

Health of refugees and migrants

Situation analysis and practices in
addressing the health needs of
refugees and migrants: Examples of
public health interventions and
practices

WHO Eastern Mediterranean Region
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ACRONYMS AND ABBREVIATIONS

AWD	Acute Watery Diarrhoea
BAFIA	Bureau for Aliens and Foreign Immigrants' Affairs
BPHS	Basic Package of Health System
CP	Child Protection
COE	Challenging Operating Environments
CRC	Convention on the Rights of the Child
CTCs	Cholera Treatment Centres
DHIS	District Health Information System
DTC	Diarrheal Treatment Centre
EPI	Expanded Programme on Immunization
EWARS	Early Warning and Response System
IDP(s)	Internally Displaced Person(s)
IEC	Information, Education and Communication
IERs	Interactive Electronic Reporting System
IHEK	Inter-Agency Health Emergency Kits
IHIO	Iran Health Insurance Organization
IMC	International Medical Corps
INGO(s)	International non-governmental organization(s)
IOM	International Organization for Migration
HEAR	Helpline Egyptians for Asylum Seekers, Migrants and Refugees
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
MER	Middle East Response
MHPSS	Mental Health and Psychosocial Support
MMU	Mobile medical units
MOH	Ministry of Health
MoHME	Ministry of Health and Medical Education
MoPH	Ministry of Public Health
MWH	Midway House
MWTF	Migrant Worker's Task Force
NCD(s)	Non-communicable disease(s)
NGO	Nongovernmental organization
NMCP	National Malaria Control Program
ONARS	Office National d'Assistance Aux Refugies et Refugies
PHC	Primary Health Care
PSTIC	Psychosocial Services and Training Institute Cairo
RAHA	Refugee-Affected and Hosting Areas
SARA	Service Availability and Readiness Assessment
SGBV	Sexual and gender-based violence
SOPs	Standard Operating Procedures
TB	Tuberculosis
TSPs	Trauma Stabilization Points
UHC	Universal Health Coverage
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNHCR	United Nations High Commission for Refugees
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency
UPHI	Universal Public Health Insurance
WASH	Water Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization
YMCA	Young Men Christina Association

WHO Eastern Mediterranean Region

EXAMPLES OF PUBLIC HEALTH INTERVENTIONS AND PRACTICES IN ADDRESSING THE HEALTH OF REFUGEES AND MIGRANTS

To achieve the vision of the 2030 Sustainable Development Goals – to leave no one behind – it is imperative that the health needs of refugees and migrants be adequately addressed. In its 140th session in January 2017, the Executive Board requested that its Secretariat develop a framework of priorities and guiding principles to promote the health of refugees and migrants¹. In May 2017, the World Health Assembly (WHA) endorsed resolution 70.15 on ‘Promoting the health of refugees and migrants’². This resolution urges Member States to strengthen international cooperation regarding the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants. It urged Member States to consider providing the necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants, as well as using the Framework of priorities and guiding principles at all levels. In addition, the resolution requested the Director-General to conduct a situation analysis and identify best practices, experiences and lessons learned in order to contribute to the development of a global action plan for the Seventy-second WHA in 2019.

Building on the WHA resolution 70.15, the WHO Eastern Mediterranean Region has developed a position paper ‘Promoting the health of refugees and migrants and a plan of action to address the public health needs of forcibly displaced populations and migrants’. The document provides an understanding of what the right to health requires and the real public health needs of these vulnerable and marginalized populations as well as determining how to implement the framework of priorities and guiding principles to promote the health of refugees and migrants. The Regional position highlights key challenges regarding migration and forced displacement throughout the region and offers strategies for optimal short and long-term regional solutions.

In alignment with WHA resolution 70.15, WHO made an online call from August 2017 to January 2018 for contributions on evidence-based information, best practices, experiences and lessons learned in addressing the health needs of refugees and migrants. This generated 57 inputs covering practices in 17 Member States in the Eastern Mediterranean Region; these were received from Member States and partners such as the Office of the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration (IOM) and the International Labour Organization (ILO). The submissions included valuable information on the current situation of refugees and migrants, health challenges associated with migration and forced displacement, past and ongoing practices and interventions in promoting the health of refugees and migrants, legal frameworks in place for addressing the health needs of this population, lessons learned and recommendations for the future.

Based on the contributions and taking into account the twelve areas of the WHO framework of priorities and guiding principles in promoting the health of refugees and migrants, the following practices that respond to these areas are highlighted.³ In addition, the report’s accompanying document highlights practices in the Region that include efforts to address the health needs of refugees and migrants. The information received from Member States and partners in response to the aforementioned WHO global call for contributions was examined and compiled in the

¹ EB Decision 140(9) on Promoting the Health of Refugees and Migrants

² WHA70.15 on Promoting the Health of Refugees and Migrants

³ For more practices and further detail of each practice, please see the compendium of practices in addressing the health needs of refugees and migrants.

accompanying document – practices in addressing the health of refugees and migrants in the Region of the Eastern Mediterranean.

1. Promoting right to health, and mainstreaming refugee and migrant health in the global, regional and national policies, planning and implementation

In **Djibouti**, refugees' access to health care has been primarily provided by international non-governmental organizations (INGOs) and refugees job opportunities have been restricted to the informal sector where refugees worked as domestic workers, fishermen, restaurant staff or labourers. On 5 January 2017, the Djibouti Head of State, President Ismail Omar Guelleh, promulgated the national refugee law adopted by the Djibouti Parliament in December 2016. The law ensures a favourable protection environment for refugees and enables them to enjoy their fundamental rights, including the inclusion of access to services and socio-economic determinants such as education, health, employment and naturalization.⁴

In **Jordan**, the large influxes of Syrian refugees into the country have overshadowed other refugee populations. Refugees from Iraq, Somalia, Yemen and other countries became less visible in Jordan with donors, as most funding has been provided in response to the Syrian humanitarian crisis. The Jordan response plan (2018 – 2020) adopts a resilient-based approach by integrating humanitarian and development responses. The response is aiming to bridge the division between responding to short-term needs and addressing mid- to long-term institutional fragilities. The plan seeks to respond and mitigate the effects of the Syrian crisis on refugees, vulnerable Jordanians, host communities and institutions.

