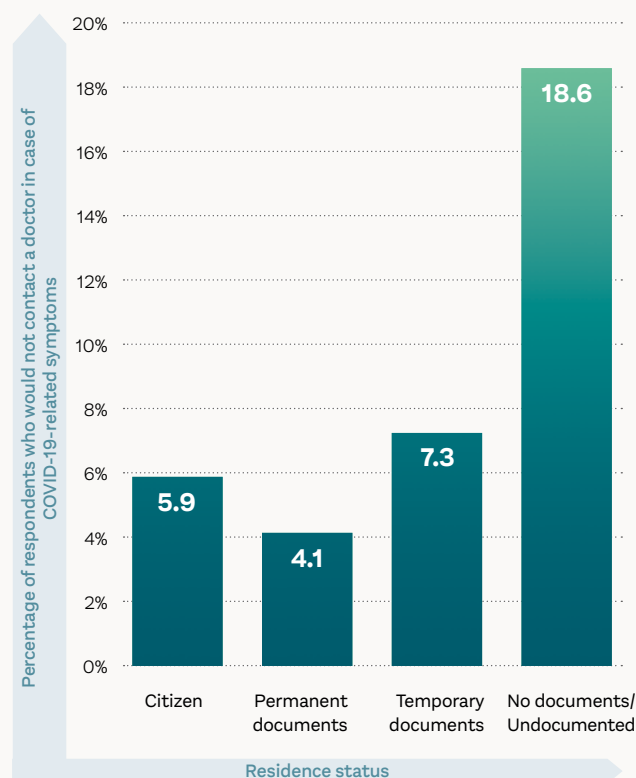
Sanjib, in his thirties, is a migrant originally from Bangladesh who had been living in a Gulf State for the last seven years. His reason for moving was to get a job to provide for his family. When COVID-19 emerged, his living conditions became extremely challenging. He had been living in an apartment with people who shared the same story as Sanjib. They were all in Kuwait with temporary documents and were trying to make a living. The crowded apartment made it difficult for Sanjib to follow the restrictions regarding physical distancing, and he also relied on public transportation to get to his job. These conditions made it hard for Sanjib to avoid transmission. Even though he tried to cover his mouth and nose, he was still more exposed because of the frequent interaction with many different people. Sanjib has been infected with COVID-19 and fears the consequences it might bring. He worries about his ability to maintain his job and to secure his financial situation.

FIG. 5. Respondents not seeking medical health care for symptoms according to their educational backgrounds



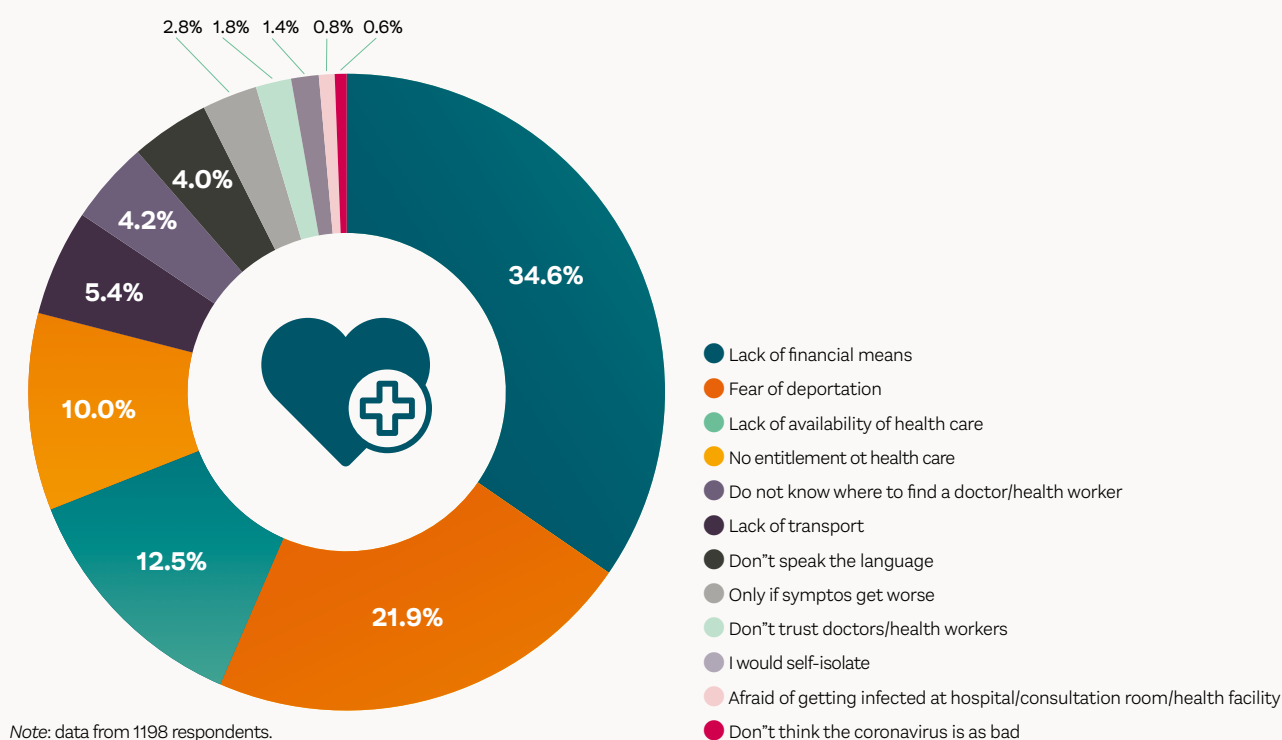
Note: data from 21 325 respondents (733 no schooling, 1412 primary education, 6177 secondary education, 13 003 higher education).

FIG. 7. Respondents not seeking medical health care for symptoms according to their residence status



Note: data from a total of 21 273 respondents, with 1198 expressing as not seeking medical care (by residence status: 6163 citizen, 5504 permanent, 7461 temporary, 1561 no documents/undocumented, remainder no clear answer).

FIG. 6. Reasons for not seeking medical care in case of (suspected) COVID-19 symptoms



Note: data from 1198 respondents.

ABILITY TO FOLLOW PREVENTIVE MEASURES AGAINST COVID-19

Following the COVID-19 outbreak, public health measures such as physical distancing, wearing face masks and increased handwashing have been promoted by governments and health institutions through many different channels of information. In the ApartTogether survey, respondents were asked about their ability and willingness to follow the different precautions and preventive measures as well as their sources of information about COVID-19.

Following COVID-19 government-initiated preventive measures

Most of the refugees and migrants who took part in the survey took precautions to avoid infection with COVID-19. Increased handwashing, maintaining physical distance and covering nose and mouth were widely followed (Fig. 8). However, respondents indicated that it was difficult to avoid public transport or stay in the home because of their living situation. It was rare that respondents said they did not follow precautionary measures because they did not want to.

Fig. 9 shows regional differences in following the recommended preventive measures. Please note that participants in the survey varied from 1084 from the WHO African Region to 6422 from the WHO European Region. Avoiding the public transport and not leaving the house were reported to be the most difficult preventive measures to be followed.

Sources of information on COVID-19

Access to understandable and reliable information is key to understanding how to protect against infection with or transmission of COVID-19. The survey found that refugees and migrants mainly got information about COVID-19 from the news in the country they are currently living in and that social media is a major source of information. It is noteworthy that more than 40% of the respondents turned to news from their country of birth to inform themselves about COVID-19 (Fig. 10).

