

Health of refugees and migrants

Practices in addressing the health needs
of refugees and migrants

**WHO Eastern Mediterranean Region
2018**



REGIONAL OFFICE FOR THE

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In response to a request, in World Health Assembly resolution 70.15, the World Health Organization issued a global call for information, including case studies, on current policies and practices and lessons learned in the promotion of refugee and migrant health. This document is based on information gathered from the contributions from Member States, IOM, UNHCR, ILO, other partners and WHO regional and country offices, in response to that global call, as well as from literature searches and reports available in the public domain. They are therefore presented without any claim to completeness. Furthermore, WHO has not independently verified the information from the contributions unless otherwise stated. Moreover, this is a “living” document which will be updated periodically as new information becomes available.

Abbreviations

AMERA	Africa and Middle East Refugee Assistance
AWD	Acute Watery Diarrhoea
BAFIA	Bureau for Aliens and Foreign Immigrants' Affairs
BPHS	Basic Package of Health System
CERF	Central Emergency Response Fund
CP	Child Protection
COE	Challenging Operating Environments
COR	Committee on Refugees
CTCs	Cholera Treatment Centres
DHIS	District Health Information System
DTC	Diarrheal Treatment Centre
ECD	Early Child Development
EPI	Expanded Programme on Immunization
EU	European Union
EWARS	Early Warning and Response System
EWARN	Early Warning and Response Network
IDP(s)	Internally Displaced Person(s)
IEC	Information, Education and Communication
IHIO	Iran Health Insurance Organization
IMC	International Medical Corps
IOM	International Organization for Migration
IPC	Infection Prevention and Control
IRC	International Rescue Committee
HEAR	Helpline Egyptians for Asylum Seekers, Migrants and Refugees
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSC	Health Steering Committee
MENA	Middle East and North Africa
MER	Middle East Response
MH	Mental Health
MHGap	Mental Health Gap
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
MoHME	Ministry of Health and Medical Education
MoPH	Ministry of Public Health
MoSA	Ministry of Social Affairs
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
ORC	Oral Rehydration Corner
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
SRH	Sexual and Reproductive Health
TB	Tuberculosis

ToT	Training of Trainers
TSPs	Trauma Stabilization Points
YFCA	Yemen Family Care Association
UHC	Universal Health Coverage
UMCs	Unaccompanied Migrant Children
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
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
YMCA	Young Men Christina Association
3RP	The Regional Refugee Resilience Plan

AFGHANISTAN

Enhancing health monitoring. Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants

CONTEXT: Afghanistan has faced continued conflict for the past four decades, causing people to move within the country and internationally. In 2017, approximately 450,000 people were forcibly displaced from their homes.

The country has a deteriorated security situation, with recurrent violations of international and human rights law. Deliberate attacks on civilians, aid workers, medical facilities and schools are frequently reported, resulting in their closure. In the absence of a political solution to the conflict, widespread hostilities are likely to persist throughout 2018.

After four decades of conflict, there are large economic and development challenges in the country. Approximately 39 percent of the population live below the poverty line, an estimated 10 million people have limited or no access to essential health services and as many as 3.5 million children are out of school. Infant mortality rates in Afghanistan are among the highest in the world and Afghanistan remains one of only two countries globally in which polio is endemic.

The volatile political situation in the region may cause further population movements, including mass returns in 2018. In this context, it is expected that the Afghan people will continue to pay a heavy price from any fighting.

PRACTICES:

Rehabilitation of health centres and hospitals: Due to an increased demand on health services from returnees at the border, health facilities are being overwhelmed with a strain on resources including adequate water, sanitation and hygiene (WASH). In response to a rise in water-borne diseases in health facilities, the Ministry of Public Health (MoPH), in collaboration with health and WASH implementing partners, launched an overall rehabilitation of facilities in health centres and hospitals across the provinces of Herat, Kandahar, Nangarhar, and Nimroz. The aim of this rehabilitation is to reduce the rate of water-borne disease in the most vulnerable populations.

Launching a monitoring and reporting system: The MoPH, in collaboration with the World Health Organization (WHO) and the International Organization for Migration (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.

Ensuring access to health services: 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 displaced persons, returnees and migrants, are ensured adequate access to essential health services. The BPHS is a strategy for the implementation of primary health care (PHC) by outsourcing BPHS service delivery to non-governmental organizations (NGOs). The BPHS is mandated to provide equitable access to healthcare services to all Afghans, including internally displaced persons (IDPs), regardless of their documentation status.

Ensuring access to treatment for chronic diseases for IDPs and returnees: 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 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.

(Source: World Health Organization)

DJIBOUTI

Integrating refugees through a new National Refugee Law

CONTEXT: Djibouti has a long history of hosting refugees. Currently, the country is home to over 27,000 refugees who are mainly from Eritrea, Ethiopia, Somalia and more recently from Yemen. Refugees' access to health care has been primarily delivered from international NGOs. Job opportunities for refugees have been restricted to the informal sector where refugees have worked as domestic help, fishers, restaurant staff or labourers.

PRACTICES: On 5 January 2017, the Djibouti Head of State, President Ismail Omar Guelleh, promulgated the National Refugee Law, which had been adopted by the Djibouti Parliament in December 2016. The law ensures a protection environment for refugees and enables them to enjoy fundamental rights, including access to health and education services and socio-economic inclusion through employment and naturalization. The Ministry of Interior, in close collaboration with other line ministries, is finalizing a decree to implement the National Refugee Law.

Partnership and coordination for preparedness and response

CONTEXT: 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 (UN) agencies. In addition, there is a national epidemic preparedness and response plan targeting the key potential outbreaks such as cholera, bloody diarrhoea and measles.

PRACTICE: 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 the United Nations High Commission for Refugees (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 Ministry of Health (MOH) in refugee hosting areas, have been trained on epidemic preparedness and response.

(Source: United Nations High Commission for Refugees)

EGYPT

Promoting refugee- and migrant-sensitive health policies and interventions

CONTEXT: Egypt is a country of origin, transit and destination for migrants. In March 2018, Egypt was hosting approximately 128,500 Syrian refugees and a further 97,221 refugees with other nationalities (who are mainly from Eritrea, Ethiopia, South Sudan and Sudan).¹ The functional responsibilities for all aspects of registration, documentation and refugee status determination in Egypt have been delegated to UNHCR under a memorandum of understanding signed by the Government in 1954. The Government of Egypt has granted free access to PHC for refugees² and a Ministers decree also assures equality in access to secondary healthcare facilities between Egyptian citizens and Syrian refugees.

PRACTICES:

The regional refugee resilience plan (3RP): The Egypt chapter of the 3RP was launched in April 2017. The plan aims to strengthen protection and support for Syrian refugees and host communities in Egypt. The 3RP partners continue to support the national health system and to enhance capacity in areas with a high density of refugees. NGO-run services were used when necessary to fill in gaps and to meet short-term needs.

Results of the 3RP: By the end of 2017, multi-sectoral case management services had assisted more than 5,000 children, adolescents and youths and a total of 1,164 Syrian sexual and gender-based violence (SGBV) survivors had received integrated care. Further, 192 health facilities had been strengthened in impacted communities and 239 healthcare professionals had received training. 67,597 primary health consultations were provided, 3,459 referrals to secondary and tertiary health care took place and 10,782 Syrian children received routine immunisation and growth monitoring services³.

Mainstreaming refugees into the national health system: The Syrian refugee population in Egypt is fully assimilated, more often living in urbanised areas than camps. The government grants refugees and asylum seekers who are registered with UNHCR a six-month renewable residence permit and since 2012, all Syrian refugees have had access to public PHC services at the same cost as the Egyptian population. Furthermore, the MOH arranges frequent vaccination campaigns in health centres and other locations where refugees and displaced persons live. UNHCR projects in Alexandria, Damietta and Greater Cairo, in collaboration with the MOH, provided access to 89 MOH PHC facilities for over 133,000 Syrian refugees.

WHO provides regular medical consultations at PHC centres, supports effective referral to secondary healthcare, runs a rehabilitation programme for children living with disabilities, conducts community health awareness sessions for newly arrived refugees and runs capacity building for Syrian communities. In addition, WHO finances the provision of secondary and tertiary health services through four specialised medical centres.

(Source: World Health Organization and United Nations High Commission for Refugees)

Providing user-friendly information on services available for refugees and migrants

Information booklet for young people, women and children:⁴ In Cairo, information booklets are produced every few years for young people, women and children, which are distributed from a central office and by community outreach workers. The booklet aims to provide useful information on how refugee status determination works, frequent legal problems, psychosocial and health services available in Cairo, sexual and gender-based violence in Egypt, the resettlement process and programmes, as well as other important information for unaccompanied children and young people. The booklet has 47 pages in its most recent form and is published in the languages of Cairo's five predominant urban refugee communities.

Helpline Egyptians for asylum seekers, migrants and refugees (HEAR): The benefits, strategies and interest in expanded phone use for asylum information are illustrated by a recent Cairo initiative. In spring 2010, a

¹ UNHCR. (2018). Monthly statistic report. Online data. Available from <<https://data2.unhcr.org/en/documents/download/63178>> (accessed 8 May 2018).

² Egypt MOH decree 601/2012.