In **Lebanon**, the Ministry of Public Health (MoPH) provides primary health care (PHC) services through its centres for every person residing in Lebanon at minimal personal contributions of the costs. In addition, the MoPH provides free vaccinations for displaced persons in all its centres and at border and registration sites, coordinates with donors and NGOs for the effective distribution of funds within the PHC system, provides mental health services under the national mental health programme with the support of the World Health Organization (WHO), United Nations International Children's Emergency Fund (UNICEF) and the International Medical Corps (IMC), and supports Syrian displaced persons with chronic medication through the Young Men Christina Association (YMCA). The tertiary care provided by the Lebanese public and private hospitals uses financial support from UNHCR and other non-governmental organizations (NGOs) for displaced Syrians.

In **Pakistan**, the government signed a cooperation agreement with UNHCR in 1993 and generally accepts UNHCR decisions to grant refugee status and allows asylum seekers to remain in Pakistan pending identification of a durable solution, granting them temporary legal residency, freedom of movement and access to essential services, including health.

The occupied Palestine territory including east Jerusalem: Advocating for the right to health

CONTEXT: The population of occupied Palestine including east Jerusalem was estimated at 4.7 million. The division of the West Bank and Gaza Strip has been particularly disruptive for the functioning of the Palestinian health system. Palestinians face complex bureaucratic impediments in

⁴ Information from the UNHCR partner submission.

trying to reach health facilities. Unrestricted access to medical care is crucial for patients and is a fundamental element of the right to health.

PRACTICES: Collaborative efforts are ongoing between the WHO Regional Office for the Eastern Mediterranean and the United Nations Relief and Works Agency (UNRWA) to support and strengthen health services for Palestine refugees. These efforts mainly focus on joint advocacy for the right to health of Palestinians under occupation and on supporting the integration of mental health services into PHC within the framework of the family practice approach. WHO, through its right to health advocacy project, has examined the scope of the complex bureaucratic impediments facing Palestinian patients in trying to reach medical facilities.

Results: The data and analyses have been presented in monthly and annual evidence-based advocacy reports. Health access in the occupied Palestinian territories including east Jerusalem (oPt incl eJ) has been raised at the World Health Assembly and through human rights reports to the highest governing bodies in the United Nations and has made recommendations to the duty bearers to realize the right to health.⁵

2. Promoting refugee- and migrant-sensitive health policies, legal and social protection and interventions to provide equitable, affordable and acceptable access to essential health services for refugees and migrants

In **Morocco**, the health status of the sub-Saharan migrant population has been a matter of concern for many years. The Ministry of Health (MOH) has undertaken several initiatives to safeguard migrants' right to access health services. In 2003, a ministerial circular allowed migrants to receive free preventive and curative care from the communicable diseases control (CDC) programmes, and in 2008, the MOH expanded free access to all services provided at PHC centres.

In **Pakistan**, the Government of Pakistan worked in collaboration with UNHCR to develop the 2014 - 2018 five-year health strategy. The strategy prioritizes the most vulnerable refugees by mainstreaming them into the national health system. Implementing this strategy will allow easy access for refugees to the preventive and curative programmes such as national programmes on tuberculosis (TB), malaria, human immunodeficiency virus (HIV), hepatitis, family planning and PHC, expanded programmes on immunisation (EPI) and programmes for non-communicable diseases.

In **Sudan**, efforts that have been in place for few years have finally paid off through a high-level agreement to include urban refugees within the same health insurance scheme that the national citizens receive. Including refugees in the health insurance scheme started with a pilot project covering the whole Yemeni population that was registered. The plan will also expand to cover different nationalities in urbanized settings. The country-wide coverage of the health insurance card may help refugees to move freely between states looking for business and employment opportunities without worrying of access to health services.

The Islamic Republic of Iran: Health insurance for refugees

CONTEXT: The Islamic Republic of Iran has provided asylum for refugees for nearly four decades and is currently host to one of the largest and most protracted urban refugee situations in the world. There are an estimated 3.5 million Afghans residing in Iran, including registered refugees, passport

⁵ WHO. (2016). Right to health. Crossing barriers to access health in the occupied Palestinian territory. Online. Available from <http://applications.emro.who.int/docs/Coun_pub_doc_2017_EN_19900.pdf?ua=1> (accessed 9 May 2018).

holders and undocumented Afghans. Since many Afghans arrived around 35 years ago, a lot of Afghans are second or third generation. According to the last registration phase that was completed in mid-2014, the government estimates that 951,142 Afghan refugees and 28,268 Iraqi refugees reside in Iran. Approximately 97 percent of them live in urban and semi-urban areas, while the remaining 3 percent reside in 20 refugee settlements that are managed by the Bureau for Aliens and Foreign Immigrants' Affairs (BAFIA) of the Ministry of Interior. Working towards ensuring refugees have the same access to health services as the host population, UNHCR complements the efforts of the MOH and Medical Education (MoHME) in providing PHC services to all refugees.

PRACTICE: Universal public health insurance (UPHI) is a government-run initiative between BAFIA, UNHCR Iran and the Iran health insurance organization (IHIO), in close coordination with the MoHME. UPHI offers all registered refugees the possibility to enrol and benefit from a comprehensive health insurance package similar to that available to Iranians. UPHI covers hospitalization, para-clinical and outpatient services, including doctor's visits, radiology, lab tests and medication costs incurred at any MOH-affiliated hospital and/or pharmacy. Complementing the Government of Iran's generous contribution, UNHCR's support covers 100 percent of the premium costs for 110,000 of the most vulnerable refugees, including those with special health conditions and their family members. The remaining refugee population enrolls in exactly the same healthcare package by paying the full premium (approximately US\$ 11 per month) to receive their booklet, which provides 12 months insurance coverage. This initiative improves refugees' access to health care and addresses their financial challenges in relation to the cost of healthcare services, reducing out-of-pocket expenses.⁶

3. Addressing the social determinants of health such as water, sanitation, housing, and nutrition

In **Egypt**, in 2017 approximately 10,744 Syrian families per month received unconditional cash grants to help with purchasing essential goods. In addition, the Micro, Small and Medium Enterprise Development Agency through its partnership with local NGOs in Alexandria is implementing a cash for work programme, which aims to provide job opportunities for unskilled workers whilst also improving public health services and waste management.⁷

Morocco, traditionally an emigration and transit country, is also fast becoming a country of destination. The country has integrated refugees and migrants into the state subsidized social housing programmes. Furthermore, refugee and migrant children can pursue their education within the public-school system and can be beneficiaries of housing loans granted by credit institutions to low-income and refugees and migrants. Refugees and migrants are also granted the right to employment.