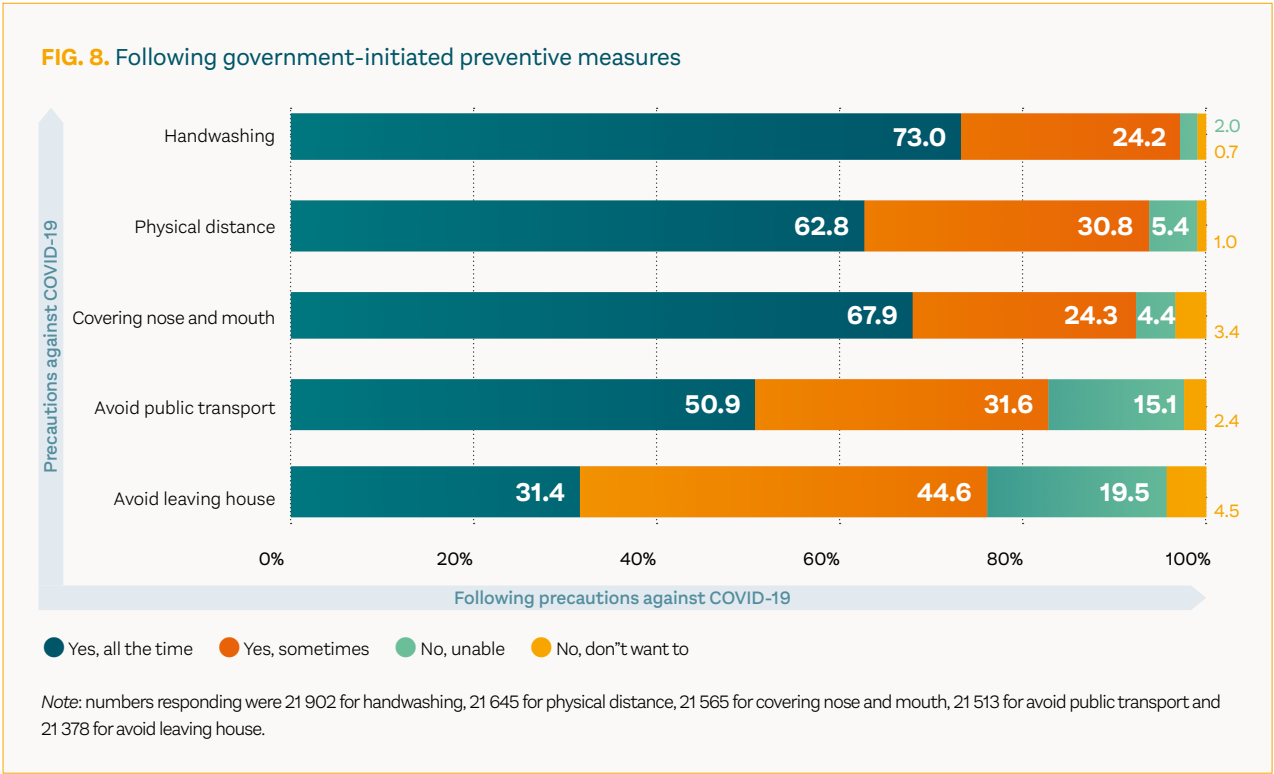
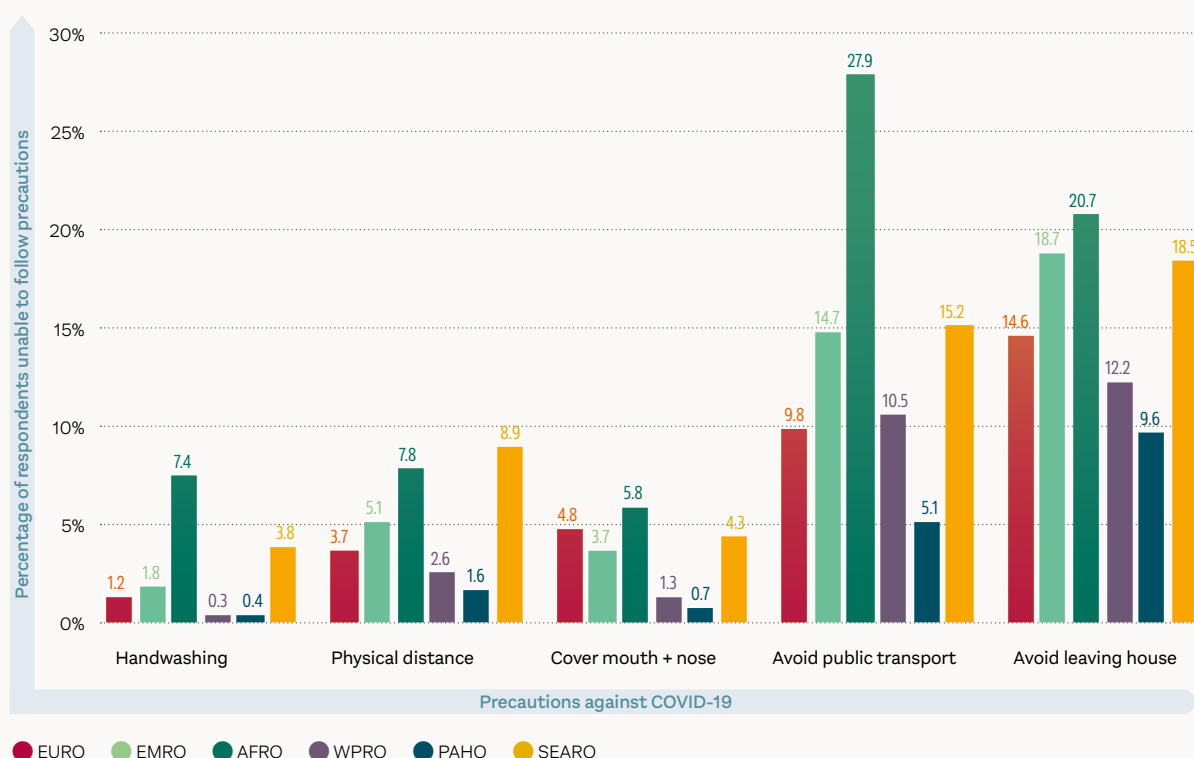
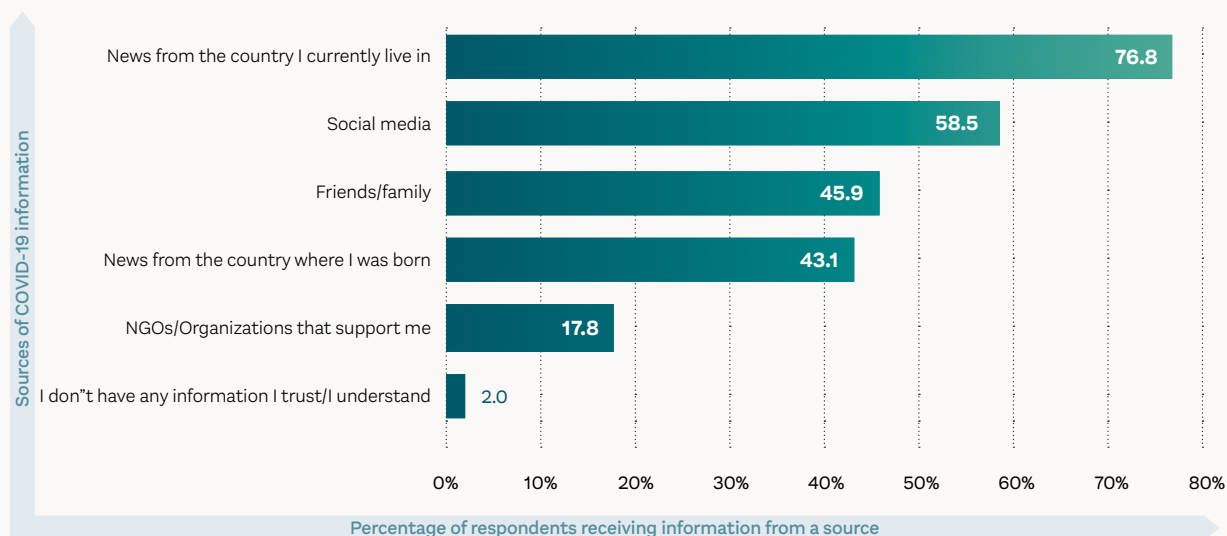