³ 3RP. (c. 2017). 'Egypt Regional Refugee & Resilience Plan 2017-2018'. Online. Available from <<https://reliefweb.int/sites/reliefweb.int/files/resources/Egypt3RPRegionalRefugee%26ResiliencePlan2017-2018.pdf>> (accessed 9 May 2018).

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

coalition of health professionals acting under the name 'Helpline Egyptians for Asylum seekers, migrants and Refugees' (HEAR)⁵ took initial steps in the creation a volunteer-staffed telephone hotline. The hotline aims to address information and communication gaps regarding asylum in Cairo. The helpline objectives are 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.⁶

Addressing mental health needs for refugees and migrants

Workshop for teachers and refugee students: Africa and Middle East Refugee Assistance (AMERA) designed a participatory-approach workshop in Cairo to explore issues between teachers and their refugee students and to find solutions. Issues raised by refugee students in the workshops included limited access to clean water to wash before or after school, difficulties facing students with learning disabilities in overcrowded educational settings, challenges in access to educational facilities for students with physical disabilities, limited social opportunities outside of school, discrimination and sexual abuse while travelling to school and family stress and tension in the home limiting opportunities to study. To address these issues, teachers were trained in the basic principles of psychological first aid including listening to a child's story, providing empathy, protecting, giving advice and information to prevent the problem from recurring, and connecting to the child's network to bolster support as needed. Role-play demonstrations showed teachers new techniques to address specific issues with students. To address declines in student performance, some teachers proceeded to visit caregivers at home to talk through issues in the hope of finding ways to enhance learning opportunities.⁷

Mental health outreach volunteers: Psychosocial services and training institute Cairo (PSTIC) was established in 2009 and is currently an implementing partner of UNHCR in Cairo. The goal of the PSTIC is to 'increase the psychosocial and mental health support presently offered to refugees', with a specific objective to offer quality mental health and psychosocial support (MHPSS) services in refugees and asylum seekers' in their own language, according to their own culture and traditions.⁸ To achieve this, PSTIC launched a 9-month training programme for refugees and asylum seekers, who are selected by their own communities, aiming to build their capacity to become psychosocial workers. The trainees learn a range of skills and activities to integrate these activities and approaches into existing programmes such as health, social welfare, and legal services. The psychosocial workers also act as an intermediary between refugees and UNHCR.

Results and lessons learned: The participatory approach of PSTIC's training programme has been found to be empowering to both psychosocial workers and the broader community of refugees and asylum seekers. It was also found to be an effective approach to identifying protection cases, given that the trained psychosocial workers conduct home visits and engage with communities on a daily basis.⁶

(Source: United Nations High Commission for Refugees)

⁵ Information collected from an online questionnaire submitted in 2017 by UNHCR.

⁶ 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).

⁷ UNHCR submission (web link provided not working).

⁸ UNHCR. (2013). Egypt 2013 Country Operations Profile. Online. Available at <<http://goo.gl/VBphZ>> (accessed 9 May 2018)

⁶ UNHCR Submission.

ISLAMIC REPUBLIC OF IRAN

Promoting and implementing social protection interventions

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 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.

PRACTICES:

Universal public health insurance: 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.

(Source: World Health Organization)

IRAQ

Support for the provision of primary health care to vulnerable crisis-affected population

CONTEXT: In November 2017, following the end of military operations in the ISIS occupied areas in Northern Iraq, there was a decline of IDPs from 3.2 to 2.9 million individuals. It is anticipated that 2018 will see a significant return of IDPs from displacement sites to areas of origin and return. In consideration of this, a camp consolidation and closure policy has been developed and is already being implemented.¹⁰ Providing access to basic services, including health, is key in efforts aimed at supporting returning IDPs to achieve sustainable solutions on return home. There is substantial and immediate need for solutions as many health facilities have either been damaged or destroyed and there is a shortage of trained health professionals. According to recent IOM research, for instance in Ninewa, 45 percent of the health facilities that had information available were unable to provide healthcare services, either because the health facility was destroyed or due to lack of human resources (qualified skilled staff).¹¹ Furthermore, Iraq has among the highest rates of tuberculosis (TB) incidence in the region.¹²

PRACTICES:

The Government of Iraq, in coordination with IOM, is addressing these challenges through: the provision of health services in multiple modalities according to different needs and locations, the revitalisation of selected PHC centres and hospitals, upgrading and supporting field hospital services, referral systems and the integration of TB services within PHC services, and through coordinating with the health cluster and governmental health authorities to synergise health services and to avoid duplication in the provision of a comprehensive package of specialized medical care at primary, secondary and tertiary levels. This comprehensive package includes paediatrics, obstetrics and gynaecology, dermatology, internal medicine, childhood vaccinations and diagnostic services (laboratory and ultrasound).

Results: IOM has prepared “standby lists” for trained and qualified staff as a part of its capacity building and readiness strategy so professionals can act in a rapid manner including in different modalities of health service provision. In 2017 and 2018, IOM’s TB medical mobile teams were able to screen presumptive cases, transport suspected cases, raise awareness on TB, collect sputum and follow-up on treatment. During the implementation period IOM supported the local health system in detecting 574 new TB cases, assisted 4,578 patients suspected of having TB with transportation, traced 2,994 contacts and raised the awareness of 180,977 people about different communicable diseases including TB.

Lessons learned: Direct communication between national health coordinators/focal points and targeted leaders and involving coordinators/focal points in the design and review of health service modality reduced problems for medical teams and helped develop recommendations. Recruitment and training of medical staff prior to military operations enabled a positive and timely response, especially in massive displacements. Integration of prevention and treatment of communicable diseases within the PHC centres network in complex emergencies reduced the cost of implementation and increased/synergized benefits and outcomes. Maintaining and repositioning stock of medication and medical supplies at the preparatory phase and during a crisis helped to maintain the supply chain to functional medical units and locations in need. Coordination with local health authorities helped to solve complicated problems and to gain improved access to specific locations. Providing a comprehensive healthcare package in high population density camps or at periphery locations reduced the number of referrals and the cost of transport.

(Source: International Organization for Migration)

¹⁰ IOM. (2017). DTM Iraq, Rounds 84, November 2017.

¹¹ IOM. (2017). Integrated Location Assessment II, DTM Iraq, November 2017. Online. Available from <<http://iraqdtm.iom.int/ILA2.aspx>> (accessed 9 May 2018)

¹² WHO. (2015). Annual TB report.

Providing direct healthcare services essential medicines and medical equipment for IDPs and returnees.

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

(Source: World Health Organization)

JORDAN

National legislation for the protection of domestic workers

CONTEXT: Jordan hosted around 80,000 international migrant domestic workers in 2016, mostly from Indonesia, the Philippines and Sri Lanka. As in other countries, women domestic workers were reported to be commonly subjected to exploitative working conditions and to abusive situations. In 2009, Jordan became the first country among the Arab States to amend its labour code to provide protection for domestic workers. The legislative amendment provided a foundation for legally recognizing and protecting the rights of domestic workers, many of whom are female migrant workers. Regulation number 90 of the revised labour code incorporates and clarifies rights and entitlements to protect domestic workers, cooks, gardeners and similar workers. Previously, in 2003, the government adopted a uniform standard working contract for all migrant domestic workers, which included provisions for employers to pay workers' travel costs, to provide work and residency permits, life and accident insurance, suitable accommodation and meals, clothing and medical care, as well as no restrictions on workers' communications and correspondence.

PRACTICE: 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.⁷

(Source: Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action; International Labour Office – Geneva: ILO, 2016)

Promoting gender equality and empowering women and girls

CONTEXT: In March 2018, over 661,800 registered Syrian refugees were seeking refuge in Jordan⁸, a rise from 283,000 registered Syrian refugees recorded in March 2013. Both registered and unregistered refugees are living in camps⁹, informal settlements, rural or urban settings. Of the registered refugees, almost half are children. 30 percent of the population in Jordan are now refugees from Iraq, Libya, the oPt including east Jerusalem, Syria and Yemen.

PRACTICES:

Amani campaign:¹⁰ 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.¹¹

Home and community-based early child development (ECD) courses: The International Medical Corps (IMC) recruited vulnerable Jordanian and Iraqi women into an ECD project through the Jordan River Foundation's Queen Rania centre. A challenge to the original project was poor retention of Iraqi women, who's attendance was found to be erratic because of reasons including worries of insecurity, general discomfort from travelling outside their immediate home environment and the economic burden of having to pay for transportation to

⁷ ILO. (2016). Promoting a Rights-based approach to Migration, Health and HIV and Aids: A Framework for Action; International Labour Office 2016.

⁸ UNHCR figures.

⁹ Approximately 79,000 were housed at the Zaatari Refugee Camp in northern Jordan; 54,000 were registered in Azraq Camp, 100 kilometers east of Amman; and 7,300 were at the Emirates Jordan Camp in Zarqa Governorate.

¹⁰ 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).

¹¹ UNHCR submission to WHO.

reach the services. In response, the IMC replaced the centralised programme design with a home and community-based programme that reached out to and met beneficiaries within their own environments. This inherently intimate approach was found to give the service provider an immediate and unfiltered insight into a family's circumstances and the community environment. The methods of the programme involved 20 Iraqi women being trained during a two-week training of trainers course on ECD. Each trainer was then expected to invite eight - 10 neighbouring women into her home to participate in five-days ECD training, which would then be repeated for new groups throughout the project period. With just limited outreach efforts, demand for these home-based trainings quickly grew within the communities, and each trainer soon found herself hosting 20 women or more — twice the expected number — in modestly-sized apartments.