In **the occupied Palestine territory including east Jerusalem Palestine**, rooftop gardens provide access to fresh organic produce, create safe educational spaces, and develop capacity for sustainable livelihoods via urban agriculture models. Furthermore, it is an investment into the continually deteriorating environment of the camps given poor infrastructure, lack of permits for repairs, and vulnerability to systematic violence. The gardens are creating capacities for women, youth and children to engage with green and organic food production methods. The gardens also have the potential to generate incomes for refugee and migrant communities through the development of sustainable and green spaces.

⁶ UNHCR. (2017). Iran factsheet. Online. Available from <<https://reliefweb.int/sites/reliefweb.int/files/resources/Iran%20Factsheet%20July%202017%20-%20Final.pdf>> (accessed 9 May 2018).

⁷ Information from Country online survey related to the livelihood sector response and from the Regional Refugee and Resilience Plan 2017 progress report <http://www.3rpsyriacrisis.org/wp-content/uploads/2017/10/3RP-Progress-Report-17102017-final.pdf>

Sudan is one of the main host countries for refugees fleeing conflict in South Sudan. As of 15 January 2018, more than 770,000 South Sudanese refugees were registered in the country, of which nearly 200,000 arrived in 2017. WHO is supporting the government to scale up screening and management of malnutrition, providing medicines and supplies as well as building the capacity of health and nutrition workers, as well as key federal and state nutrition directors through training in nutrition literacy.

Yemen: Integrated water, sanitation and hygiene (WASH) response

CONTEXT: Kharaz camp, which is a temporary home to some 16,000 people of whom almost half are children, is mainly populated with Somali refugees. It is situated in a remote location in Lahj governorate. The provision of health services including WASH activities in the camp benefits both refugees and the local populations.

PRACTICES: WASH activities include water chlorination, frequent water testing, vector control and waste management, the distribution of hygiene kits, jerry cans and chlorine tablets, in addition to the use of hygiene promoters to inform communities on the importance of cleanliness and how to reduce the spread of disease. Furthermore, UNHCR supported preparedness for potential cholera cases through the rehabilitation and isolation of a ward in the camp clinic as well as the establishment of a diarrhoea treatment centre (DTC), enhanced infection prevention control including further training of medical staff on case management, disseminated WHO guidance and best practices, and coordinated with authorities including the surveillance department at the district level.

Results: Increased access to clean water, both in terms of quantity and quality, with some 2600m³, or 696,847 gallons of water distributed weekly for the families in the camp. A further 1,800m³ of clean water was disbursed to the police station, health centre, schools, mosques, warehouses and power station within the camp weekly.⁸

4. Enhancing health monitoring and health information systems

In **Afghanistan**, the MoPH, in collaboration with WHO and IOM and its displaced tracking matrix, launched a monitoring and reporting system within the MoPH's control and command centre. The system aims to allow the most up-to-date information on mass population movements and to facilitate an early and quick response to provide much needed health services to displaced populations. The reporting system also aims to register attacks on and closure of health facilities, in order to enable rapid response to conflict-affected populations that are deprived of healthcare services.

In **Egypt, Libya, Morocco, Tunisia, and Yemen**, IOM has implemented a regional programme on migrant health promotion and assistance since 2015. While activities are tailored to each country context, regional engagements allow participating stakeholders and actors to come to the table to discuss best practices, challenges and ways forward. Overall, this programme has supported innovative responses to health monitoring and information management in emergencies and in crisis settings whereby national health systems have collapsed or are not equipped. In more stable settings such as in Morocco and Tunisia, going forward will involve crosscutting thematic programmes supporting the national authorities to operationalize existing or developing policies that seek to improve migrants' health. During a regional dialogue, national authorities from the relevant countries advocated to include migration as a priority in all public policies (for instance

⁸ United Nations High Commission for Refugees submission to WHO.

education, justice, security, social), since the health and wellbeing of migrants do not rely on public health measures alone. Health interventions require a multidisciplinary approach, involving different ministries working together to promote integrated and complete care for migrants.

In **Jordan**, since 2015, public health surveillance has been done through an innovative national programme called the interactive electronic reporting system (IERS), being implemented across Jordan with WHO's support. IERS introduces case-based, integrated disease surveillance to be used by clinicians within the consultation, and provides clinical decision support, as well as best practice prescribing guidance and real-time reporting of information. Modules for communicable disease, non-communicable disease, mental health, pandemic influenza preparedness, foreigner screening and event-based surveillance have been developed and implemented within IERS. Outcomes for healthcare access and utilisation, communicable and non-communicable diseases have been monitored through IERS, including for refugee populations living in Jordan. A specific module on foreigner screening is included to monitor the status of TB, HIV and Hepatitis B among refugees.

Lebanon continues to show exceptional commitments and solidarity to displaced persons from Syria. As of October 2017, UNHCR registered almost one million Syrian refugees along with almost 300,000 Palestinian refugees in Lebanon. In 2017, WHO supported the development of an information technology (IT) platform (DHIS2), which was established in a selected number of health facilities. WHO is currently supporting the MoPH in the platform's expansion. The goal of the platform is to target all PHC centres within the MoPH networks as well as laboratories and hospitals and some private clinics and schools, reinforcing the 50 existing surveillance sites and establishing 246 new sites, and to provide support to staffing, logistical support, IT equipment and technical support.

In the **Syrian Arab Republic**, millions of refugees and IDPs are living in poor conditions in overcrowded camps, greatly increasing the risk of the rapid spread of communicable diseases. WHO has strengthened and expanded the disease surveillance and response system (EWARS). EWARS supports the early detection of and response to highly contagious childhood diseases such as polio and measles, helping avert their further spread.

Libya: Health service availability and readiness assessment (SARA)

CONTEXT: Libya experiences one of the most complex mixed migration situations in the world. According to the displaced tracking matrix, in November 2017 there were 192,762 IDPs and 435,574 migrants in Libya. However, the real number of migrants is estimated to be over 700,000 across the country. Fragmented government, widespread insecurity, collapsed economy, long porous borders and disrupted social services are the main contributors to the migration challenges in Libya. The health of migrants is a major concern due to difficult and dangerous journeys to or through Libya, which makes many migrants vulnerable to poor health on their way to destination or detention. Poor living conditions, inappropriate nutrition and lack or difficult access to preventive and curative health services may put these migrants at serious health risks. The risks are compounded for those living in detention centres due to extremely poor living conditions. Many people tragically die during the journey. The health system of Libya has been severely affected by the crisis and the increased pressure on national capacity from the additional population who require health care.