FIG. 9. Percentage of respondents unable to follow public health social measures across WHO regions



Note: total respondents were 21 714 for handwashing, 21 460 for physical distance, 21 380 for cover mouth and nose, 21 328 for avoid public transport, 21 194 for avoid leaving house; number of participants differed by region for each precaution, e.g. for handwashing numbers were 6422 for EURO, 6501 for EMRO, 1084 for AFRO, 3283 for WPRO, 2572 for PAHO, 1852 for SEARO; AFRO: WHO African Region; EMRO: WHO Eastern Mediterranean Region; EURO: WHO European Region; PAHO: Pan American Health Organization; SEARO: WHO South-East Asia Region; WPRO: WHO Western Pacific Region.

FIG. 10. Sources of information on COVID-19



Note: data from a total of 22 649 respondents for each information item; there might be an overlap of category friends/family with that of news from the country where I was born.

PERCEIVED IMPACT OF COVID-19 ON MENTAL HEALTH

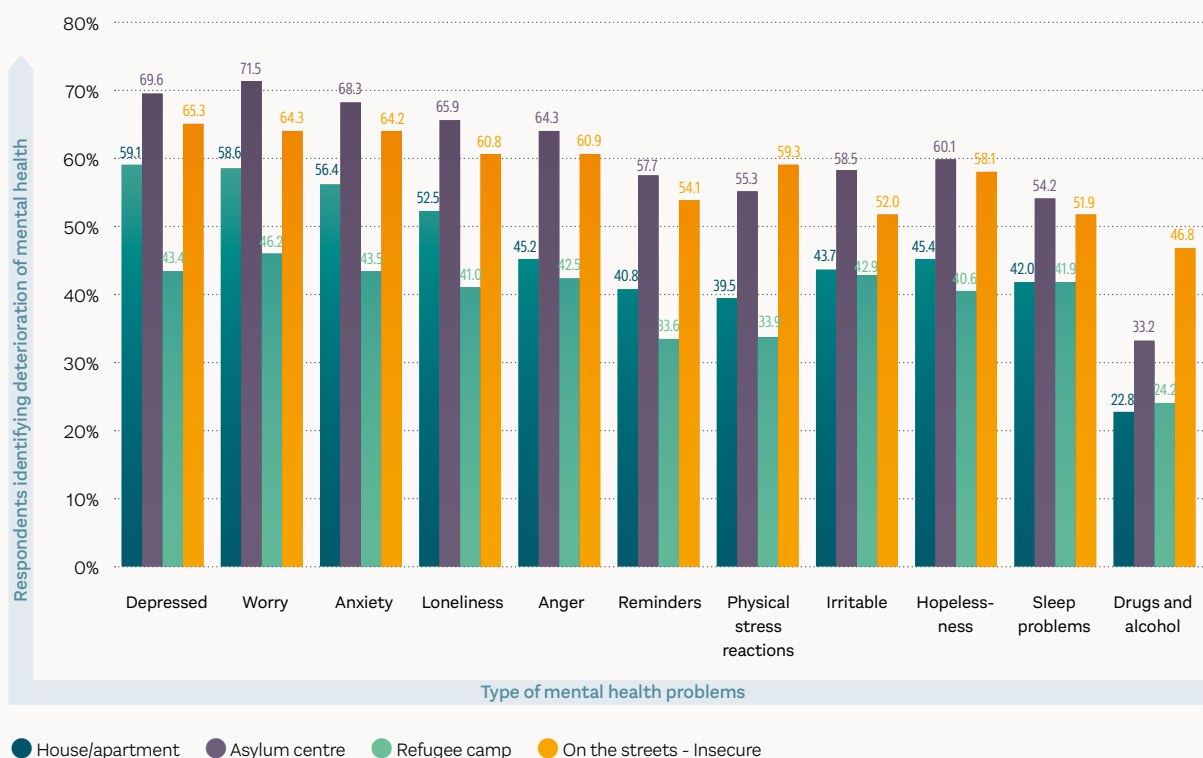
The ApartTogether survey sought information on the mental health status of the refugee and migrants participating in the survey through questions probing whether psychological problems were more present since the outbreak of COVID-19 than before. Among the participants a large proportion of the participants reported perceived worsening of mental health status due to COVID-19. They indicated they were feeling more depressed, worried, anxious, lonely, angry, stressed, irritated, hopeless, having more sleep related problems and used more drugs and alcohol (Fig. 11). Among the participants reporting worsening of their mental health, refugee and migrants living in asylum centres or on the streets were the ones that reported most worsening.

Story of Layla



Layla from Kenya is now living in an asylum centre in Ireland. Layla is a single parent and the COVID-19 pandemic has made her more worried about the future of her children: "Corona virus has affected everyone's way of life. For me, as a single parent seeking asylum, it's very scary because there's the extra added worry of who would look after my kids should I fall sick. The fear can be paralysing. I worry more and stress more."

FIG. 11. Respondents identifying deterioration of mental health since the COVID-19 pandemic according to their housing condition



Note: number of respondents for each issue: 15 272 depressed, 15 475 worry, 15 279 anxiety, 14 731 loneliness, 13 324 anger, 13 463 reminders, 12 350 physical stress reactions, 13 349 irritable, 13 314 hopelessness, 13 231 sleep problems, 8914 drugs and alcohol (survey question used this term); number of participants differed by housing situation, e.g. for safety the numbers responding were 17 736 for house/apartment, 409 for asylum centre, 1392 for refugee camp, 220 for on the streets or in insecure accommodation.



Story of Lili



For the Vietnamese migrant Lili, the biggest consequence of the COVID-19 pandemic has been the feeling of loneliness.

Lili has been living in Denmark for the last two years. After completing her master's degree in the country, she decided to stay and search for a job.

The feeling of loneliness is not solely connected to the absence of her family and friends from her country of origin. "I feel like there is no one I can rely on now. I don't have like a safety net financially," she explains.

Lili's feelings of loneliness and frustrations about COVID-19 are made more severe by the fact that her residence status in Denmark is temporary and that she is unemployed. "I always feel like third class citizen here as a non-EU-citizen. I get no support from the system here or my country, I can't contact them so far," Lili explains.

Story of Abdul



Abdul is a refugee from Afghanistan. He is one of the many refugees with temporary documents living in an Indonesian refugee camp. Abdul is suffering from several health problems and the COVID-19 pandemic has only exacerbated his situation. His mental health is, therefore, under a lot of pressure and he finds it difficult to keep up hope. "I am suffering from stress and depression because of my unknown future. I am living as refugee for six years in Indonesia with lots of health problems and less hope. Corona virus just give me more stress and tension."