Results: Attendance rate consistently surpassed 90 percent. This overwhelmingly positive response was maintained throughout the subsequent training sessions. The programme reached 2,100 mothers in the course of 8 months.¹²

Providing health services to refugee, migrant and host populations

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.

PRACTICE:

Integrated urban clinics: The 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. 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.¹³

(Source: United Nations High Commission for Refugees)

Addressing social protection needs for vulnerable children

CONTEXT: 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.

PRACTICE: 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, including cash assistance, case management and service referral mechanisms. The package includes behaviour change communication and monitors children's enrolment and attendance in school. Vulnerable families living in host communities receive an unconditional cash transfer of US\$ 28 per child per month, to contribute towards meeting their children's basic needs and prevent them to turn to negative coping strategies²⁰.

Results: From February 2015 to November 2017, monthly assistance was provided to 55,000 girls and boys from 15,000 of the most vulnerable Syrian families registered as refugees. Monitoring results have shown that the cash transfers allowed families to increase children-related expenses on schooling and health, and academic performance improved for some children as well as intra-household relationships.

Lessons learned: Cash+ programmes are an example of ways to connect humanitarian responses to long-term development goals. *(Source: Beyond Borders: How to make the global compacts on migration and refugees work for uprooted-United Nations Children Fund, 2017)*

¹² Information from an online questionnaire submitted in 2017 by UNHCR, IMC run programme.

¹³ Information collected from an online questionnaire submitted in 2017 by UNHCR.

²⁰ UNICEF. (2017). Beyond borders report. Online. Available from <https://www.unicef.org/publications/files/UNICEF_Beyond_Borders_Nov_2017.pdf> (accessed 9 May 2018).

LEBANON

CONTEXT: Seven years into the Syrian conflict, Lebanon continues to show exceptional commitment and solidarity to people displaced by the war. As of October 2017, the Government of Lebanon estimated that the country hosted 1.5 million Syrians (including 997,905 registered as refugees with UNHCR), along with 34,000 Palestinian refugees from Syria, 35,000 Lebanese returnees, and a pre-existing population of more than 277,985 Palestinian refugees¹⁴. Refugee camps have not been established in Lebanon. Instead, the majority of the Syrian displaced population are living in villages and cities and are increasingly residing in informal settlements. Tensions between refugees and host communities are rising as the large presence of refugees is further straining the social, economic and political structures of the country. It has been common for aid donations to be delivered through in-kind support. These benefits have been perceived by local communities, who are often poor, to be exclusively helping the displaced population with little to no benefit to local people.

Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants: Lebanon did not sign the 1951 convention relating to the status of refugees and does not adapt to the international framework regarding hosting refugees. Due to the large influx of displaced Syrians in Lebanon, the government had to set up the 'Lebanon crisis response plan' with UNHCR and other key partners to contain the crisis. The plan aims to target the crisis situation whilst simultaneously sustaining the host community. In March 2015, the Minister of Public Health mandated the creation of a national health steering committee (HSC) headed by the MoPH. The HSC's responsibility is to set the strategic directions for the health sector, including prioritizing health interventions and steering the allocation of resources. In October 2016, the MoPH issued the health sector response plan to increase access to healthcare services to reach as many displaced persons and hosting communities as possible, prioritizing the most vulnerable, strengthen healthcare institutions and enable them to withstand the pressure caused by the increased demands for services and the scarcity of resources, prevent and control outbreaks of epidemic prone diseases with focus on early warning system reinforcement, reinforce child and youth health as a part of a comprehensive health approach; and support the school health programme. PHC centres are requested not to differentiate between Lebanese and non-Lebanese patients regarding the provision of services and the collection of nominal fees.

PRACTICES:

The MoPH provides PHC services through its centres for every person residing in Lebanon at minimal personal contributions of the costs. Refugees and displaced persons have access to all PHC essential services for a nominal minimal fee, topped up by contributions from donors and humanitarian partners. In addition, 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, and provides mental health services under the national mental health programme with the support of WHO, UNICEF and the IMC.

WHO, through funds made available by donors (China, the European Union, Japan and Kuwait), facilitated access for Syrian displaced persons and refugees to chronic medication through the national chronic medication programme operated by the Young Men Christina Association (YMCA). The tertiary care for Syrian displaced persons and refugees provided by the Lebanese public and private hospitals is financed by UNHCR and other NGOs. The humanitarian community covers 75 percent of hospital costs, while the remaining 25 percent needs to be covered by displaced persons and refugees themselves, who most often cannot afford it. This is creating a financial strain on hospitals as well as those refugees and displaced persons seeking health care.

The Lebanon crisis response plan has targeted 2.8 million people in Lebanon, of which 1.5 million are Syrians, 1.3 million are vulnerable Lebanese, 257,400 are Palestinian refugees in Lebanon and 31,500 are Palestinian refugees from Syria.

Lessons learned and way forward: Seven years into the Syrian crisis, the Lebanese health system is still showing substantial resilience from being able to adapt to the sudden and sustained increase on demand, which has been supported by international funds. However, the capacity of the country is overstretched.

¹⁴ UNHCR, UNRWA and GoL.

Certain services are particularly strained such as obstetrics and neonatal wards in hospitals. Nonetheless, the MoPH has succeeded, despite the high number of displaced persons, to maintain the decrease in maternal and child mortality until 2015 (although since 2016, an increase in maternal mortality ratio and neonatal mortality rates has been observed). MoPH also continues to strengthen the PHC network accessed mainly by displaced persons, to support service provision by supplying needed medication and vaccines, and to regulate the distribution of funds encouraging NGOs' support to PHC centres including subsidizing the fees for displaced persons and vulnerable host communities.

As per the national health response strategy, the displaced population will continue to benefit from the same entry point into health care as the Lebanese population instead of creating costly parallel healthcare structures. However, hospitalization remains very costly for displaced persons and refugees. The MoPH encourages donors to address the inadequate financing of primary, secondary and tertiary health care as this saves lives whilst concurrently supporting the sustainability of health institutions in Lebanon.

Provision of equitable access to UHC, including access to quality essential health services, medicines and vaccines, and healthcare financing for refugees and migrants: The refugees, migrants and displaced persons in Lebanon are mostly living within the local communities (only 20 percent live in transit sites). Therefore, these populations have the same access to health care as Lebanese nationals. In Lebanon there are around 1000 health centres that are run mostly by NGOs, with less than 30 percent run by the MoPH, the Ministry of Social Affairs (MoSA) or municipalities. The MoPH developed a set of standards for these health centres to become PHC centres under the national PHC network. Around 207 centres are currently considered under the network and receive support from MoPH to fully provide all the PHC services. All centres provide health services regardless of nationality.

PRACTICES:

Expansion of the PHC centres network ensuring quality standards: Each PHC centre has its own catchment area with an average of 20,000 inhabitants, varying between urban and semi-urban areas. Efforts have been made by all partners of the health sector to include displaced persons and refugees into the existing PHC system. Whenever a case of unmet needs for displaced persons has been shown by partners, MoPH identifies the centre that can cover the gap and the centre has been added to the network. The MoPH provides free of charge immunisation for displaced persons in its centres and on border and registration sites. Furthermore, the MoPH provides the centres with free vaccines and acute and chronic medications to satisfy the needs of all patients visiting the PHC centres regardless of nationality, as well as free capacity building for staff and in-kind support in the form of equipment, educational materials and guidelines. The services subsidized for displaced persons and refugees cover consultations fees, laboratory tests, antenatal care and other reproductive health services as well as the management of infectious and chronic diseases.

Refugees, displaced persons and nationals can access comprehensive PHC services with user fees ranging between US\$ 5 - 11. The expanded programme on immunization (EPI) and acute essential medicines are free of charge and chronic medication is available at a nominal handling fee of US\$ 0.75 per prescription. In addition, in around 100 PHC centres, humanitarian actors provide additional subsidies to reduce the user fee to US\$ 2 – 3 per consultation.¹⁵

Access to secondary and tertiary health care: UNHCR finances secondary and tertiary care for Syrians in Lebanon, supporting around 44 hospitals in Lebanon and covering 75 percent of fees for emergency cases. The other 25 percent is sometimes covered by NGOs or by the refugees themselves. Hospitals are overburdened with Syrian patients who are unable to pay even the reduced fees required from them, as well as patients whose hospitalization is not subsidized at all. Due to a decrease in funding, UNHCR partners are rendered to prioritize only life-saving conditions when covering hospitalization fees. As per the national health response strategy some hospitals have adopted restrictions to cost-recovery. Hospitals, especially public ones, have faced a significant deficit.

Results: In 2017, data on Syrian patients, which was collected from 207 supported PHC centres showed: the total number of beneficiaries, 140,114; paediatric services, 279,613; antenatal care services, 100,087; family

¹⁵ Information collected from UNHCR Submission.

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, 770,726.¹⁶

Lessons learned and way forward: The country infrastructure may not be able to hold the extra burden for much longer, which may lead to deterioration in the quality of health services. Strengthening the infrastructure of the country in all areas is significantly needed. There is a need to empower the role of MoPH devolved departments to coordinate activities at the region and district levels to reach out to a larger population. Likewise, MoPH needs to enhance the role of municipalities in planning and implementation and to empower them to address social determinants of health, in particular nutrition, shelter, livelihoods and WASH. The MoPH continues to encourage all partners operational on PHC to work with PHC centres within the MoPH network.

Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants: The MoPH national health strategy identified PHC as a main entry point to achieve UHC. This has led to the progressive growth of the national PHC centres network, which offers a set of health services that has also been progressively expanded to include malnutrition screening, NCD early detection and mental health.

PRACTICES:

The expanded program of immunization: The expanded program on immunization (EPI) that was established in 1987, aims to guarantee the right of every child in Lebanon to immunization and protection from diseases. The EPI provides effective and safe vaccines, regardless of social status or parent's education level. Through the MoPH PHC centres, the essential vaccines for children are distributed and administered for free. In accordance with this policy, the MoPH has dealt with the influx of displaced persons by committing to routine immunization, particularly for polio and measles at border and registration sites and at informal settlements. Services are available to all people living in Lebanon regardless of nationality.

Malnutrition screening and management: The MoPH, with the support of UNICEF, has initiated malnutrition screening for children under five years of age at all PHC centres, border and registration sites and at informal settlements. Nurses are being trained on systematic malnutrition screening that targets children under five. Health professionals at some centres are also trained on case management and are provided with therapeutic food. Governmental hospitals also receive training on management of severe malnutrition. The different levels of the health sector are connected. MoPH staff in PHC centres screen for acute malnutrition (children under five, pregnant and lactating women) and refer non-complicated cases to qualified PHC centres for treatment, and cases with complications to governmental hospitals for treatment. The treatment of identified cases at the level of PHC centres is paid for by the MoPH, with the support of UNICEF. However UNHCR covers hospitalisation costs for all cases with complications.

Screening for non-communicable diseases: The MoPH, with the support of WHO, has initiated the NCDs screening protocol to be adopted in all its centres. The initiative targets individuals who are 40 years old and above. It aims to screen for any risk of cardiovascular disease as well as to provide treatment when needed. The MoPH, with WHO support, has provided the point of care testing machines and strips to support the NCD initiative for Lebanese and non-Lebanese.

Providing reproductive health services: The MoPH, with the support of UNFPA, provides family planning supplies and commodities to all its centres for improved reproductive health. The nurses engage in outreach and health education on family planning together with the services provided in the centres. In addition, the MoPH has developed a basic maternal and child health care package to be implemented at PHC centres at a flat rate that includes at least four antenatal care visits, delivery and post-natal care, and the provision of vaccines up to two years of age, in accordance with the national immunization calendar. UNFPA and other partners have supported the MoPH in accelerating training for health professionals on clinical management of rape, both at PHC centres and in selected referral hospitals. In addition, intensive awareness activities among youth and vulnerable population on sexual and reproductive health are conducted by humanitarian partners in coordination with the MoPH and the MoSA.

¹⁶ Information collected from an online questionnaire submitted in 2017 by the Ministry of Public Health.

Addressing mental health issues: The MoPH mental health programme in Lebanon, with the support of partners, has introduced guidelines and protocols for mental health screening and identification, using WHO mental health gap (MHGap) modules. Nurses and general practitioners in PHC centres and in hospitals are trained on MHGap and on referral. The MoPH provides psychotropic medications for the most vulnerable populations including refugees, displaced persons and migrants.

Lessons learned: The MoPH with humanitarian partners have been working to minimize the effects of financial barriers to accessing healthcare by designing models of financial support at PHC services. In parallel, efforts to improve access for health services have been focused on expanding the scope of services provided for the most vulnerable at the PHC level. At the same time, an important support was provided to improve quality of care by intensive training of human resources for health and by providing modules, protocols and standards of care. Despite these efforts, cultural barriers and religious beliefs remain key constraints to accessing certain services such as family planning and post-natal care among the displaced. Medications, be it for acute or chronic health conditions, are a major attracting factor for beneficiaries of PHC services and are crucial to reducing mortality and morbidity as well as to decreasing hospitalization. Therefore, it is important to have them continuously available. A gap remaining is support for secondary care, specifically laboratory and radiology testing, which would improve the quality of care and the evidence-base behind clinical decisions.

Recommended future priority actions: Important future actions include reinforcing the implementation of the PHC programmes in PHC centres, strengthening the support of NGOs to support displaced persons with the laboratory and investigations tests fees, encouraging donors to provide funds for chronic medications, and continuing capacity building for human resources in health.

(Source: Ministry of Public Health))

Strengthening the health system, reducing morbidity and mortality among refugees and migrants through short- and long-term interventions.

CONTEXT: By reinforcing the Lebanese health system's resilience, higher-quality, more coverage and more sustainable health services can be provided to refugees and migrants as well as to the most vulnerable host populations in Lebanon. WHO's support in Lebanon has included leveraging available humanitarian funds to accelerate the strengthening of health systems, to build health professional capacities and to fill critical gaps.

PRACTICES:

Support to strengthening health services: Special emphasis has been given in supporting improved access to health services, with the main focus being on PHC reinforcement. WHO supported the expansion of the early detection and risk assessment for NCDs initiative at PHC levels, reaching out to the poorer population groups including Syrian refugees and migrants. WHO also helped the implementation of a NCD stepwise survey that included targeting Syrian refugees. This is the first data available on NCD prevalence and risk factors among Syrian refugees. In addition, WHO, through funds from the American, EU, Japanese and Kuwaiti governments, was able to ensure non-interrupted access to NCD medications. Similarly, WHO supported the mental health strategy implementation that included establishing a mental health registry whereby data on mental health cases was made available from sentinel sites in selected PHC centres, private clinics and hospital affiliated clinics, on both Lebanese and Syrian refugees and migrants. This data will enable the observation of mental health prevalence trends over time. The strategy implementation also included providing technical support for the development of a national strategy for substance use and a national strategy for mental health in prisons, noting that a large number of Syrian refugees are in Lebanese prisons. Furthermore, it included supporting the production of mental health awareness and education material and providing technical support for the development of a 5-year national surveillance strategy.

Expansion of the National Early Warning and Response System (EWARS): 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. Trainings were conducted

with the support of WHO to surveillance and response teams on monitoring accuracy, timeliness and completeness of reporting.

Improving adolescent and youth health through supporting school health programmes: The protracted nature of the Syrian crisis has overstretched the capacity of the Lebanese education system. Thousands of vulnerable school-aged children are in need of educational assistance. The health sector continues to support the efforts of the Ministry of Education and Higher Education, MoPH and WHO to reinforce the national school health programme to improve adolescent and youth health. The programme, which targeted 1,200 schools in 2017, includes activities that contribute to school health education, a healthy environment, opportunities for physical education and recreation and programmes for counselling, social support and mental health promotion.

Results: More than 10,000 patients were screened for NCDs and referred to PHC centres for further management, data on the prevalence of NCD and their risk factors among both Lebanese citizens and refugees is now updated and available at the national level, more than 170,000 patients with chronic NCD conditions have continuous access to quality medications, and around half of them are supported by humanitarian partners. A national draft for substance use is completed. A functional mental health registry is established with a first set of data shared with key stakeholders. In addition, 55,000 brochures for patients' psychoeducation (depression, post-traumatic stress disorder, developmental disorders, psychosis, and dementia) and 5,000 pocket-size booklets (MHGap job aids), both in Arabic and English, were distributed. A 5-year national strategy on surveillance is available with a plan of action, and the EWARS system is digitalized at central and Qada level, with a plan to continue full digitalization of EWARS by end of 2019 at health facility level. Youth health, through the national school health programme, reaches a large proportion of the most vulnerable children in public schools with health awareness and medical screening.

(Source: World Health Organization)

Addressing violence against women and girls

Emergency shelter for women and girls

PRACTICE: 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. 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.

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.

There is a shortage of safe shelters for SGBV survivors around the world and in the Middle East and North Africa (MENA) region. Forcibly displaced and stateless women and girls face additional obstacles in accessing shelters, including a shortage of space, the need to travel long distances to reach shelters, a lack of information and an inability to bring their children along. There is also a gap in the provision of specialized

shelter services for SGBV survivors with disabilities. Therefore, it is good practice 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.¹⁷

(Source: United Nations High Commission for Refugees)

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.

PRACTICE: 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 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.²⁵

(Source: Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action; International Labour Office – Geneva: ILO, 2016)

¹⁷ ABAAD. (c. 2016) Emergency shelter for women and girls – Lebanon. Online. Available from <<http://www.refworld.org/pdfid/5a38e02e4.pdf>> (accessed 9 May 2018)

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

LIBYA

Assessing refugees' and migrants' needs to inform interventions

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 accurate number of migrants is estimated to be over 700,000 across the country. Out of the reported number, approximately 20,000 migrants are based in 32 detention centres under the control of Department of Combating Illegal Migration (DCIM) and militias. Provisions for the deprivation of liberty of non-citizens for immigration-related violations are contained in two laws: Law Number 6 (1987) on regulating entry, residence and exit of foreign nationals to/from Libya as amended by Law Number 2 (2004) and Law Number 19 of 2010 on combating irregular migration. Under both laws, violations of migration provisions are criminalized and sanctioned with fines and imprisonment. According to observers, the 2010 law on combating irregular migration (law number 19) allows for the indefinite detention, followed by deportation, of those considered to be irregular migrants.

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 healthcare.

PRACTICES:

Health Service Availability and Readiness Assessment: 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.