PRACTICES: To assess the readiness of Libya's health sector to deliver healthcare to the population, the Libyan MOH and WHO conducted a health service availability and readiness assessment (SARA) in 2017.⁷

Results: Results of the SARA survey showed that 17 percent of hospitals, 20 percent of PHC facilities and 9 percent of other specific service facilities were not closed. There is also an imbalance of health workers and shortages of medicines, equipment and diagnostic materials. Overall the service availability and readiness of the specific and specialized services were below the target. Conversely, the target on workforce density, facility density and maternity bed density were well achieved.

Lessons learned: The repeated emergencies have not allowed for a proper recovery of public sector health services. The SARA findings recommended investing in health system strengthening to be able to respond to the needs of Libyan people, refugees and migrants.

5. Providing universal health coverage and equitable access to quality essential health services, financial support and protection, and access to safe, effective, quality and affordable essential medicines and vaccines for refugees and migrants

In **Afghanistan**, in 2017, there were approximately 489,000 undocumented Afghan people returning home from neighbouring countries. These undocumented returnees face significant difficulties in accessing social services and consequently often experience significant poverty. Under the basic package of the health system (BPHS) in Afghanistan, the whole population, including migrants, returnees and displaced persons, are ensured adequate access to essential health services. The BPHS is a strategy for the implementation of PHC by outsourcing BPHS service delivery to NGOs. The BPHS is mandated to provide equitable access to healthcare services to all Afghans, including IDPs, regardless of their documentation status.

In **Jordan**, most Syrian refugees live in Jordan's disadvantaged communities where rents are affordable or in tented settlements rent-free in return for labouring on local farms. With limited work opportunities and depleted savings, the coping strategies may negatively affect their children who, as a result, often dropout from education. As a result, these children are all-too-often compelled to work or forced to marry. To address these risks the government of Jordan has implemented a Cash+ programme, which is a comprehensive package of social protection interventions for vulnerable families. Families receive an unconditional cash transfer per child per month to contribute towards the child expenses. Monitoring results have shown that the cash transfer has allowed families to increase spending on their children's schooling and health. Cash+ programmes are an example of ways to connect humanitarian responses to long-term development goals.⁸

In **Sudan**, since August 2016 over 36,000 cases of acute watery diarrhoea (AWD) and/or cholera have been recorded and 820 deaths have occurred across all 18 states, especially affecting vulnerable groups such as refugees and migrants.¹¹ WHO supported the MOH response through providing technical and operational support to 89 cholera treatment centres (CTCs) in states hosting refugees from South Sudan, treating over 13,000 cases of AWD in refugee populations, and providing medicines, medical supplies and operation cost for staffing and referral. In addition, MOH

⁷ WHO. (2017). Libya health emergencies and humanitarian update. Online. Available from <<http://www.who.int/hac/crises/lby/libya-health-situation-report-june-july2017.pdf>> (accessed 9 May 2017).

⁸ UNICEF. (2017). Beyond borders report. Online. Available from <https://www.unicef.org/publications/files/UNICEF_Beyond_Borders_Nov_2017.pdf> (accessed 9 May 2018).

¹¹ Information collected from WHO Submission.

supported by WHO, UNHCR and health partners conducted a preventative oral cholera vaccination campaign covering approximately 140,000 South Sudanese refugees.

Lebanon: Access to primary healthcare for refugees, displaced and vulnerable nationals

CONTEXT: A high proportion of refugees are living within local communities (only 17 percent live in transit centres) and have the same access to health care as Lebanese nationals. Refugees and migrants have access to the national PHC system network. Lebanon has around 1000 PHC centres, of which 220 are government facilities and 700 are NGO clinics¹², in addition to an unidentified number of informal practices and/or health rooms.

PRACTICES: In identified facilities, displaced Syrians and vulnerable Lebanese persons have access to subsidised care at PHC level. The current package includes consultation, laboratory and diagnostic tests for pre-defined vulnerable groups, free vaccinations, free acute and chronic medication as well as two free ultrasounds for pregnant women. The MoPH developed a set of standards for these centres to become PHC centres under the PHC network. In parallel, displaced Syrians can access PHC services through mobile medical units (MMU) which provide consultations, dispense medication free of charge and refer patients back to PHC centres. The MoPH also provides free of charge immunisation services for displaced populations in its centres and at the border and registration sites.

Results: Around 207 centres are currently considered under the PHC network and receive support from MoPH to fully provide all the PHC services regardless of nationality. Data collected from 207 supported PHC centres regarding Syrians from 2013 - 2017 showed the total number of beneficiaries 140,114; paediatric services: 279,613; antenatal care services: 100,087; family planning services: 49,357; dental and oral health services: 91,504; cardiovascular services: 33,168; distribution of chronic medications: 204,119; distribution of non-chronic medications: 770,726.¹³ 72.5 percent of persons registered as refugees by UNHCR received vaccinations at PHCs.¹⁴

Lessons learned and way forward: Without further support, the country infrastructure may not be in a position to hold the additional responsibilities. This may lead to the potential deterioration of the quality of services. Strengthening the infrastructure of the country in all areas is very much needed, keeping in mind that refugees have their rights to return back home safely. MoPH continues to encourage all partners working on PHC to work with PHCCs within a MoPH network. There is a need to strengthen the roles of MoPH at regional and local levels to coordinate activities at the region and district levels in reaching larger populations. In addition, it is essential to enhance the roles of municipalities in planning and implementation and empower them to address social determinants of health, particularly nutrition, shelter, livelihood, water, sanitation and hygiene.

6. Providing humanitarian assistance and long term public health interventions to reduce mortality and morbidity among refugees and migrants including addressing communicable and non-communicable diseases

In **Afghanistan**, 36 percent of IDPs and returnees in Afghanistan are diagnosed with life-threatening non-communicable diseases (NCDs). However, addressing this need has often been overshadowed by more urgent cases of trauma and outbreaks. In 2017, WHO, together with the Afghan Red Cross, began to supply essential medicines and supplies for NCDs as part of the emergency response for

¹² UNHCR. (c. 2016). Lebanon crisis response plan 2017 – 2020. Online. Available from <<http://www.3rpsyriacrisis.org/wp-content/uploads/2017/01/Lebanon-Crisis-Response-Plan-2017-2020.pdf>> (accessed 9 May 2018).

¹³ Information collected from an online questionnaire submitted in 2017 by the Ministry of Public Health.

¹⁴ WHO (2016), Expanded Programme on Immunization (EPI) 2016 Cluster survey, Lebanon.

IDPs and returnees. The overall response strategy is also strengthening the capacity of frontline workers through new training on how to recognize, assess and treat NCDs.