EXPERIENCES OF PERCEIVED DISCRIMINATION

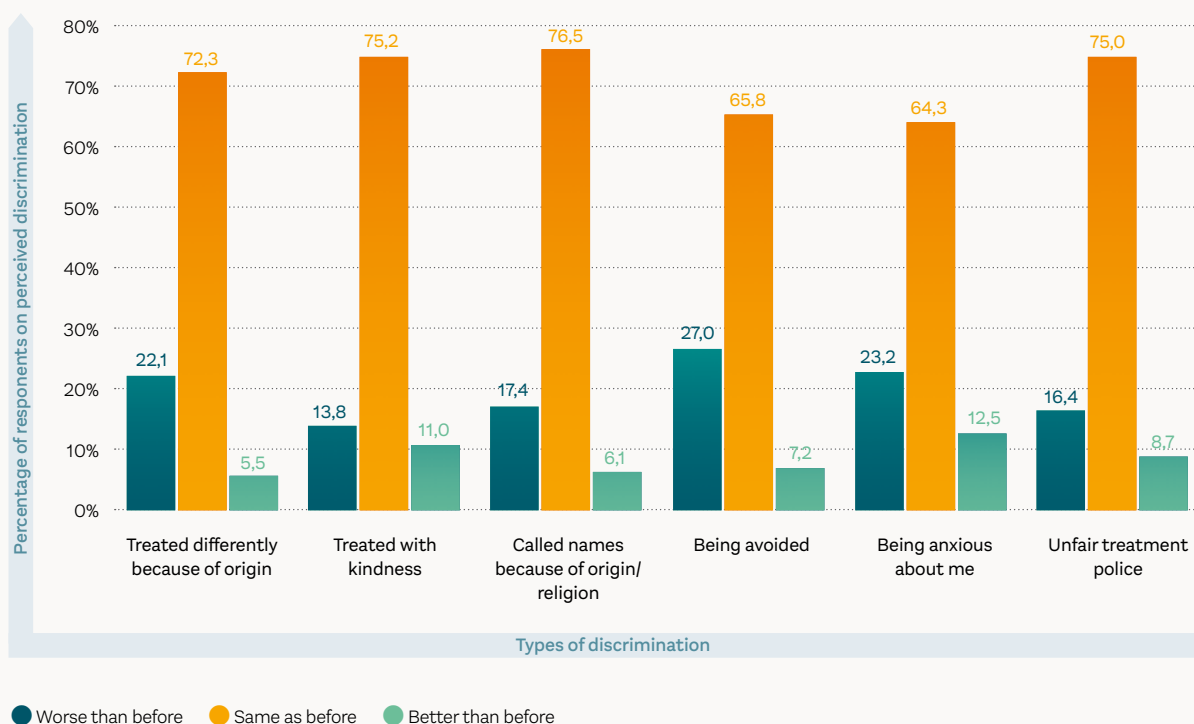
Feeling loss of social support and connectedness with social networks may be exacerbated by the experience of discrimination, which is a major determinant of people's well-being. There have been anecdotal reports in the news and media of discrimination, stigmatization and xenophobia against refugees and migrants around the world since the onset of the COVID-19 pandemic. This section gives some illustrative elucidation as to how refugees and migrants who participated in the survey perceived such discrimination and how COVID-19 further impacted these experiences.

In the ApartTogether survey, respondents were asked whether they were treated worse, the same or better than before the pandemic. While it is positive to note that most participants indicate that they were treated the same, a significant proportion felt that discrimination had worsened in various ways (Fig. 12).

According to the survey such perceived discrimination was particularly felt among the younger age groups (20–29 years of age), where at least 30% of respondents felt that they were treated less well because of their origin (Fig. 13). Please also note that this was the two largest age groups among the participants which might partially explain this outcome.

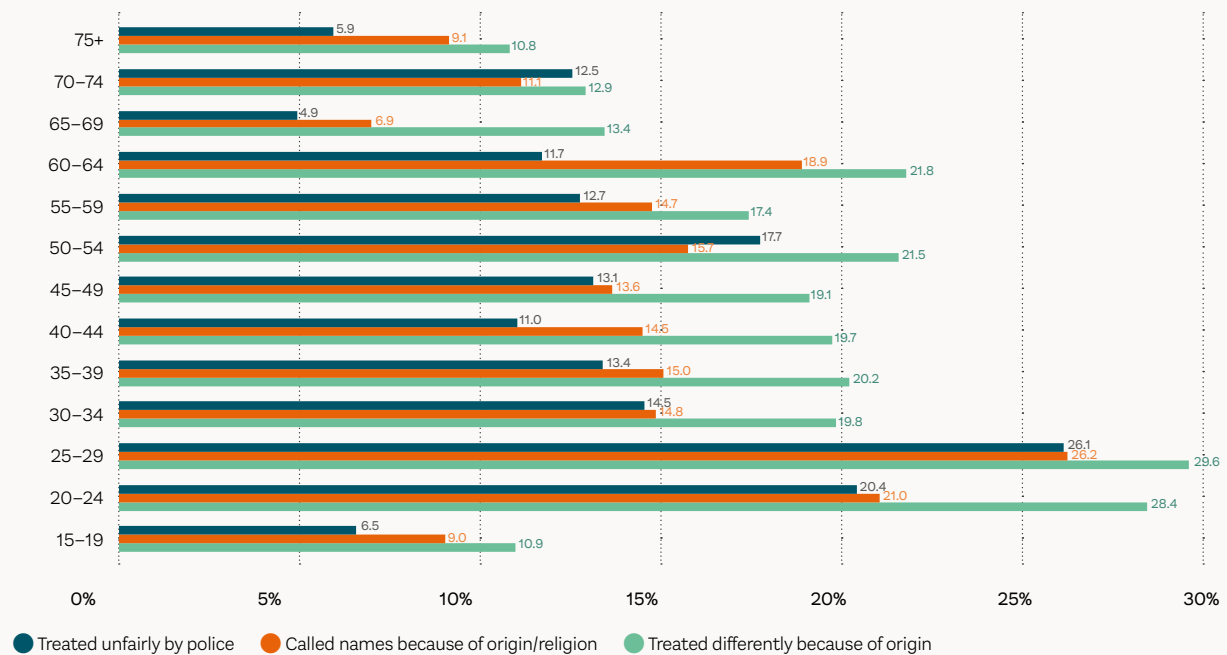
Refugees and migrants living in a house or apartment and in refugee camps were much less likely than others to report increased discrimination since the pandemic (Fig. 14). People living on the street, in insecure accommodation and in asylum centres particularly felt that they were treated worse than before.

FIG. 12. Respondents identifying deterioration of perceived discrimination due to the COVID-19 pandemic