Results: The assessment findings show an imbalance in the distribution of health workers and shortages of medicines, equipment and diagnostic materials between different areas. The findings indicated that the system was having the greatest difficulties to cope with the health needs of the population in areas affected by conflict or in areas with high levels of displaced or migrant populations. The results showed that 17 percent of hospitals, 20 percent of PHC facilities and 9 percent of other specific service facilities were not closed. 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.

Providing health services to migrant and host populations

Integrating refugees and migrants into an early warning and response network: A public health risk assessment was conducted in detention centres by IOM. WHO expanded the early warning and response network (EWARN) of communicable diseases in Libya and provided technical support to IOM for selected detention centres to be covered by EWARN. Since 2016, WHO, in collaboration with the MOH and local NGOs, has provided medical supplies and mobile medical teams as part of the emergency response for IDPs in schools and camps. In collaboration with UNICEF and the national centre of disease control, WHO was able to vaccinate IDPs and migrants during polio and measles national immunization campaigns in 2017.

IOM, UNHCR and WHO collaborative response: To improve the availability of health services to migrants, which is still erratic, WHO, in close collaboration with IOM and the MOH, established a disease early warning system (EWARS) in the detention centres. IOM is now leading the efforts in detention centres to ensure that PHC services are available to detainee migrants, together with providing and facilitating referrals to public and private sector hospitals. In most cases IOM pays for the hospital services of migrants in detention centres.

UNHCR is providing psychosocial support as well as supplying lifesaving medicines to hospitals caring for migrants. IOM and WHO are also providing life-saving medicines and supplies to hospitals and PHC centres in areas hosting a large majority of migrants.

(Source: World Health Organization)

MOROCCO

Promoting refugee and migrant health

CONTEXT: Traditionally an emigration and transit country, Morocco is also quickly becoming a country of destination. Refugee' and migrant' experiences in Morocco depend largely on the characteristics of their journey, the location of settlement and their ability to assimilate (based upon factors such as language, culture and religious similarities).

PRACTICES:

Providing free access to primary health care: The health status of sub-Saharan migrant populations in Morocco has been a concern for many years. The MOH has undertaken several initiatives to ensure that migrants have the right to access health services. Two ministerial circulars have been issued. The first was in 2003 that permitted migrants to receive free preventive and curative care services delivered under communicable disease control programmes. The second was in 2008 on expanding free access to all health services provided by the network of PHC facilities.

Subsidized social housing programmes: The Kingdom of Morocco has integrated refugees and migrants into State subsidized social housing programmes. Refugees and migrants' can pursue their education within the public-school system; can be beneficiaries of housing loans granted by credit institutions; and are granted the right to employment.

Integrating health into the national migration strategy: The MOH, in collaboration IOM and other key partners, and with the support of the Ministry in charge of Moroccans Resident Abroad and Migration Affairs, has committed to a participatory and inclusive process to develop a national strategic plan on the health of migrants, for the period 2017-2021. This plan is consistent with the national strategy for immigration and asylum. Pursuing the goals of UHC, the government is considering options for health coverage of refugees and migrants (for instance inclusion in the health services coverage plan for the most deprived or the creation of a specific health insurance scheme).

Results: On 26 October 2015, a framework partnership agreement was signed between the MOH, the Ministry in charge of Moroccan Residents Abroad and Migration Affairs, the Ministry of Interior and the Ministry of Economy and Finance. This partnership agreement refers to a basic medical coverage scheme for refugee and migrant women.

(Source: World Health Organization)

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

Promotion of psychosocial wellbeing of migrants: To facilitate the access of migrants to health programmes, promotion and prevention services, the MOH introduced a peer health education approach for the promotion of the psychosocial wellbeing of migrants. A pool of peer educators was identified from various NGOs and communities represented in the country. A first training of peer educators was organized in 2016 with the support of IOM.

Assisting migrants to access primary care and specialized services: UNHCR in collaboration with the Association Urgence is implementing various activities including accompanying 4,255 refugees and asylum seekers at national level in receiving 9,385 free medical consultations, developing partnerships with local pharmacies to facilitate access to medicines for refugees and migrants, organizing a medical caravan in Oujda (April 2017), establishing referral networks with hospitals for cases requiring specialized care (1,450 refugees

benefited from 1,534 consultations), and assisting 314 refugees who were suffering from complications of chronic conditions requiring medical or surgical management.

Access to tuberculosis and HIV/AIDS diagnosis and treatment

PRACTICE: As part of the activities of the national tuberculosis (TB) control programme of the MOH, 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 benefited from HIV testing organized by 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 sensitized to HIV prevention.

(Source: World Health Organization and United Nations High Commission for Refugees)

OMAN

Protecting children rights and equal treatment of women at work

CONTEXT: The Sultanate of Oman is not a State party to the 1951 Convention on the status of refugees and its 1967 protocol. There are no specific national laws or administrative regulations governing the status of asylum-seekers or refugees. All non-citizens in Oman fall under national immigration laws also known as 'expatriate law'. By the end of October 2017, there was a registered expatriate population of 2.1 million persons (45.4 percent of the total population of the Sultanate). Every foreign worker who is living legally in Oman enjoys all the civic amenities, freedom and access to daily life needs.

PRACTICES:

Formation of the commission for child welfare: The royal decree (RD No 85/92), and the approval of the child law (RD 22/2014) has ensured children's civil rights, health and education rights free of charge. The decree and law prohibit all substances, behaviours and practices that threaten child's mental and physical health.

Employment of women: The labour law enables the employment of women, with the right to work in harmony with men without discrimination for the same work.

(Source: Ministry of Health)

PAKISTAN

Identifying refugees and guaranteeing refugee basic rights

CONTEXT: Pakistan is not a party to the 1951 Convention relating to the status of refugees nor its 1967 Protocol and has not enacted any national legislation for the protection of refugees or established procedures to determine the refugee status of persons who are seeking international protection within its territory. Such persons are therefore treated in accordance with the provisions of the Foreigners Act 1946. In the absence of a national refugee legal framework, UNHCR conducts refugee status determination under its mandate (statute of the office of the UNHCR adopted by the general assembly Resolution 428 (V) of 14 December 1950) and on behalf of the Government of Pakistan in accordance with the 1993 cooperation agreement between the Government of Pakistan and UNHCR.

PRACTICE: The government generally accepts UNHCR decisions to grant refugee status to persons in Pakistan, allows asylum-seekers to remain in Pakistan (who are still undergoing the procedure) and permits refugees to remain in Pakistan pending identification of a durable solution. Since 2007, the Government of Pakistan has issued identification cards to Afghan refugees registered with UNHCR. In addition, a pledge was approved by the Government of Pakistan to document Afghan nationals who currently have no identification, to adopt a national refugee law and to assume a visa regime for different categories of Afghan nationals.

Results: Approximately 1.34 million Afghans are currently holding a proof of registration (PoR) card that provides them with temporary legal residency, freedom of movements and exemption from the application of the Foreigners Act 1946.

Lessons learned: Despite Pakistan not being a party to the 1951 Convention nor its 1967 Protocol and not having national legislation for the protection of refugees, Pakistan continues to accept, host and provide social services to over two million refugees from Afghanistan.

Addressing needs of refugees and host communities

CONTEXT: Pakistan has been hosting Afghan refugees for nearly four decades, with the first wave of refugees arriving in 1979, followed by subsequent influxes of refugees in 1992 and 2001. Between 1979 – 2001, more than 4.4 million Afghans sought refuge in Pakistan. At the height of the displacement over 3.2 million refugees were living in the country. As a result, Pakistan has ranked as the world's top refugee hosting country for 22 out of the past 37 years. Since 2002, 3.9 million refugees have returned to Afghanistan, following the largest ever voluntary repatriation programme in UNHCR's history.

Approximately 1.5 million refugees remain in Pakistan to date and subsequently Pakistan is continuing to host the world's largest protracted refugee situation, which constitutes 10.5 percent of the global total refugee caseload. This large scale protracted displacement has had an inevitable humanitarian, socio-economic and environmental impact on Pakistan, including effects on the country's infrastructure and an over-straining of public service delivery systems, including health care.

PRACTICE: The refugee-affected and hosting areas (RAHA) programme was launched in 2009 by the Government of Pakistan, in close partnership with UN agencies, to address the needs of refugees and to re-address the impact of the protracted displacement in host communities. RAHA provides assistance to both Afghan refugees and the Pakistani communities in-which they live, through a set of integrated interventions in the education, health, water and sanitation, infrastructure, environmental rehabilitation and social protection sectors. Issues including gender equality and the promotion and prevention of gender-based violence are targeted through community services. The programme aims to build the resilience of community midwives by carrying-out comprehensive capacity building.

Results: Over 590,000 children benefited from education projects and more than 700 schools were either constructed or rehabilitated. Nearly 1.1 million people have benefited from RAHA health projects with over 160,000 patients treated each year.

Lessons learned: RAHA was the cornerstone to implementing the regional multi-year solutions strategy for Afghan refugees (SSAR) in Pakistan (2012-2017) and an important element of the Government of Pakistan's strategies and policies on the management of Afghan refugees.

By enabling improved access to quality services and opportunities for all, RAHA is protecting the development outcomes of the host communities, promoting peaceful co-existence and ensuring that no one is left behind, including those most vulnerable (including the poorest individuals and youth).