In **Jordan**, support for coordination and provision of basic health services was provided at the “Berm” spontaneous settlement through the UN clinic for asylum seekers located at the North Eastern border of Jordan. Three vaccination campaigns have been conducted since December 2017. SIA(EVC) using bOPV and vitamin A for Syrian asylum seekers at the Berm using trained Syrian health care workers with an estimated coverage of 80%. By end of 2017, a total of 10,592 Syrian children (between 0 – 15 years) have been vaccinated. In addition, a total of 5,254 children between 6 – 59 months received vitamin A supplementation. Furthermore, WHO purchased inter-agency health emergency kits (IHEK) covering 10,000 people for three months.

In **Lebanon**, the MoPH, with continued support from WHO, has initiated the NCDs screening protocol to be adapted in all its centres. The initiative targets individuals 40 years and above and aims to screen people for any risks of cardiovascular disease and provide treatment as needed. MoPH has provided the point of care testing machine and strips to support the NCD initiative for Lebanese and non-Lebanese people. In addition, MoPH provides free vaccination for displaced persons in all its centres and on border sites and on registration sites.¹⁵

In **Somalia**, the MOH in collaboration with IOM, is deploying a mobile and rapid response team adaptable for all aspects of the development, humanitarian, transition and recovery phases of migration. This approach also caters to mobile, migrant and cross-border populations. It will be able to monitor populations on-the-move and to provide services that are adaptable to migration flow. In the Somali context, this is the most notable for the IDPs in the country.

Iraq: Primary health care, trauma care and referrals for conflict-affected population

CONTEXT: Although major military operations concluded in late 2017, the humanitarian crisis in Iraq is far from over. The toll of four years of intensive combat on Iraq’s civilian population has been enormous. It is anticipated that 2018 will see a significant return of IDPs from displacement sites to areas of origin and return.¹⁶ However, many people in Iraq remain displaced and vulnerable and will still require assistance when they return home.

PRACTICES: The Ministry and Directorates of Health continue to provide assistance to IDPs. In 2017, WHO supported this effort through a mobile network of 69 mobile clinics and 96 ambulances. In particular, mobile health services are being used to target hard-to-reach populations with healthcare and immunisation services. WHO led the health cluster emergency response to the Mosul Operation, most of which occurred during 2017. A highlight of the response was the effective manner in which trauma management services, including first-aid, triage, stabilization of cases and referrals were carried out.

Results: The health cluster was able to address the needs of 25,000 people through Trauma Stabilization Points (TSPs) and field hospitals that followed the shifting front-lines in active conflict. Additionally, the health cluster was able to ensure the provision of a comprehensive package of PHC services including treatment of common diseases, vaccination, nutrition screening referral and treatment of children, reproductive health services to women, communicable disease surveillance and management, referrals of complicated cases (both emergency and non-emergency), physical rehabilitation, mental health and psychosocial services, and awareness raising campaigns to those in

¹⁵ Information collected from an online questionnaire submitted in 2017 by the Ministry of Public Health.

¹⁶ IOM. (2017). DTM Iraq, Rounds 84, November 2017

need at all points along the population displacement route, including mustering/screening sites, IDP camps and among host communities.⁹

Syrian Arab Republic: Responding to acute and chronic needs of refugees and IDPs

CONTEXT: Seven years of conflict has driven almost 12 million people from their homes. Millions of refugees and IDPs are now living in camps. The poor conditions including overcrowding in the camps makes them a site with high-risk of the spread of communicable diseases. More than half of the country's hospitals and PHC centres are only partially functioning or have been damaged beyond repair.¹⁰

PRACTICES: In 2017, WHO worked to improve the health of refugees, migrants and IDPs by strengthening the provision of essential primary and secondary health care services across Syria. WHO has also focused its efforts on supporting outreach health care for refugees and IDPs in camps, settlements and hard-to-reach areas. In addition, WHO provided direct technical and financial support to seven partners providing healthcare services in IDP camps and donated medicines, supplies and equipment to help maintain essential services in hospitals and other health care facilities throughout Syria. These efforts benefited all segments of the population, including refugees, migrants and IDPs.

Results: In 2017, with the support of WHO 16 mobile medical clinics conducted almost 400,000 consultations, distributed almost 14 million treatments and supported over 560,000 trauma cases across the country. Over 21,000 patients were referred for treatment through the strengthened referral system. The organization donated 689 pieces of medical equipment (anaesthesia machines, operating theatre equipment, intensive care unit beds and other equipment) to help keep hospitals and clinics functioning.

7. Protecting and improving the health and well-being of women, children and adolescents living in refugee and migrant settings

In **Jordan**, the Government continues to provide an essential service package free of charge to eligible refugees, which includes counselling, antenatal care, family planning and vaccinations.

Lebanon: The protracted nature of the Syrian crisis has overstretched the capacity of the education system. Thousands of vulnerable school-aged children are in need of education assistance. The health sector continues to support the efforts of the Ministry of Education and Higher Education/MoPH/WHO school health programme to improve adolescent and youth health. The programme reached 1,200 schools in 2017. It incorporates activities that contribute to a healthy environment such as health education, opportunities for physical education and recreation and programmes for counselling, social support and mental health promotion.¹⁹

Pakistan: UNHCR, following the Convention on the Rights of the Child (CRC), is providing specific assistance of girls and boys through community activities aimed at gender equality and promotion and prevention of gender-based violence. The Refugee-Affected and Hosting Areas (RAHA) programme is in place, aiming to increase the resilience of the refugee communities. The programme is building the capacity of community midwives in Afghan refugee villages and the surrounding hosting areas.

⁹ Information collected from WHO submission.

¹⁰ WHO. (2017). Syrian Arab Republic. Annual report 2017. Online. Available from <<http://www.who.int/emergencies/crises/syr/syria-who-annualreport2017.pdf?ua=1>> (accessed 9 May 2018).

¹⁹ UNHCR. (c. 2016). Lebanon crisis response plan 2017 – 2020. Online. Available from <<http://www.3rpsyriacrisis.org/wp-content/uploads/2017/01/Lebanon-Crisis-Response-Plan-2017-2020.pdf>> (accessed 9 May 2018).

United Arabs Emirates: Protection of women victims of human trafficking

CONTEXT: In the United Arab Emirates (UAE), Abu Dhabi and Dubai are two of the cities with a high prevalence of HIV cases. These are the biggest cities in the UAE, a country with a very large migrant population. These cities also have significant sex work activity as well as incidences of human trafficking. Sex workers are among the populations most at risk of infection due to difficulties in practicing 'safe sex'. This population also faces challenges in accessing treatment and care services due to the illegality of their work, fear of social rejection and/or hierarchical power relations.