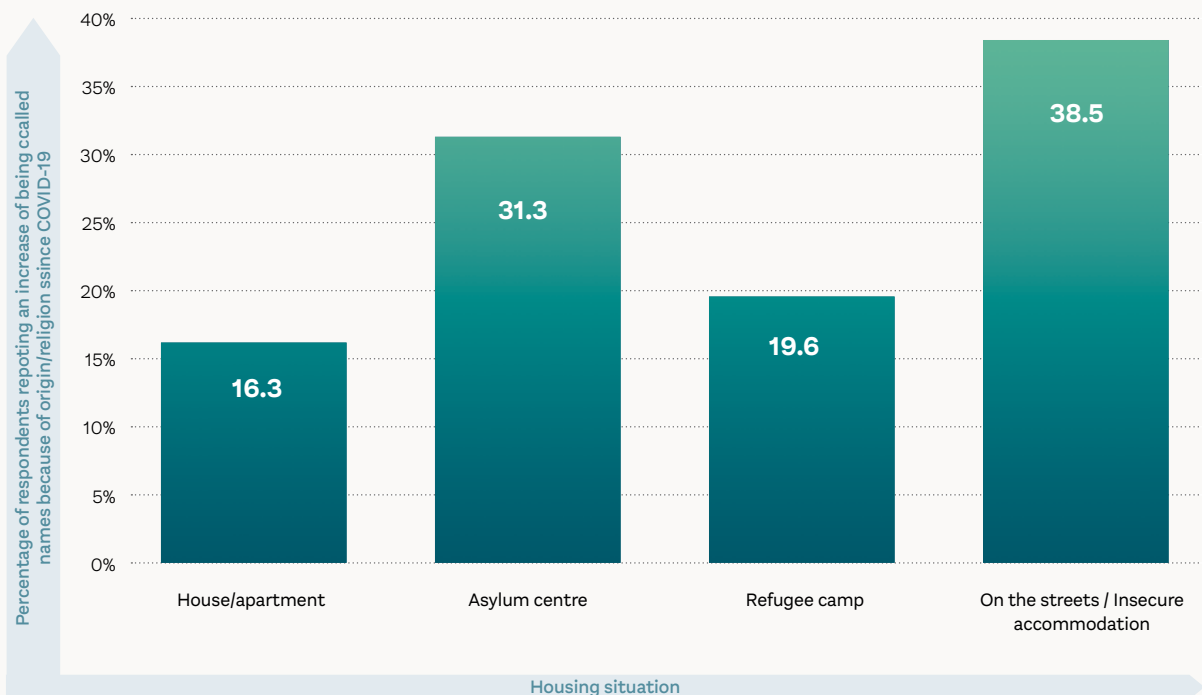
Note: data from a total of 30 558 respondents.

FIG. 13. Worsening of discrimination experienced by respondents because of COVID-19 in relation to their age



Note: data from 25 008 respondents; number of respondents differed across different discrimination items for the age groups, e.g. called names because of origin/religion, numbers were 1101 aged 15–19 years, 2722 aged 20–24 years, 5197 aged 25–39 years, 5473 aged 30–34 years, 3868 aged 35–39 years, 2485 aged 40–44 years, 1566 aged 45–49 years, 1066 aged 50–54 years, 739 aged 55–59 years, 447 aged 60–64 years, 185 aged 65–69 years, 69 aged 70–74 years, 90 aged 75 years and over.

FIG. 14. Respondents identifying deterioration of perceived discrimination according to their housing status



Note: a total of 23 550 respondents related to housing (20 903 house/apartment, 586 asylum centre, 317 refugee camp).

Story of Sam



Sam is a migrant in Greece living on the streets. His living conditions as a homeless person are rough, and during the pandemic he has experienced additional hardship and stigmatization. Sam exemplifies this hardship through his struggles to access lavatories and washing facilities during the pandemic: "Corona has been a nightmare for the homeless as essential services shutdown, and I was not able to access toilets anywhere. I ended up with a urinary tract infection and at the hospital due to the extreme pain. Overall, many people were kind and gave me food or money when they saw me alone on the street; others were very hostile when I wanted to access their toilet in cafes."

Story of Machona



Machona, a male teacher and refugee from the Democratic Republic of Congo living in Uganda, provided an account of how refugees are often blamed for spreading COVID-19. "Discrimination was there before COVID, but it has worsened. Let me give you an example from a settlement that holds almost one hundred and twenty-seven thousand refugees. There are twenty cases confirmed positive. So when people hear that you are a refugee, they think 'so these are the people that are bringing COVID-19 in the host communities'. We are facing such challenges."



PERCEIVED IMPACT OF COVID-19 ON DAILY LIFE

In addition to the social stressors on people's well-being, stressors in the daily living situation may strongly impact the mental health of refugees and migrants. This section documents findings from the survey on how the COVID-19-related government-initiated preventive measures impacted the daily lives of refugees and migrants in the different life domains

At first, respondents were asked how much the COVID-related measures initiated by the government had had an impact on their lives on a scale from 0 (not at all) to 10 (extreme). Participants reported an average of 7.5 on this scale, indicating great impact on the lives of participating refugees and migrants. Fig. 15 shows this for various WHO regions.

The survey also explored how COVID-19 impacted the refugees and migrants in their various matters of life and livelihoods. While in many of the cases, there had been little or no impact among the participants in the survey, it is remarkable to note that in terms of work, safety and financial situation, at least 50% of the respondents considered that they had been impacted by the pandemic (Fig. 16). Acknowledging the inadvertent sampling bias of the survey respondents (see Methodology), this should be alarming as the likely situation among refugees and migrants, might be considerably worse. The survey did capture that

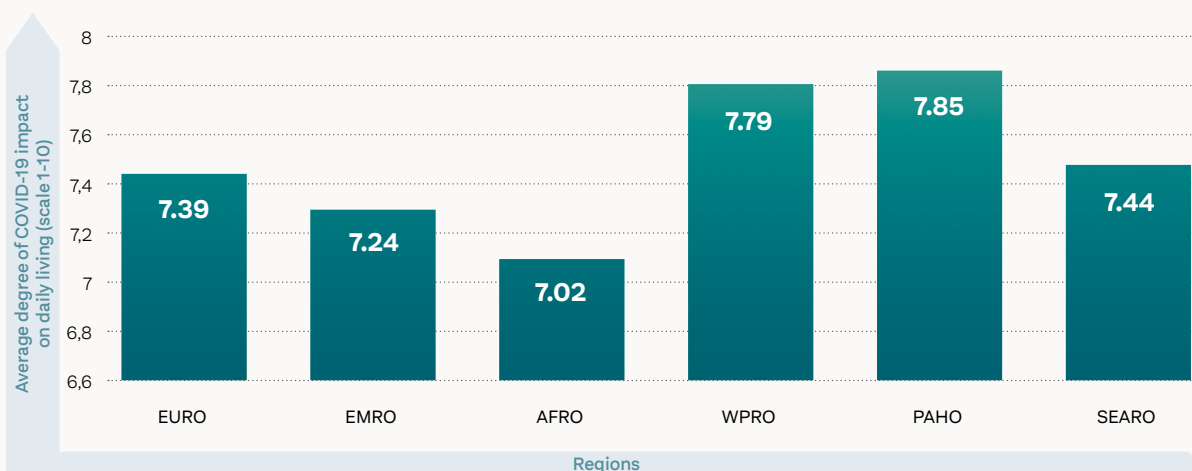
respondents living in asylum centres and on the streets or in insecure accommodation felt that their conditions had considerably worsened more than did those living in houses or apartments (Fig. 17). This requires particular attention of governments, civil society, NGOs and international organizations alike.

Irregular migrants (in the survey terminology "respondents with no documents" or "undocumented"), as Fig. 18 shows, clearly have experienced a stronger impact on their daily living conditions by the pandemic than other groups, especially regarding their access to food, clothes, support from organizations and medical care. In many instances this was a deterioration of 50% or more within this category.

The impacts described here are likely even more pronounced for those living on the street and in insecure accommodation, as would be expected. Refugees and migrants living in such insecure housing situations or in asylum centres reported a strong deterioration of their access to housing, food, access to work, clothing, medical care and support from NGOs (Fig. 17), which is alarming.