Provision of equitable access to UHC, including access to quality essential health services, medicines and vaccines, and healthcare financing for refugees and migrants

CONTEXT: Despite there being no refugee and migrant-sensitive health policies in Pakistan, Afghan refugees have complete access to the same health services used by host communities without discrimination. As of 31 August 2017, the total number of registered Afghan refugees in Pakistan was 1,392,234. Since 2002, 4.3 million refugees have been repatriated from Pakistan to Afghanistan. In 2016, nearly 381,000 Afghans were repatriated and between April - August 2017, 48,267 registered refugees were repatriated. Out of the total remaining population of refugees, 32 percent reside in 54 refugee villages and 68 percent reside within the host communities.

Provision of care in refugee villages: Health services in refugee villages are being provided by UNHCR partners. UNHCR is following a health sector strategy to transition the PHC services to the nearby government

hospitals. Currently most of the curative services have been transitioned, while vaccination and maternal and child health services are being provided by UNHCR partner agencies. All routine and polio campaign vaccines are provided by the provincial health authorities. Issues of gender equality and the prevention of gender-based violence are targeted through community-based services with a united approach for local, refugee and migrant communities.

Mainstreaming refugees into the national system: UNHCR's five-year health strategy (2014 to 2018) that was developed together with the Government of Pakistan prioritizes services for the most vulnerable refugees by mainstreaming them into the national health system. This allows for easy access to preventive and promotive programmes through the national programmes on TB, malaria, HIV, hepatitis, the national programme for family planning and PHC, the expanded programme on immunization (EPI) and other programmes for non-communicable diseases.

(Source: United Nations High Commissioner for Refugees)

Enhancing health monitoring and health information systems

The refugee health information system is maintained by UNHCR together with a government department, the Commissionerate for Afghan Refugees (CAR) for the 54 afghan refugee villages. The refugees living in host communities access local health facilities and their information is reported through the district health information system (DHIS) maintained by the Department of Health. Though there is fragmented integration with the government health information system, UNHCR is working closely with the government through its RAHA programme to fully integrate the refugee health services into the local health systems for sustainability of interventions and health system strengthening.

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

Control of communicable and non-communicable diseases in refugee villages and hosting populations: There is a national framework for the control of communicable and non-communicable diseases including immunization, disease-specific and integrated vector control programmes. WHO has been supporting outbreak investigation and response to outbreaks of acute watery diarrhoea, measles, dengue, malaria, leishmaniosis and other priority diseases outbreaks in the refugee camps and hosting areas.

Capacity building of health authorities and UNHCR health staff: The standard WHO guidelines on various communicable diseases are being shared and promoted for use in the camps as well as in host communities, to improve outbreak control and knowledge on health. WHO, with the financial support of UNHCR, carried out capacity building activities for the health staff of UNHCR and the project directorate of health of the Afghan commissionerate working in the afghan refugee camps. The capacity building activities were on topics including communicable diseases, surveillance and response, case management of acute watery diarrhoea, malaria, leishmaniosis, measles and other notable priority diseases.

(Source: World Health Organization and United Nations High Commission for Refugees)

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

CONTEXT: In Pakistan there is minimal xenophobia against refugees. Registered refugees are issued proof of registration cards and those who are currently unregistered are being provided with an Afghan citizen card by the Government of Pakistan. Refugees after acquiring registration are free to reside either in the designated camps/refugee villages or in the allowed urban areas. The humanitarian response plan includes objectives to increase tolerance towards Afghan refugees, to promote their social cohesion and peaceful coexistence with host communities and to reduce their social and economic vulnerabilities through implementation of RAHA projects.

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

Lessons learned: Similar customs, religion and social norms of the refugee and host communities have led to favourable social inclusion.

(Source: United Nations High Commissioner for Refugees)

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

UNHCR's 2015 - 2017 multi-year strategy for Pakistan revolves around three key operational priorities. Firstly, durable solutions for the protracted refugee situation, secondly, protection and assistance to UNHCR's persons of concern, and thirdly, enhanced partnerships and collaboration with the government and NGO sectors for service provision. A country-specific livelihood strategy is being developed by UNHCR to try and overcome challenges in relation to poverty. The strategy aims to support Afghan refugees in acquiring transferable skills, enabling them to achieve self-reliance throughout their stay in Pakistan or after their voluntary repatriation to Afghanistan. The strategy will be aligned with the regional multi-year solutions strategy for Afghan refugees (SSAR) focus on youth empowerment through education, skills training and livelihoods.

Results: Most of the UNHCR operations conducted for the refugee communities is in coordination with the Government of Pakistan (Commissionerate for Afghan Refugees), and with sister UN agencies where required.

Coordinated health response: The health cluster led by WHO 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.

(Source: United Nations High Commissioner for Refugees)

THE OCCUPIED PALESTINE TERRITORY (oPt) INCLUDING EAST JERUSALEM

Advocating for the right to health

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

PRACTICE: 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 Palestinian 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.¹⁸

(Source: WHO Regional Office)

Improving the health and well-being of women, children and adolescent living in refugee and migrant settings

CONTEXT: Refutrees, a volunteer-run non-profit organization, is part of a growing movement in oPt including east Jerusalem that seeks people-led sustainable development for Palestinian refugees, helping end donor reliance through food sovereignty and green, social innovation. Refutrees identified that development programmes in the area have tended to reinforce donor reliance and fail to address systemic causes of poverty and deteriorating health across Palestinian refugee communities.

Refutrees has partnered with Lajee Centre in Bethlehem's Aida refugee camp to build a community rooftop garden. This is a pilot project to inspire sustainable livelihoods and community health.

PRACTICE: Rooftop gardens in refugee communities 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.

Lessons learned: 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.

(Source: UNHCR)

¹⁸ 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).

QATAR

Providing access to refugees and migrants to the national health insurance scheme

CONTEXT: The State of Qatar hosts 80 refugees (55 percent female and 31 percent children), and 57 asylum seekers (46 percent female and 37 percent children), who are mostly of Iraqi origin. The functional responsibilities for all aspects related to refugee status determination in the country are carried out by UNHCR. Despite the absence of a national framework regulating issues related to asylum, the State of Qatar generally respects international refugee protection standards. The system for entering Qatar does not allow any migrants to remain in the country, hence there are no laws and policies on this issue.¹⁹ All non-citizens in Qatar fall under the scope of the national immigration laws (expatriate law) with regard to their legal status in the country, including refugees and asylum-seekers registered with UNHCR.²⁰

The social health insurance scheme in the State of Qatar provides universal health insurance for all people in the country²¹. A state-issued health card is required for access to government-run healthcare facilities, which provide free or heavily subsidised healthcare services to both citizens and residents. Expatriates living in Qatar must first obtain a residence permit before applying for a health card. National immigration law stipulates that work sponsorship is an essential pre-requisite for becoming a legal resident and that deportation is a possible consequence of overstaying a legal residency permit.

PRACTICES: Qatar have eased visa restrictions for Syrian nationals. Currently there are almost 54,000 Syrians living in Qatar, of whom 47,000 hold full residency permits and 7,000 are on renewable visitor visas (that allows them to access health services despite not having employment). Approximately 25,000 of these Syrians have arrived during the past four years of the Syrian conflict.²²

(Source: Ministry of Public Health)

¹⁹ Formal communication: Email to WHO from the Legal Affairs Department, MOPH.

²⁰ UNHCR. (2013). Submission by the United Nations High Commissioner for Refugees For the Office of the High Commissioner for Human Rights' Compilation Report - Universal Periodic Review: The State of Qatar, September 2013. Online. Available from <<http://www.refworld.org/docid/528345c24.html>> (accessed 9 May 2018)

²¹ Law no 7 of 2013 (17 July 2013) governing Social Health Insurance

²² The New Statesman Magazine. (2017). Exclusive interview: the Qatari foreign minister on Syria and the refugee crisis, 29 September 2015, The New Statesman Magazine. Online. <<https://www.newstatesman.com/print/node/201400>> (accessed 25 September 2017)

SAUDI ARABIA

Health workers mobility Saudi Arabia/Sudan

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.

PRACTICE: Bilateral agreement on health worker mobility: 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.

(Source: Ministry of Health)

SOMALIA

Promoting refugee and migrant health in Somalia

CONTEXT: There are currently over two million IDPs in Somalia due to protracted and new displacement as a result of conflict, drought, flooding, forced evictions and an influx of returnees. Over one million of these displacements are attributed to the recent drought in 2017²³. Populations are being forced to migrate to meet life-saving priority needs, including internally, internationally to bordering countries as well as those returning from Kenya, Saudi Arabia and Yemen. These populations on the move are often joining already over-crowded IDP settlements²⁴. Somalia also has some of the worst health indicators in the world; 137 deaths per 1,000 live births, with a higher number in south and central Somalia; and a maternal mortality rate of 732 deaths per 100,000 live births²⁵. The drought, as well as concurrent outbreaks of acute watery diarrhoea (AWD)/cholera and measles, have overburdened an already weak health system.