PRACTICES: In 2006, the Dubai police established a General Department of Human Rights to help strengthen protection of women who are victims of sex work trafficking and to provide them with HIV prevention and testing services. This department was initially conceived as a short-term intervention, however has since become part of the ongoing institutional and organizational structure of the police force. The department disseminates information, education and communication (IEC) materials to expatriates in various locations, including at HIV-testing centres (translated into their own languages). It seeks to link persons in need to HIV-testing and drug-treatment services. It also helps identify cases of sex work-related human trafficking.²⁰

Results: Since its establishment, the department has identified around 50 new cases of sex work-related human trafficking per year. It has linked persons in need to key health service providers, such as HIV-testing and drug-treatment services.

8. Promoting continuity of care for refugees and migrants, in particular for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, mental health and other chronic health conditions as well as those with physical trauma and injury

In **Egypt**, in some areas of Greater Cairo, a community-based psychosocial workers network is providing culturally-relevant psychosocial and mental health support to Syrian refugees. This project was implemented by a partner of UNHCR, Terre des Hommes, through the Psycho-Social Services and Training Institute in Cairo (PSTIC).²¹

Iraq is integrating mental health into the PHC services²² of refugee camps through building the capacity of the non-specialised health workforce. This capacity includes the assessing and managing priority mental health conditions under supervision of mental health professionals (psychiatrists) and strengthening non-specialized mental healthcare provision. This is being achieved through piloting psychological interventions that can be delivered by non-specialist community workers and healthcare staff and by establishing referral pathways between mental health and psychosocial support (MHPSS) actors, and PHC units in refugee camps.¹¹

In **Jordan**, emergencies in neighbouring countries, especially Syria and Iraq, have placed a strain on Jordanian national infrastructure, resources and services, including health and mental health care. However, the situation has also provided an opportunity to strengthen the mental health system and services in Jordan, given the increasing need and demand for mental health services by the local and refugee populations. WHO has been supporting the Government of Jordan since 2008 on

²⁰ ILO. (2016). Promoting a Rights-based approach to Migration, Health and HIV and Aids: A Framework for Action; International Labour Office 2016

²¹ Information collected from an online questionnaire submitted in 2017 by UNHCR.

²² UNHRC. (2017). Iraq, Syrian refugee statistics. Online. Available from <<https://data2.unhcr.org/en/documents/download/59159>> (accessed 9 May 2018).

¹¹ Information collected from an online questionnaire submitted in 2017 by UNHCR.

integrating mental health into the PHC system. This system is now widely distributed, encompassing all governorates including peripheral areas.

In **Morocco**, as part of the activities of the national tuberculosis control programme of the Ministry of Health, a national TB screening campaign was organized from 24 March to 28 April 2017 in collaboration with partners and thematic migration associations. Furthermore, 5,553 migrants were tested for HIV through the national programme for the prevention of sexually transmitted infections and AIDS, with the support of NGOs. Through similar partnerships and collaborations, a total of 12,013 migrants were exposed to HIV prevention.

In the **Syrian Arab Republic**, prolonged exposure to violence has left many refugees, migrants and IDPs susceptible to profound distress. WHO has supported the scaling up of MHPSS services by training healthcare staff and community health workers on basic mental health interventions and supporting the integration of MHPSS into primary healthcare centres. Over 400 primary health care and community centres throughout Syria are now offering integrated MHPSS services.

Middle East response to HIV, tuberculosis (TB), and malaria²⁴

CONTEXT: In January 2017, the Middle East Response (MER) programme was initiated. It is an innovative multi-country approach supported by the Global Fund aiming to deliver the continuum of care in challenging operating environments (COE), through the provision of essential HIV, tuberculosis and malaria services. The interventions are geared towards addressing the needs of key populations and other vulnerable groups, including IDPs, refugees and people in hard-to-reach areas in Syria, Yemen as well as to Syrian and Palestinian refugees in Jordan and Lebanon. The grant was signed for the period 2017 - 2018, with a total of US\$ 33 million.

PRACTICES: HIV, TB and malaria are not prioritized in COEs where overloaded health systems and scarce resources are directed in provision of only basic health services. To address this challenge, the MER offers a new and innovative approach where the IOM, in the capacity of a principal recipient to the Global Fund's financial allocations, manages a consolidated grant that covers the four aforementioned countries through a single management platform based in IOM Jordan. It provides greater value for money by bringing together the Global Fund's investments and combining the three disease programmes as well as supporting the strategic regional partnerships when delivering health services in hard-to-reach areas within the COEs. The MER interventions are prioritizing non-interruption of diagnosis and prevention of stock-outs, as well as treatment and prevention of the three diseases among the key and vulnerable populations (defined by geographical and hard-to-reach areas with a high proportion of people in need). The MER's approach also involves more flexible implementation arrangements, which allow adjustments to programmes as the country context changes.

Results

In **Jordan**, 21 percent of Syrian refugees live in camps while 79 percent live in urban, peri-urban and rural areas. Most of these people are dispersed across the country, frequently changing locations, and living in insecure, even inaccessible areas near the Syrian border. This makes TB diagnosis, treatment and follow-up challenging. The main focus of MER interventions is in four priority governorates of Amman, Irbid, Mafraq and Zarqa, where most refugees and migrants stay and where the refugee camps are located. IOM with sister UN agencies supports the national TB programme in Jordan to detect and treat cases amongst refugee populations. The programme also includes TB awareness-raising, active case finding with symptom screening, mobile X-ray and Xpert testing in refugee camps, hard-to-reach areas and urban communities by community health workers and mobile medical units. IOM facilitates referrals, diagnostic tests and hospitalization. To address

²⁴ Information collected from IOM submission to WHO.

additional caseloads, MOH TB centres are supported with diagnostic equipment, consumables, TB drugs and additional staff.

In **Yemen**, an estimated 60 to 78 percent of the population live in malaria risk areas, with roughly 25 percent located in high risk areas (>1 cases in 1000), mainly concentrated on the western side of the country (Tehama Region). Al Hudaydah and Hajjah are the two governorates with the greatest areas at high risk of malaria transmission. Low altitude areas of Saada and Taizz and pockets along the western edges of Al-Mahweet, Raymah and Lahj are also known to be areas of relatively high risk for malaria transmission. IOM, under MER, has already distributed 450,000 long lasting insecticidal treated mosquito bed nets through mass distribution campaigns targeting the highest priority districts in the governorates of Lahj, Ibb and conflict prone Taiz. The campaign also includes health promotion and awareness building in the community for proper use of the bed nets, focusing on pregnant women, children, the elderly, IDPs, refugees and migrants. Local communities have been trained and sensitized regarding prevention of malaria and proper use of mosquito nets. The distribution campaign was coordinated through governorate health directorates and the national malaria control programme.