The survey also attempted to seek insight as to the strategies that refugees and migrants have used to cope with

FIG. 15. Overall impact of COVID-19 among refugees and migrants across WHO regions

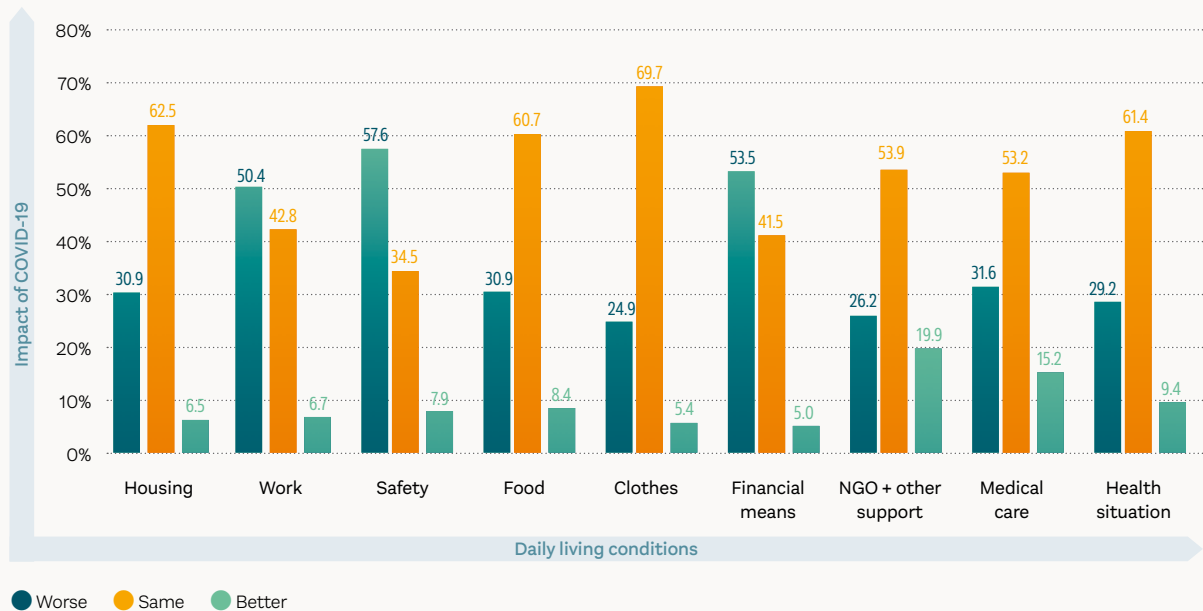


Notes: scale of 1 (not at all) to 10 (extreme); data from 19 587 respondents (938 AFRO, 5857 EMRO, 5782 EURO, 2291 PAHO, 1700 SEARO, 3019 WPRO); AFRO: WHO African Region; EMRO: WHO Eastern Mediterranean Region; EURO: WHO European Region; PAHO: Pan American Health Organization; SEARO: WHO South-East Asia Region; WPRO: WHO Western Pacific Region.

the situation and feel better during the pandemic: Participants frequently mentioned staying in contact with family and friends, keeping oneself busy, entertaining oneself,

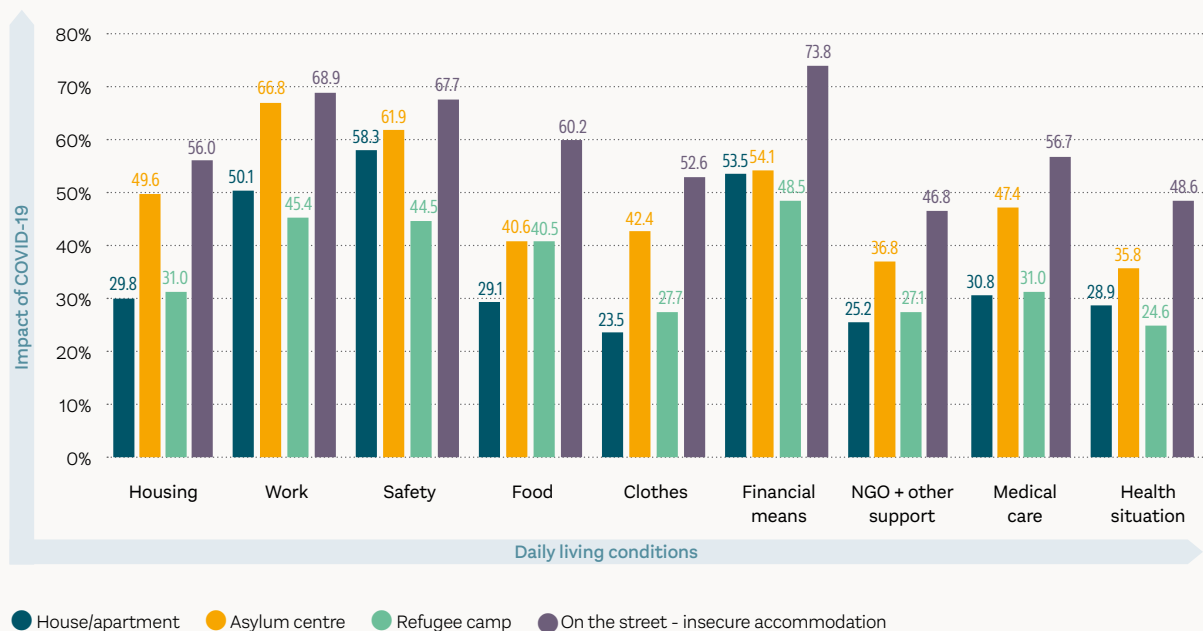
seeking information, and meditating and praying (Fig. 19). This underscores the importance of social connections and the possibilities for finding (reliable) information.

FIG. 16. Respondents identifying being impacted by COVID-19 in various aspects of their daily living conditions



Note: total respondents were 19 951 for housing, 18 783 for work, 20 142 for safety, 19 964 for food, 19 519 for clothes, 20 015 for financial means, 14 020 for NGO + other support, 18 937 for medical care, 19 597 for health situation.

FIG. 17. Respondents identifying deterioration of access to various daily living conditions due to COVID-19 according to their housing situation



Note: total responses 19 574 housing, 18 433 work, 19 757 safety, 19 580 food, 19 142 clothes, 19 642 financial means, 13 739 NGO + other support, 18 576 medical care, 19 230 health situation; number of participants mentioning a deterioration differed with their housing situation, e.g. for deterioration in safety 17 736 lived in house/apartment, 409 lived in asylum centre, 1392 lived in refugee camp, 220 lived on the streets or insecure accommodation.

Story of Kia



Kia is an irregular migrant from Ethiopia. She is pregnant and is living on the streets in a European country. Her situation as an irregular migrant makes it difficult for Kia to receive the medical care that she requires for her health and the health of her unborn child. She worries about the consequences of having the baby soon. "I am six-month pregnant lady with no medical attention and this crisis of coronavirus has a major impact on my baby's life cause my plan was to go to England. Now that's impossible so if I have the baby here, by myself, my child will be illegal too."

Story of Jasmine



Jasmine is a refugee from Pakistan who has been living in Italy for three years with temporary documents. Jasmine is aware of the consequences of not getting a job in Italy or in another European country. A job is her only chance of providing herself with permanent residency status, and COVID-19 has only made this more difficult. She is all by herself with no one to support her and is in desperate need of financial support to maintain her residence permit in Italy. Jasmine explains how the trouble to finding a job is affecting, since she needs a job in order to apply for citizenship: "I am about to lose my housing facilities in the month of August without job and money in hand."