PRACTICES:

Flexible delivery model: The Somalia MOH, in close collaboration with IOM, is using a health service delivery model that has been adjusted for the Somali context, in which health services are concentrated in urban areas and conflict, insecurity and environmental shock displacement is extensive. IOM's service delivery model is building the capacity of the existing health system by utilizing MOH human resources in a hybrid model comprised of both MOH and IOM staff. It is reducing donor dependency and building the capacity of the national workforce. This model is more sustainable than traditional aid models where development and humanitarian partners have provided the infrastructure, medical supplies and human resource capacity, however at the end of the project service provision has reduced or been suspended. This model focuses on investment in mobile and rapid response health teams instead of static clinics, accommodating the shifting paradigm whereby many countries remain in crisis for long periods, sometimes decades.

The mobile and rapid response team model (RRT) model is adaptable for all aspects of the humanitarian, development, transition and recovery phases, enabling financial and human resources to be deployed and re-deployed across Somalia based upon the rapidly changing context. This approach also caters to mobile, migrant and cross border populations, including the ability to monitor populations on-the-move and to provide services adapting to migration flow. In the Somali context, this is most notable for the IDP population in the country.

Results: In 2017, Somalia had one of the worst AWD/cholera outbreaks ever recorded, with more than 78,000 cases and 1,100 AWD/cholera related deaths reported in 52 districts across 16 regions of the country.²⁶ Most of the cholera cases were from inaccessible or partially-accessible areas, where overall case fatality rates were also higher, in comparison with accessible areas. Through the Central Emergency Response Fund's (CERF) rapid response funding mechanism, IOM scaled up from four to 33 teams, more than a threefold expansion in operations, specifically due to the drought and AWD/cholera outbreak. Through these rapid response teams, IOM provided access to emergency and life-saving PHC, following the strategy launched by the health, WASH, and nutrition clusters, known as the integrated emergency response team model. This includes access to PHC as well as health education, and referrals to cholera treatment units as necessary. Through both static and mobile teams, IOM provided 478,789 health consultations to cross border and displaced populations and host communities, as well as 79,174 immunizations to children through the routine programme of immunization, a total of 68,838 antenatal care consultations, 23,277 post-natal care visits, and supported 3,772 facility-based deliveries. IOM utilized Somalia MOH staff for team deployment, provided clinical quality oversight, trained and ran on-site capacity building, support with infectious disease preparedness and response, reported into the health management information system (HMIS), and prepositioned medical supplies and commodities.

Lessons learned: Acute emergency response should enhance the gains made by development partners to build the autonomy of the national health system. Humanitarian partners can utilize models of service delivery that capitalize on available in-country human resources for health, while complementing with technical expertise, medical supplies and logistical support, and can support to strengthen reporting into the national health management information systems. Furthermore, health service delivery models that incorporate flexible modalities such as mobile and rapid response teams allow for quick realignment in response to emergencies, without the need for lengthy resource mobilization in the acute phase of an emergency.

²³ OCHA. (2018). Somalia Humanitarian Response Plan.

²⁴ IOM. (2018). Somalia Consolidated Appeal.

²⁵ UNICEF

²⁶ OCHA. (2017). Humanitarian Bulletin, December 2017.

SUDAN

Reducing morbidity and mortality linked to a cholera outbreak

CONTEXT: Population movements increase the risks of epidemic-prone diseases. In 2017, an acute watery diarrhoea (AWD)/cholera outbreak affected the Gedaref, Gezira, Khartoum, North Kordofan, River Nile, Sennar, and White Nile states in Sudan. The White Nile state is hosting a large South Sudanese refugee (SSR) population and had the highest number of cases in June 2017²⁷. In July 2017, cases were reported in camps hosting internally displaced Sudanese in Dafur.²⁸ Since August 2016, the outbreak with over 36,000 cases and 820 deaths, spread across all 18 states, especially affecting vulnerable groups such as refugees and migrants.²⁹

PRACTICES:

Strengthening health information and disease surveillance system: Up to 127 alerts of outbreaks were investigated; 92 percent of the alerts were on AWD in five states hosting refugees where 13,564 cases and 324 related deaths were reported and responded to. Five alerts of measles and scabies were investigated and responded to.

Cholera case management: WHO supported the Sudan MOH response through providing technical and operational support to 89 cholera treatment centres (CTCs) in states hosting SSRs. The response treated over 13,000 cases of AWD in refugee populations and provided medicines and medical supplies in addition to operational costs for staffing and referral.

Preventative oral cholera vaccination campaign: Sudan MOH supported by WHO, UNHCR and health partners conducted a preventative oral cholera vaccination campaign covering about 140,000 South Sudanese refugees.

Water and sanitation activities: A water surveillance system was established in areas hosting refugees. The system used trained staff and water quality monitoring to ensure safety for human consumption and supported vector control and environmental sanitation.

(Source: World Health Organization)

Assessing needs and gaps in response urban refugees

CONTEXT: Sudan continues to be a source, transit and destination country to mixed migration movements including internal displacement. Despite positive developments in Darfur and conditions for return in some parts of the region being met, returning communities still face difficulties to accessing basic services. The eastern part of Sudan is expected to remain the entry point for Eritrean migrants, the majority of whom continue to transit through Khartoum. The situation in Syria and Yemen is expected to remain unstable and therefore new Syrian arrivals are expected to continue to arrive in Sudan, mainly settling in the capital. The South Sudan conflict, food insecurity and increased violence are unlikely to end, causing South Sudanese to cross into Sudan. The primary responsibility to protect refugees and migrants rests with the Government of Sudan, however WHO, UNHCR, IOM and other partners continue to support the Government to coordinate and implement responses.

PRACTICES:

Community outreach: In 2013, a programme for refugees in Khartoum was started. The programme aimed to work in collaboration with the Government of Sudan's committee on refugees (COR), to carry-out an integrated population assessment to understand the gaps, coping mechanisms and needs of the refugee and asylum-seeking populations in the city. By better understanding the profile and assets of this community,

²⁷ ACAPS. (2017). Sudan. Cholera outbreak briefing note. Online. Available from <<https://reliefweb.int/report/sudan/acaps-briefing-note-sudan-cholera-outbreak-16-june-2017>> (accessed 9 May 2018).

²⁸ WHO. (2017). WHO and partners, including UNICEF, scale up efforts to minimize spread of acute watery diarrhoea/cholera in the Eastern Mediterranean Region. Online. Available from <<https://reliefweb.int/report/somalia/who-and-partners-including-unicef-scale-efforts-minimize-spread-acute-watery>> (accessed 9 May 2018).

²⁹ Information collected from WHO Submission.

UNHCR Sudan hoped to have a “robust foundation for urban decision making and programming, identify priorities and responses, and develop the multi-year Urban Refugee Strategy.”

The urban refugee population assessment is a household survey using a “multi-sector, mixed-method assessment (integrating different qualitative and quantitative assessment components) across all the main sectors such as legal and physical protection, livelihoods, education, health, etc.” It was designed to tie to the results based framework. The assessment tool was complemented by focus group discussions. It was accompanied by service mapping, capacity assessments of service providers, geo-mapping of densely populated areas and a labour market assessment.

The process took approximately one year to complete including the time for preparations, assessments and report writing. Challenges of the assessment included delays due to permissions, gaps left by local assessment teams and the inability to afford modern survey tools such as tablets (iPads) that linked directly to a central database. Nevertheless, ownership for the results was enhanced through this process-heavy exercise.

More than 1,000 refugees participated in the quantitative and qualitative parts, proportionally distributed across countries of origin, gender and age. Another key component of the assessment exercise was the “knowledge transfer” including the “report back” to the community assessed, the visualization of data in the form of infographics and the multi-stakeholder workshops.

Health and social protection for refugees

Inclusion of Yemeni refugees in the national health insurance scheme: Advocacy efforts that had been in place for a few years finally paid off through a high-level agreement to include urban refugees within the same health insurance scheme that the nationals receive. Including refugees in the health insurance scheme started with a pilot project covering the whole Yemeni population registered, with plans to expand to different nationalities in urban settings.

The country-wide coverage of the health insurance card was understood to help refugees move freely between states looking for business and employment opportunities.

An evaluation on utilization and coverage is envisaged, documenting lessons learned as well as best practices for scaling up. This will directly contribute to the new way thinking about service delivery in relation to the Federal MOH led Humanitarian-Development-Peace nexus forum.

(Source: United Nations High Commission for Refugees)

SYRIAN ARAB REPUBLIC

Monitoring and responding to acute and chronic needs of refugees and internally displaced

CONTEXT: In Syria, millions of IDPs and refugees are living in rudimentary conditions in overcrowded camps, greatly increasing the risk of the rapid spread of communicable diseases.

PRACTICES:

Early warning and response system: 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.

Supporting outreach health care for IDPs and refugees in camps, settlements and hard-to-reach areas: In 2017, 16 mobile medical clinics and teams supported by WHO conducted almost 400,000 consultations and referred 21,000 patients for further treatment. In addition, WHO provided direct technical and financial support to seven partners providing healthcare services in IDP camps. WHO also focused on comprehensive trauma care by improving access to immediate trauma care so as to reduce the incidence of patients with lifelong disabilities; enhancing the emergency referral system; supporting the provision of phased trauma care and physical rehabilitation services; and strengthening the management of patients with disabilities. Increasing numbers of healthcare facilities are now providing physical rehabilitation services.

Strengthening the health system: Ensuring there are enough medicines, medical supplies and equipment to maintain essential services in hospitals and other healthcare facilities throughout Syria is an important part of health system strengthening. WHO donated medicines, supplies and equipment to help maintain essential services in hospitals and other healthcare facilities throughout Syria. In 2017, WHO distributed almost 14 million treatments across the country and supported over 560,000 trauma cases. Over 21,000 patients were referred for treatment through the strengthened referral system. These efforts benefited all segments of the population, including IDPs, refugees and migrants.