Lessons learned and ways forward: By seeding these activities across the four countries, MER is helping to prevent and contain outbreaks of diseases. The programme is bringing a new perspective in managing public health programmes in COEs by implementing highly focused interventions and helping to close the gap between the key and vulnerable populations' needs and the availability of health services. The MER programme is serving important needs in the context of COEs by providing continuous treatment and essential preventive services, and by aligning its interventions with the national preventive programmes and ensuring their role as the leading providers of services.

9. Promoting workers' health including occupational health safety in work places where refugees and migrant workers are employed, in order to prevent work injuries and fatal accidents

In 2009, **Jordan** became the first country among the Arab States to amend its labour code to provide protection for domestic workers. This legislative amendment provided a foundation for legally recognizing and protecting the rights of domestic workers, many of whom are female migrant workers. To render the legislation effective, information was disseminated to raise employer and worker awareness on the new protections and on consequences of violations. Complaint mechanisms have also been established to enforce these initiatives. Tougher enforcement mechanisms are aiming to enhance the accountability of recruiters and employers, according to their statutory and contractual obligations with regards to domestic workers.²⁵

Lebanon: Protecting domestic workers

CONTEXT: Lebanon hosts at least 200,000 migrant domestic workers, primarily from Bangladesh, Ethiopia, Nepal, the Philippines and Sri Lanka. As in many countries, migrant workers in Lebanon often face difficult and poor working conditions. The sponsorship system that controls foreign labour in Lebanon warrants that migrant workers who leave or quit their employers lose their residency status, no matter whether departure is for cause of abuse or contract violations.

PRACTICES: The Migrant Worker's Task Force (MWTF) is a grassroots volunteer organization advocating for improved treatment and social advancement of the migrant worker community in

²⁵ ILO. (2016). Promoting a Rights-based approach to Migration, Health and HIV and Aids: A Framework for Action; International Labour Office 2016

Lebanon, with significant efforts dedicated to increase health awareness. The MWTF offers peer education sessions on sexual and reproductive health (encompassing modules on female and male anatomy, menstrual cycle and masturbation, hygiene, sexually transmitted infections, HIV/AIDS and protection). In collaboration with AltCity.me, it organizes “health day” events that provide an occasion for migrants to receive a general check-up and undergo voluntary HIV tests. In the waiting rooms, patients are exposed to slide shows and informational sessions on health issues, including on protection and treatment of sexually transmitted infections such as HIV. The MWTF also helps to put in place a referral system with doctors and free access to clinics for migrants who cannot obtain affordable health care in Lebanon.²⁶

10. Promoting gender equality and empowering refugee and migrant women

In **Jordan**,²⁷ under the auspices of the child protection (CP) and the sexual and gender-based violence (SGBV) sub-working group, the United Nations Population Fund (UNFPA), UNHCR, the United Nations Children's Fund (UNICEF), Save the Children International, and the International Rescue Committee (IRC) launched the inter-agency CP and SGBV awareness-raising ‘Amani campaign’. In Arabic, Amani means "safety" or "to feel safe." The campaign is an important component of the inter-agency strengthening SGBV and child protection services and systems project, which also includes the inter-agency emergency standard operating procedures (SOPs) on CP and SGBV, and the development of CP and SGBV case management training tools and training programmes. A guide was developed, including posters, which have been distributed among refugee populations with key messages for communities, children and parents on how to better protect children and adults from harm and violence. Syrian refugee girls have created animation videos on harassment and early marriage with the support of IRC and UNFPA. The videos were presented at the 2nd women's film week in Amman on March 15, 2014. The animation videos are now used as a prevention tool in camps and outside.

Lebanon: Addressing violence against women and girls

CONTEXT: In August 2013, the Lebanese NGO named ‘ABAAD’, a resource centre for gender equality, established the Al-Dar Emergency Midway House (MWH) to provide safe, temporary shelter to survivors and those at risk of SGBV. There are now three MWHs administered by ABAAD in Lebanon.

PRACTICES: The MWHs provide emergency shelter, case management and referrals to tailored services, including medical services, psychosocial and legal assistance, vocational training and language classes. Each MWH shelters as many as 20 women and their children, including boys aged 12 and younger, for a maximum of two months. More than 65 percent of the SGBV survivors in the MWHs are refugee women. The shelters are the first of their kind in Lebanon designed to serve women and girls from both the refugee and the host community. Male SGBV survivors, including men and boys between the ages of 12 to 18, are referred to a select number of separately administered shelters that welcome them, such as Mission De Vie and UPEL. The mothers of boys in the shelters are encouraged to visit them to keep family ties strong.

Results: Since their establishment more than three years ago, the MWHs have hosted more than 400 women, girls and boys.

²⁶ ILO. (2016). Promoting a Rights-based approach to Migration, Health and HIV and Aids: A Framework for Action; International Labour Office 2016

²⁷ Save the Children. (2014). "AMANI" CAMPAIGN LAUNCHES CHILD PROTECTION AND GENDER BASED VIOLENCE KEY MESSAGES'. Online. Available from <<https://jordan.savethechildren.net/news/amani-campaign-launches-child-protection-and-gender-based-violence-key-messages>> (accessed 9 May 2018).

Lessons learned and ways forward: It is important to build and maintain relationships with the surrounding community to gain support for the work of the shelter and to increase security and inclusion. A close working relationship with the police and other security providers is essential to prevent and respond to any security incident. The location and layout of the shelter is important to its success: Survivors need open spaces to improve their wellbeing. The MWH structures and services need to adapt to work with survivors with disabilities. Accommodating survivors with psychosocial disabilities can be challenging and sometimes risky. There is a need for specialized emergency safe shelters for SGBV survivors that require mental health related support. It is recommendable to establish shelters that are more easily accessible to all refugee and host-community women and girls, including persons with disabilities. The MWHs could be expanded as well as replicated in other contexts, as long as they are adapted to meet the specific needs of the survivors and they take into account the specific legal, social and security contexts unique to the location.²⁸

11. Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

Egypt: In spring 2010, a coalition of health professionals acting under the name ‘Helpline Egyptians for Asylum seekers, migrants and Refugees’ (HEAR)¹² took initial steps in the creation a volunteer-staffed telephone hotline. The hotline aimed to address information and communication gaps regarding asylum in Cairo. The helpline objectives were to allow people to call in and ask questions, to request help with problems or to ask for referrals from trained volunteer-staff, who have a full guide of details of service and healthcare providers available.³⁰

Pakistan: UNHCR undertakes regular advocacy and capacity building of provincial and district authorities, communities and law enforcement agencies on the rights of refugees and migrants. UNHCR continue to advocate for preserving the temporary protection space and will support the Government of Pakistan to find sustainable solutions for registered refugees in Pakistan.

