UNHCR
UN High Commissioner for Refugees
المفوضية السامية للأمم المتحدة لشؤون اللاجئين

ARAB STRATEGY ON

ACCESS TO PUBLIC HEALTH SERVICES IN ASYLUM AND DISPLACEMENT CONTEXTS IN THE ARAB REGION




Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts in the Arab Region

Primary health care is a right for all, and constitutes the active basis for providing health services to refugees/ displaced persons and asylum seekers in a comprehensive and integrated manner, according to scientific and practical foundations, ensuring the availability of curative and preventive services to all target groups and their hosting communities; which represents the basic axis of health development.

Due to the crises in the Arab region, the numbers of refugees/ displaced persons and asylum seekers are increasing in an upward pattern, and these numbers remain negatively impacted by the ongoing conflicts in some countries of the Arab region. Refugees/displaced persons and asylum seekers also suffer from increased rates of disease (illness) due to their chronic health problems, the difficulties faced by health systems in host countries to provide health services and the inaccessibility of those services when they do exist.

Stemming from the third goal of the 2030 Sustainable Development Goals on health, which calls for the enjoyment of good health and well-being at all ages, and given that refugees/ displaced persons and asylum seekers are among the most vulnerable groups to the deterioration of the health situation, UNHCR initiated the drafting of "The Arab Strategy on Access to Public Health in Asylum and Displacement Contexts in the Arab Region", which the General Secretariat of the League of Arab States, according to its internal mechanisms, presented to the Council of Arab Health Ministers, and it was adopted at its 52nd Ordinary Session in Geneva (May 2019).

This Strategy is consistent with the Global Compact on Refugees, offering approach for easing pressure on host countries of refugees, displaced persons and asylum seekers, in line with international obligations including International Human Rights Law, International Refugee Law, International Humanitarian Law and relevant international instruments as well as humanitarian principles.

This Strategy aims to support efforts to meet the health needs of refugees/ displaced persons and asylum seekers by strengthening health systems, preventing diseases and providing the necessary health care, to reduce morbidity, early mortality and disability, in order to achieve universal health coverage in line with the Sustainable Development Goals (2030).

The Strategy, also provides a guiding framework for the Arab States, which contributes to responding to the public health needs of refugees/ displaced persons, asylum seekers and host communities alike effectively and within a holistic approach that can be adapted to fit the national policies and priorities of each country. In addition, the Strategy creates a stimulating environment that supports access to public health services of all target groups in the Arab States.

The Secretariat General of the League of Arab States (Social Affairs Sector), in cooperation with the United Nations High Commissioner for Refugees and Partners, will continue to advocate for the provision of public health services to refugees/ displaced person and asylum seekers, leaving no one behind, by follow-up on the implementation of the action plan annexed to this Strategy and its executive program.

Amb. Dr. Haifa Abu Ghazaleh

Assistant Secretary General
Head of Social Affairs Sector
League of Arab States

Mr. Ayman Gharaibeh

Director, Bureau for the Middle East
and North Africa United Nations High
Commissioner for Refugees

Arab Health Ministers Council
Ordinary Session (52)
19-20 May 2019, Geneva

Resolution No. (4)

The Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts in the Arab Region

The Arab Health Ministers Council in its Ordinary Session (52), and after consulting the following:

- The memo of the Technical Secretariat of the Arab Health Ministers Council on the subject matter;
- The draft Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts in the Arab Region;
- The recommendation of the 7th meeting of the Technical Consultative Committee of the Arab Health Ministers Council;
- The draft Resolution issued by the Executive Bureau of the Arab Health Ministers Council, in its preparatory meeting for the work of this session in this regard, that was convened at the Arab League Mission's Headquarters in Geneva on 19th of May 2019, and upon discussion, has decided:

1- The adoption of the "Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts in the Region."
2- Requesting the United Nations High Commissioner for Refugees' Regional Office to the Arab Republic of Egypt and to the League of Arab States to prepare a draft plan of action and executive program for the Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts in the Region, within two months as of dated, in coordination with the Technical Secretariat of the Arab Health MinistersCouncil, and to provide the General Secretariat with the aforementioned plan of action to be presented to the Member States for comments.
3- Reaffirming the importance of registering, refugees, asylum-seekers and displaced persons in the hosting Arab countries, in coordination and cooperation with the various governmental sectors concerned, the concerned United Nations' organizations and its competent agencies.
4- Inviting the international community, donor countries, international and regional organizations to provide sufficient financial and technical support to the hosting Arab countries, to sustain the funds for the necessary health needs of refugees, asylum-seekers and displaced persons.

مجلس وزراء الصحة العرب
الدورة العادية (52)
بتاريخ 19-20 مايو 2019 بجنيف

قرار رقم 4 بشأن

الاستراتيجية العربيّة بشأن إتاحة خدمات الصحة العامة في سياق اللجوء والنزوح في المنطقة العربيّة

إن مجلس وزراء الصحة العرب في دورته العادية الثانية والخمسين، بعد اطلاعه على،

- مذكرة الأمانة الفنية لمجلس وزراء الصحة العرب حول الموضوع،
- مشروع الاستراتيجية العربيّة بشأن إتاحة خدمات الصحة العامة في سياق اللجوء النزوح في المنطقة،
- توصية الاجتماع السابع للجنة الفنية الاستشارية لمجلس وزراء الصحة العرب،
- مشروع القرار الصادر عن المكتب التنفيذي لمجلس وزراء الصحة العرب، في اجتماعه التحضيري لأعمال هذه الدورة بهذا الشأن، الذي انعقد بمقر بعثة جامعة الدول العربيّة بجنيف بتاريخ 19 مايو 2019 وبعد المناقشة،

يقرر:

1. اعتماد "الاستراتيجية العربيّة بشأن إتاحة خدمات الصحة العامة في سياق اللجوء والنزوح في المنطقة".
2. الطلب من المفوضية السامية للأمم المتحدة لشؤون اللاجئين - المكتب الإقليمي لدى جمهورية مصر العربيّة ولدى جامعة الدول العربيّة، بإعداد مشروع خطة عمل وبرنامج تنفيذي للاستراتيجية العربيّة بشأن إتاحة خدمات الصحة العامة في سياق اللجوء والنزوح في المنطقة العربيّة" خلال شهرين من تاريخه، بالتنسيق مع الأمانة الفنية لمجلس وزراء الصحة العرب، وموافاة الأمانة العامة بها لعرضها على الدول العربيّة الأعضاء لإبداء ملاحظاتها حولها.
3. التأكيد على أهمية تشجيع تسجيل النازحين واللاجئين وملتمسي اللجوء بالدول العربيّة المستضيفة بالتنسيق والتعاون مع مختلف القطاعات الحكومية المعنية، ومنظمات الأمم المتحدة ووكالاتها ذات الصلة.
4. دعوة المجتمع الدولي والدول المانحة والمنظمات الدولية والإقليمية إلى تقديم الدعم المالي والفني الكافيين للدول العربيّة المستضيفة، لاستدامة تمويل الاحتياجات الصحيّة للنازحين واللاجئين وملتمسي اللجوء.

The preparation and review team

of the Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts

United Nations High Commissioner for Refugees

Coordination and Preparation of the Strategy

Mr. Kaidar Ayoub

Senior Government Liaison Officer

Strategy's Preparation Team

Dr. Maha El Rabat

Public Health Expert and Professor of Public Health, Faculty of Medicine

Ms. Ann Burton

Chief of the Public Health Section

Linguistic Review Team

Ms. Silja Rezk

Reporting Officer

Ms. Aline Mikhael

Assistant Government Liaison Officer

Ms. Hend Amin

Government Liaison Associate

League of Arab States

Coordination and Preparation of the Strategy

Health and Humanitarian Aid Department

Minister Plenipotentiary

Said El Hadi

Director of Health and Humanitarian Aid Department - Responsible of Technical Secretariat of Arab Health Ministerial Council