Scaling up mental health and psychosocial support: Prolonged exposure to violence has left many IDPs, refugees and migrants susceptible to profound distress. WHO has supported the scaling up of mental health and psychosocial support services (MHPSS) by training healthcare staff and community health workers on basic mental health interventions and has supported the integration of MHPSS into PHC centres. Over 400 PHC and community centres throughout Syria are now offering integrated MHPSS services.

(Source: World Health Organization)

TUNISIA

Partnership to improve migrants' access to health

CONTEXT: Tunisia has recently adopted two new legislations: First, UHC by the new constitution (Article 38, 2014) and second, prevention and fight against trafficking in persons (Law number 61, 2016). However, the application of these new laws needs to be strengthened. In fact, currently migrants in an irregular situation or without health insurance must pay for all medical costs (in the public and private sectors). Access to public hospitals for chronic treatment of urgent diseases 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 specialized care.

PRACTICE:

Advocacy to include migrants in HIV national programmes: WHO, IOM and the Joint United Nations Programme on HIV and AIDS (UNAIDS) lobbied to improve the situation. WHO supported the drafting and finalization of the Global Fund financing concept note for the years 2016 - 2021. WHO country office is supporting NGOs intervening near decision-makers to allow access to health services for some migrants.

Results: A Global Fund mechanism is in place, with a budget for the treatment of 200 migrants, leaving or transiting through Tunisia.

(Source: World Health Organization)

United Arab 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:

General Department of Human Rights: 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.³⁰

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.

(Source: Promoting a Rights-based Approach to Migration, Health, and HIV and Aids: A Framework for Action; International Labour Office – Geneva: ILO, 2016)

³⁰ International Labour Organization submission to WHO.

YEMEN

Preventing the spread of infectious diseases

CONTEXT: In Yemen's capital, Sana'a, persons of concern are living in an urban environment and are as susceptible, if not more so, than the Yemeni host population to diarrheal diseases. Many refugees and asylum seekers are struggling to cover their basic needs and have sought shelter in poor conditions due to the absence of stable livelihood opportunities.

PRACTICES:

Long term public health interventions: UNHCR uses a community based-approach to ascertain and address issues in the refugee community. Changes are not imposed but rather are initiated together with the urban refugee population. UNHCR promotes community structures through committees to address problems through certain mechanisms such as community mobilizers. A network of community mobilizers, who have been selected by the community is involved in outreach aimed at increasing mobilization and participation. Community mobilizers have increased participation and ownership through training various groups and committees to facilitate refugees' activities in diverse sectors. Monthly coordination meetings with representatives of refugees and local authorities give the opportunity for refugees' voices to be heard.

Emergency response: To reach communities with prevention information and to limit the spread of the deadly disease, UNHCR's partner, Yemen Family Care Association (YFCA) as well as other related partners, have focused on community outreach activities. This has included, firstly, community awareness sessions at UNHCR supported healthcare centres, community centres and refugee settlement areas at high risk, including in areas where suspected cholera cases have been reported or anticipated, secondly, mass information materials, including thousands of flyers on cholera awareness and prevention, disseminated in numerous languages, thirdly, active case detection, surveillance and referral services of suspected cases to nearest WHO diarrhoea treatment centre (DTC) or oral rehydration corner (ORC), fourthly, home visits to suspected cases by UNHCR's partners, to provide key prevention messages to family members, promote early detection and correct disinfection of contaminated areas to protect both the family and wider community, and fifthly, close monitoring through weekly cholera updates on activities, including challenges and achievements facing the outreach teams, quantitative information on suspected and confirmed cases treated at the ORP and the health clinics supported by UNHCR through a standardized report form.

(Source: United Nations High Commission for Refugees)

Addressing social determinants of health

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.

PRACTICE:

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

Preventing spread of disease and Identifying vulnerable cases

CONTEXT: Basateen is a sub-urban neighbourhood to the city of Aden, home to a large population of Somali refugees. The neighbourhood represents one of the most under-developed locations in Yemen, with families sheltering in dire conditions, including makeshift shelters with weak water and sanitation services. These conditions place the population at increased risk of epidemics.

PRACTICES:

Improving infection control measures in Basateen clinic: Infection prevention and control (IPC) activities have included rehabilitation, improvement of isolation measures and establishing an oral rehydration centre, capacity building of medical staff on case management, and distribution of WHO guidelines and best practices for IPC.

Community mobilization: Community health workers have been trained and equipped to assess diarrhoea cases, to begin the rehydration process and to refer suspected cases to management centres. Community mobilization and awareness has been implemented at the community level targeting refugees, migrants and the host community.

Leveraging community-based protection network: UNHCR through its partners has established and identified refugee committees to better communicate, provide counselling and disseminate messages with the scattered community. These committees operate from community and drop-in centres and provide psychosocial and legal counselling to vulnerable refugees, especially women and young girls who have survived SGBV. The counselling includes free of charge information about rights, procedures, services, new regulations, policies and other counselling options.

In 2009, UNHCR signed an agreement with 'ADPSN', a local implementer, that enables refugees with disabilities to have easy access to rehabilitation services, such as physiotherapy, assistive devices and vocational training.

The drop-in centre also conducts training on early interventions for staff in the camp and in the urban area of Basateen, as well as training on awareness of disability for school staff and courses on physiotherapy for medical staff.

The programme also incorporates the provision of holistic programmes to support unaccompanied minors, including basic needs such as accommodation and formal and non-formal education.

(Source: United Nations High Commission for Refugees)

REGIONAL INITIATIVES

Middle East Response to HIV, tuberculosis and malaria: A summary of selected practices

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, Mafrq 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 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 way 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. (Source: International Organization for Migration)

Enhancing the health monitoring and health information systems in Egypt, Libya, Morocco, Tunisia and Yemen

CONTEXT: Since April 2015, IOM implemented a regional programme on migrant health promotion and assistance funded by the Ministry of Foreign Affairs of Finland. The programme covers Egypt, Libya, Morocco, Tunisia, and Yemen, and has implemented a set of tailored activities to assist migrants with health needs, namely, direct assistance to migrants in need of medical and humanitarian assistance, assistance to national authorities to respond to and manage the health needs of migrants and their host communities in migrant-dense areas, capacity building of governmental and non-governmental health structures to deliver quality “migrant-friendly” and “psychosocially aware” healthcare services, information sharing on available health care, health issues and other issues of concern to migrants with health needs, and support to the government and civil society to assist the most vulnerable cases, including victims of trafficking, women migrants, single mothers and unaccompanied migrant children.

While activities are tailored to each country context, regional engagements allow participating stakeholders and actors to come to the table to discuss the best practices, challenges and ways forward. One key thematic area highlighted in the programme that persists as a challenge, an opportunity and a priority throughout the region, is enhancing health monitoring and health information systems in an effort to improve the health and wellbeing for both migrants and host communities. Indeed, when working with the national health systems in countries ranging from Morocco to Yemen, on migration, health and information management is an ambitious goal. National health structures and systems range in their capacity, their resiliency and their willingness to adapt to the ever-evolving needs of local populations and migrants transiting through their borders. More nuanced approaches, rooted in local (not just national) understandings of the needs and the capacities, will improve national health systems, creating more sustainable and quantitatively rich health systems and results-based interventions.

PRACTICES:

Yemen: Mobile health clinics: IOM continuously monitors the situation of vulnerable migrants through its mobile health clinics. Furthermore, IOM Yemen has developed an online recording system managed through multiple ‘migrant response points’ that issue each migrant with an electronic identification card used to record IOM assistance received. The system is supporting the needs of migrants on the move, tracking where they receive assistance and their vulnerability, and records and updates their health information.³¹

Libya: Detention facilities risk assessment: A public health risk assessment is currently being conducted in detention facilities across the country to firstly, identify the key health related problems and risks that persist in the country, secondly, define baseline conditions for basic health and wellbeing for detained migrant populations, and thirdly, develop a risk response plan; and fourthly, establish a system for monitoring and control to assess the health risk trends in an evolving context.

Lessons learned and way 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 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.

To establish efficient information management mechanisms, the national health systems must involve not only the central level of governments, but also the local levels via governorates and municipalities. Developing mechanisms that respond to all levels of governance will expand the reach and operationalization of policies that seek to address and improve the health of migrants and host communities.

³¹ IOM. (2016). Profile Comparison of Migrants, Yemen. Online. Available from <<https://www.humanitarianresponse.info/system/files/documents/files/tcn-migrants-snapshot-january-2016.pdf>> (accessed 9 May 2018). Through extensive screening data recording at MRPs, IOM Yemen is able to measure and track indicators of vulnerability, including physical and psycho-social injuries suffered, human rights violations and other factors regarding the health and wellbeing of migrants transiting through Yemen.

Innovative and new technologies should be deployed to facilitate and optimize migrants' access to health systems. The public sector could build on pre-existing information management systems utilized in the private sector.

Furthermore, sharing success stories in other countries will help to increase the willingness of governments to collaborate with relevant actors on building national health systems that are conducive to improving access to health for migrants and that acknowledge the needs on the ground, at all levels of government and geographical areas.

(Source: International Organization for Migration)

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