Story of Nicole



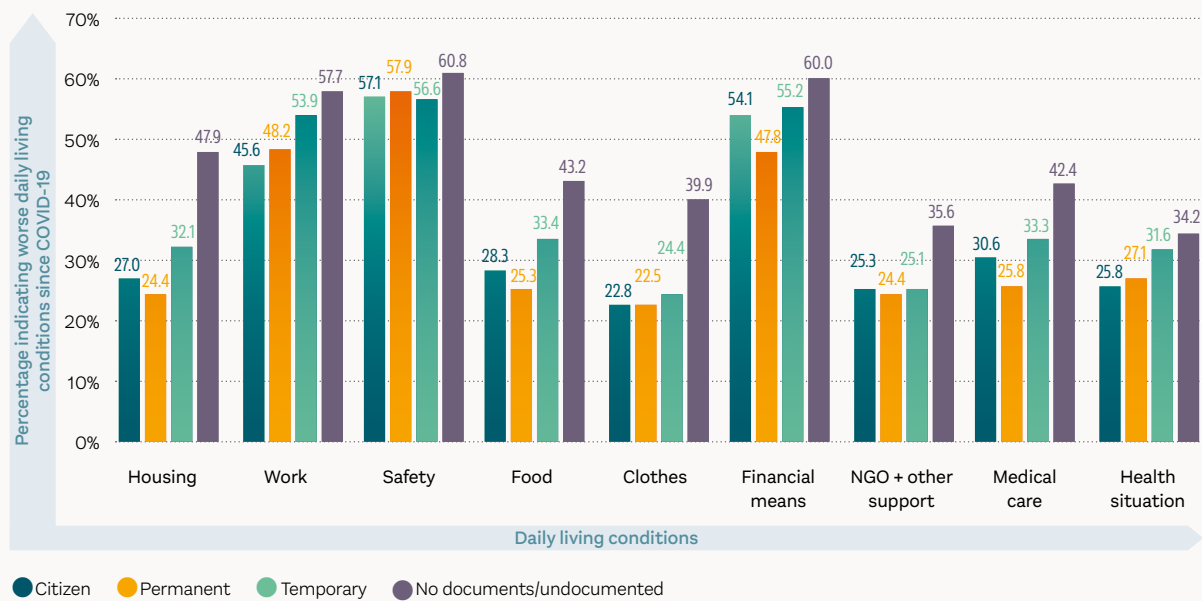
Nicole is a Filipino migrant living in the United States and working as a teacher. She copes with the COVID-19 pandemic by keeping herself busy, focusing on her family and friends: "I keep myself busy like watching movies, listen to a favourite radio station and meditate or pray. If I want to involve my children, I invite them to cook their favourite food," Nicole explains. She also makes sure to check up on friends more frequently than before the pandemic.

Story of Yonas



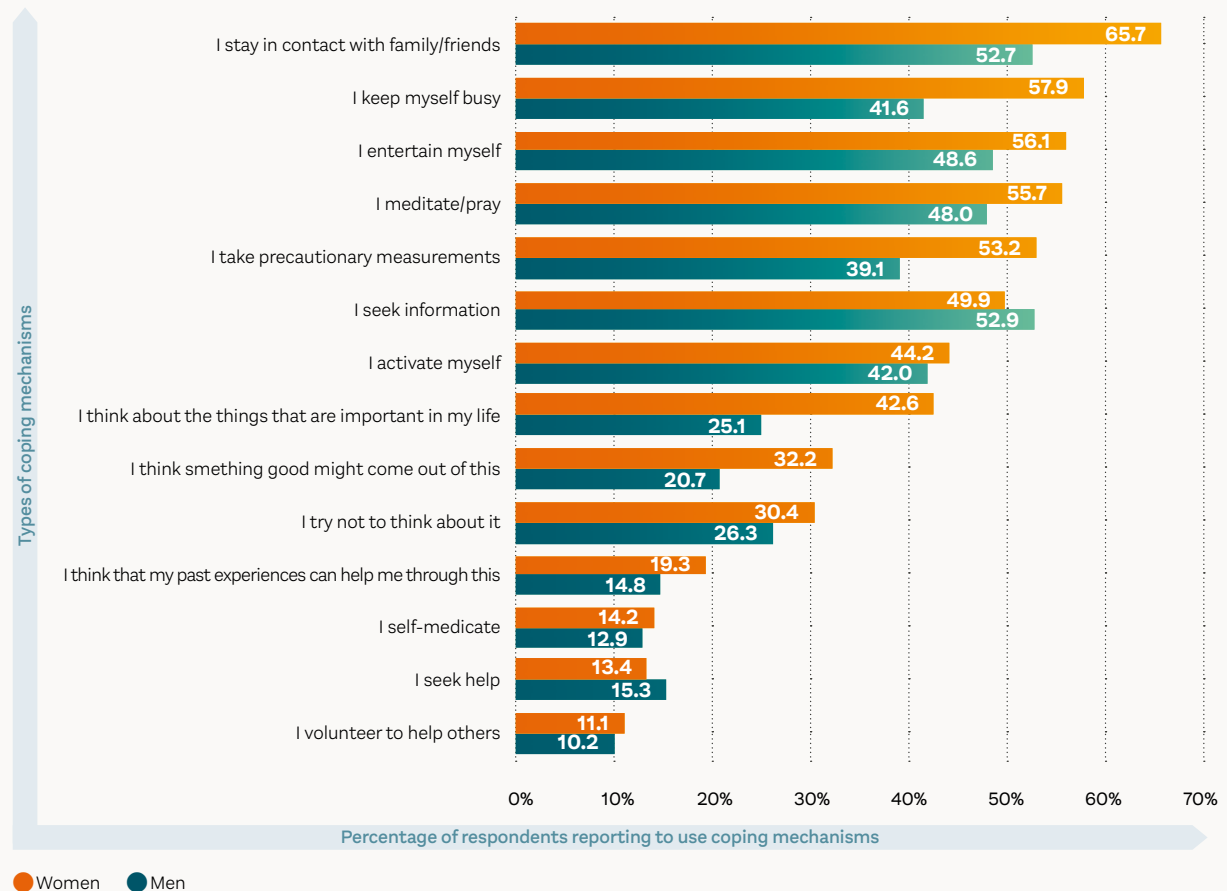
Yonas is from Eritrea and lives in a refugee camp in a European country. According to Yonas, living in the camp is stressful. In addition to his fear of violence, Yonas now also worries about COVID-19. He says: "In here, the situation is not good. Overcrowded camp. No physical distance among refugees. We use the same toilet and shower. Food line about 20 000 refugees."

FIG. 18. Percentage of respondents with deteriorated daily living conditions due to COVID-19 according to their residence status



Note: total respondents were 19 600 for housing, 18 478 for work, 19 795 for safety, 19 611 for food, 19 169 for clothes, 19 671 for financial means, 13 792 for NGO + other support, 18 627 for medical care, 19 296 for health situation; number of respondents varied with housing situation differed, e.g. for deterioration in safety 5776 were citizens, 5190 permanent, 7416 temporary, 1413 no documents/undocumented.

FIG. 19. Strategies that help refugees and migrants to cope with the COVID-pandemic



Note: total respondents 20 685 (including non-binary and trans); 12 147 male, 8521 female.



CONCLUSIONS AND WAY FORWARD

Reduction of barriers to seeking health care for refugees and migrants

This brief survey suggests that refugees and migrants living in insecure accommodation such as in informal settlements would be less likely to seek medical care in case of (suspected) COVID-19 symptoms. For the benefit of both individuals and common public health, it is essential to ensure that everyone can and does access health-care services. The fear of deportation is cited by respondents without documents as a barrier to seeking health care. To overcome this, the needs of and not the legal and/or migratory status of refugees and migrants should inform the medical care they receive; this will realize the goals of universal access to health care and the right to health. Policy and legal principles have been developed to overcome barriers of this type and to remove any linkage between immigration enforcement systems and health-care provision (a so-called firewall). Refugees and migrants in this study also reported that financial constraints would prevent them from seeking health care if they had symptoms of COVID-19.