Jordan: Integrated urban clinics

CONTEXT: In Jordan, there was a growing resentment among local urban populations to Iraqis, based upon the opinion that the arrival of Iraqis to Jordan not only resulted in a spike in the cost of living, but that assistance was being provided exclusively to Iraqis that was unavailable to Jordanians and other nationalities who met many of the same vulnerability criteria. This resentment contributed to the existing rift between Iraqis and local communities and exacerbated the feelings of isolation and apprehension within Iraqi families.

PRACTICES: Integrated urban clinics: The International Medical Corps (IMC) are supporting Jordan Health Aid Society urban clinics, which are located in areas with a known concentration of Iraqi refugees. The urban clinics are providing services based on need rather than nationality. Teams of outreach workers attached to each clinic are raising awareness of healthcare services in a way that is benefiting entire communities, including both Iraqis and non-Iraqis.

²⁸ ABAAD. (c. 2016) Emergency shelter for women and girls – Lebanon. Online. Available from <<http://www.refworld.org/pdfid/5a38e02e4.pdf>> (accessed 9 May 2018)

¹² Information collected from an online questionnaire submitted in 2017 by UNHCR.

³⁰ UNHCR. (2012). ‘Urban refugee protection in Cairo: the role of communication, information and technology’. Online. Available from <<http://www.unhcr.org/4fbf4c469.html>> (accessed 9 May 2018).

Results: The interaction between Iraqis and non-Iraqis in the clinic waiting rooms and during health education sessions has created networking opportunities and has helped promote the process of social inclusion for Iraqis in urbanized Jordan communities.³¹

12. Enhancing partnerships, inter-sectoral, intercountry and interagency coordination and collaboration, enhancing better coordination between humanitarian and development health actors

In **Djibouti**, following the resurgence of the Oromo crisis in Ethiopia, a contingency plan has been drawn and set up, which was last updated in February 2017. The plan's purpose is to define the general line and coordination mechanisms to be set up in the event of an influx of refugees from Ethiopia. This plan is recognized by the Government Office National d'Assistance Aux Refugies et Refugies (ONARS) and by all United Nations agencies. In addition, there is a national epidemic preparedness and response plan targeting the key potential outbreaks such as cholera, bloody diarrhoea and measles. A simulation exercise in the context of the Oromo crisis took place, following which the contingency plan was adjusted to respond more effectively. Led by UNHCR, the exercise team included ONARS staff and UNHCR field focal points (including WASH, health and shelter professionals). Recently the health partners, including staff from the MOH in refugee hosting areas, have been trained on epidemic preparedness and response.³²

In **Pakistan**, most of the operations conducted for refugee communities is in coordination with the Commissionerate for Afghan Refugees and UN agencies. The health cluster provides active support to the refugee camps in the prevention and control of communicable diseases and in outbreak response. UNHCR develops an annual contingency plan that envisions inclusion of UN agencies and partner organizations besides the Government of Pakistan to mitigate effects of natural or man-made disasters. The government, WHO and UNHCR are working together on communicable disease surveillance and outbreak response in refugee villages and hosting communities. The health cluster forum also advocates for the needs of afghan refugees and works with partners to strengthen the collaborative response.

In **Tunisia**, migrants in an irregular situation or without health insurance must pay for all medical costs. Access to chronic treatment is not systematic and regular interventions from the Ministry of Health or hospitals are required. This challenge is encountered with HIV/AIDS patients who require frequent specialised care. WHO, UNAIDS and IOM are aiming to resolve the challenge through continuous advocacy. In addition, the Global Fund provides a budget for the health treatment of 200 migrants, leaving or transiting from Tunisia.

Saudi Arabia/Sudan: Regional partnership for health workers mobility

CONTEXT: Health worker mobility is considerable among the Middle East and Arab Region with an influx towards the rich Gulf States. Sudan is considered one main source country with increasing trends of out-migration to the Gulf, especially Saudi Arabia. The mobility is mainly physician-led and rising in trends with Sudanese physicians constituting up to 15 percent of the total health workforce in the MOH institutions in Saudi Arabia (over 9000 physicians). Other public and private sectors in Saudi Arabia also attract a considerable number of Sudanese health workers. Mobility of the health workforce in Sudan has been largely unmanaged with active involvement of recruitment agencies and inappropriate recruitment practices.

³¹ Information collected from an online questionnaire submitted in 2017 by UNHCR.

³² Information collected from an online questionnaire submitted in 2017 by UNHCR

PRACTICES: Saudi Arabia and Sudan opted recently to sign a bilateral agreement on health worker mobility with the intension of maximizing gains and alleviating adverse effects. It was reached and signed between the two ministers of health following a long process of preparations and negotiations. The document was prepared in the spirit of mutual gains and underwent several inputs from both sides until finalized and signed. Implementation of the agreement is currently underway with encouraging results supported by strong political support from both countries. The two countries have identified focal persons and technical committees to enhance and monitor implementation.

Lessons learned: This mobility arrangement represents a win-win situation within the context of the WHO Global Code of Practice for International Recruitment of Health Personnel. The gain for Saudi Arabia revolves around staffing the expanding network of health facilities across the country in addition to ensuring sustainable arrangements with Sudan, one vital source country. There is also the potential of sending Saudi residents to be exposed to training in Sudan. The gains for Sudan are many, including enhancing training capacity and improving its quality, better planning and predictability of the health workforce, and the potential of linking mobility to rural retention. The formal arrangements between the two countries provide for reliability and mitigate inappropriate recruitment practices. Health workers will no longer pay expensive recruitment fees and their rights will be better observed under such formal arrangements. This innovative mobility case between the two countries is attracting regional and global interest. It carries potential for addressing a long-standing challenge of largely unmanaged mobility trends, which have been characterized by a lack of bilateral arrangements and dominance of inappropriate recruitment practices.³³

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