Public health measures to prevent COVID-19

Most refugees and migrants said they always or often followed precautionary measures. Some, however, highlighted that they had more difficulties in following the measures because of the situation in which they were living. This is not an issue limited to the refugee and migrant populations. But, nonetheless, it shows the specific issues for these refugees and migrants who participated in the survey.

The initial findings from the survey show again that the living situation is an important determinant for mental health and social well-being, as well as discrimination, during this pandemic. Those living on the streets or in insecure accommodation may face a significantly higher impact from the pandemic. Those living in more difficult living situations are also much less likely to be able to follow precautions against COVID-19. Initiatives to improve housing conditions and providing accommodation or shelter for those living on the streets or in insecure accommodation are essential.

Targeted and accessible information for all

Almost 80% of the refugees and migrants who filled out the survey reported that they found information on COVID-19

from news from the country they were currently living in. Moreover, refugees and migrants with lower levels of education appear to be much less informed about COVID-19 and the measures to take, as also were certain age groups.

Information on COVID-19, about what national or local government-initiated preventive measures have been taken and how to protect one's self and others should be widely accessible in every country in multiple languages. It should also be targeted across different sociodemographic indicators using a variety of methods to maximize uptake.

Some subgroups of the refugee and migrant population may be in situations of greater difficulty, such as those living in refugee camps, and those who depend on governments, international organizations and NGOs for information. Results of the survey show the importance of NGOs and organizations supporting refugees and migrants as information providers on COVID-19, particularly for people residing in asylum centres and refugee camps and for irregular migrants. However, COVID-19 measures have resulted in reduced services and fewer staff present, leading to reduced possibilities for interacting with staff and acquiring information on COVID-19. Adequate initiatives should, therefore, be taken to ensure access to information, culturally and linguistically, for all refugee and migrant groups, including for those depending on information from NGOs and other organizations.

Combat discrimination

Many refugees and migrants reported a perceived increase in discrimination since the pandemic. Governments have a responsibility to address discrimination and stigmatization and should actively focus on sensitization campaigns to prevent these. Sufficient attention should be given to tackling these issues because of their potential impact on individuals' health and well-being. Countries should ensure that discriminatory practices towards refugees and migrants are discouraged.

Improve daily living conditions

The pandemic has created increasingly difficult living conditions for all, but particularly for certain groups of refugees and migrants and those living in more precarious situations, such as in insecure accommodation or as irregular

migrants. Policy measures for the general population need to consider the living and working situation of these groups in order to minimize the detrimental impact of certain measures.

Provision of psychological support during and after the pandemic

The pandemic has a considerable impact on the mental health of refugees and migrants. Refugees and migrants living on the streets or in insecure accommodation face particular mental health difficulties and require additional support compared with those who living in less disadvantaged conditions in order to deal with the high increase in mental health problems. Adequate and accessible psychological support is required, but also measures to tackle other factors that may impact their mental health, such efforts to improve their housing or working conditions and their social connectedness.

Foster connectedness

COVID-19 and the public health and social measures to manage and curb the pandemic have seriously impacted the connections of refugees and migrants with their social networks, in particular networks in the country where people are currently living.

Pandemic response plans of governments should pay due attention to the decrease in connectedness that refugees and migrants are confronted with. Fostering relationships of refugees and migrants with their social networks is crucial to avoid isolation and loss of connectedness. The most important strategy mentioned by refugees and migrants to make them feel better was staying in touch with family and friends. It is, however, often difficult for them to do so due to the circumstances they live in. Important measures, therefore, need to be taken to support and maintain social support networks.

These initial findings from the survey also show the importance of social media as an information source for many refugees and migrants. Many organizations have shifted to an online accessibility and information provision. Given the limited means many refugees and migrants have, their resources for Internet connection are likely limited, and improving this situation should be a priority.

Participation of refugees and migrants

The WHO Constitution strongly advocates the right to health for all. This must include refugees and migrants, a view expressed in WHO's Global Action Plan, Promoting the

Health of Refugees and Migrants, which is aligned with the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration.

Refugees and migrants should not be treated differently in society as that may hamper their basic human rights and rights to health. Targeted and needs-based approaches to programmes and interventions, including those for refugees and migrants, will ensure this. Refugees and migrants should not be left behind and should be included in public health actions in response to the pandemic and in the efforts to advance the goal of universal health coverage.

This survey was part of a response to the call for information on the impact of COVID-19 on refugees and migrants across the world. The survey has had some methodological and implementation limitations, as discussed above, but despite these, it provides a glimpse into the challenges faced by refugees and migrants at a global level. Further systematic studies exploring the issues highlighted in this report are needed. The value of the survey and this advocacy brief is to provide elements for a better understanding of living conditions of refugees and migrants and the various socioeconomic and public health impacts they face during the COVID-19 response, to advocate for leaving no one behind and for providing universal health care to all including all refugees and migrants irrespective of their status and origin. This is enshrined in the WHO transformation and the principles of the triple billion target: promote health, keep the world safe and serve the vulnerable.

The ApartTogether survey capturing self-reported impact of COVID-19 on refugees and migrants sheds light on some of the challenges faced by the target groups. Notwithstanding the methodological limitations, the information presented in this advocacy brief gives indications on the areas that need to be prioritized for further research and policy implementation. For example, additional data are needed to answer questions regarding the specific vulnerabilities and health impacts that are additionally created by COVID-19 disaggregated for refugees and migrants, how this manifested among the various income quintiles within these population groups and so on. This will be critical in the development of targeted interventions and, consequently, impactful programme delivery on the ground.

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HIGHLIGHTS

- ▶ The 30 000 refugees and migrants – be it refugees, people seeking international protection, internally displaced people, internal migrants, international migrants for various reasons, returnees or people stranded due to COVID-19 situations, irregular migrants and stateless people – who participated in the survey indicated that the pandemic has had a significant impact on their access to work, safety and financial means, as well as on their social and mental well-being. Overall on a scale of 0 to 10 (1 being no impact, and 10 the worst), nearly three quarters of the respondents indicated that COVID-19 impacted them at a scale of 7 or higher.
- ▶ Respondents living on the streets or in insecure accommodation and in asylum centres and irregular migrants reported suffering the worst impact of COVID-19 on their daily lives and were less likely to seek care for suspected COVID-19-symptoms. Over a quarter of the respondents without any schooling indicated that they wouldn't seek medical care even when they had COVID-19 symptoms.
- ▶ Of those who indicate not seeking health care, 35% of the survey respondents report financial constraints prevent them from seeking health care, and a further 22% fear of deportation.
- ▶ Refugees and migrants participating in the survey highlighted significant impact on their mental health conditions – at least 50% of the respondents across various parts of the world indicated that COVID-19 brought about greater level of depression, worry, anxiety and loneliness.
- ▶ One in five respondents also expressed deterioration of mental health in terms of increased use of drugs and alcohol.
- ▶ Refugees and migrants also experienced significant discrimination. Again, respondents living in asylum centres or living on the streets and in other precarious conditions, such as those on unpaid work or sent home without pay, indicated being affected the worst in terms of perceived discrimination – highest prevalence among those living on the streets or insecure accommodation – 40% of those belonging to this group that participated in the survey.
- ▶ Refugees and migrants should be included as full residents and as part of the solution in response plans.
- ▶ Policy and legal principles and practice should delink immigration enforcement systems from health-care provision.
- ▶ Public health measures to prevent COVID-19 should encompass fully refugees and migrants.
- ▶ Poor housing and working conditions should be tackled.
- ▶ This perception survey provides better understanding of living conditions of refugees and migrants during COVID-19 response to advocate for leaving no one behind and for providing for the most vulnerable within the WHO principles of the triple billion target: promote health, keep the world safe and serve the vulnerable.