Mr. Abdelmonem El hakim

Health and Humanitarian Aid Department

Strategy's Review Team

Refugees, Expatriates and Migration Affairs Department

Minister Plenipotentiary

Enas El Fergani

Director of Refugees, Expatriates and Migration Affairs Department

Ms. Lobna Essam Azzam

Refugees, Expatriates and Migration Affairs Department

Table of Contents

Acronyms and Abbreviations

BBP	Basic Benefits Package
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
EMR	Eastern Mediterranean Region
HAUS	Health Access and Utilization Survey
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDP	Internally Displaced Person
LAS	League of Arab States
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MENA	Middle East and North Africa region
MOF	Ministry of Finance
MOFA	Ministry of Foreign Affairs
MOH	Ministry of Health
MOP	Ministry of Population
MOSS	Ministry of Social Solidarity
MOU	Memorandum of Understanding
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
OAU	Organization of African Unity
PHC	Primary Health Care
RC/RW	Refugee Communicators/ Community Workers
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually-Transmitted Infection
TB	Tuberculosis
UNFPA	United Nations Population Fund
UHC	Universal Health Coverage
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
VAW	Violence Against Women
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Glossary of Terms

1- Refugees:

Refugees are people fleeing conflict or persecution. They are defined and protected in international law, and must not be expelled or returned to situations where their life and freedom are at risk. (Source: UNHCR). International law defines a refugee as a person who "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it." (Source: UN General Assembly, Convention Relating to the Status of Refugees, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, available at: http://www.refworld.org/docid/3be01b964.html).[1]

2- Internally Displaced Person/People:

Internally displaced persons are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border. (UN Guiding Principles on Internal Displacement, 22 July 1998), ADM 1.1,PRL 12.1, PR00109/98/, available at: http://www.refworld.org/docid/3c3da07f7.html

3- Stateless Person:

A 'stateless person' means a person who is not considered as a national by any state under the operation of its law. UN General Assembly, Convention Relating to the Status of Stateless Persons, 28 September 1954, United Nations, Treaty Series, vol. 360, p. 117, available at: http://www.refworld.org/docid/3ae6b3840.html.[2]

4- Asylum-seeker:

An asylum-seeker is someone whose request for international protection has yet to be processed. The UDHR establishes that everyone has the right to seek and enjoy asylum. Asylum-seekers also enjoy the right to non-refoulement. See: UN General Assembly, Declaration on Territorial Asylum, 14 December 1967, A/RES/2312(XXII), available at: http://www.refworld.org/docid/3b00f05a2c.html; UNHCR, Note on Non-Refoulement (Submitted by the High Commissioner), 23 August 1977, EC/SCP/2, available at: http://www.refworld.org/docid/3ae68ccd10.html.

1 More information on applying this definition can be found in UNHCR's Handbook and Guidelines on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees, December 2011, HCR/1P/4/ENG/REV. 3, available at: http://www.refworld.org/docid/4f33c8d92.html.

2 More information on applying this definition can be found in UNHCR's Handbook on Protection of Stateless Persons, 30 June 2014, available at: http://www.refworld.org/docid/53b676aa4.html.

5- Health:

According to the World Health Organization; Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is also defined as the state of complete physical and mental well-being of a living individual, which allows them full and synchronized performance to all their biological functions, with the objective of attaining their life and natural growth.

6- Public Health:

Is the art and science of prevention of diseases and decreased mortality, and to work on enhancing and developing individual and communal health, where they live, through organized efforts of the community to keep the environment healthy and clean, combat communicable diseases, spreading awareness on personal hygiene, in addition to enhancing nursing and medical services with the aim of early detection and diagnosis, and to provide preventive treatment to various diseases, and to develop livelihoods and community services to allow individuals to obtain their rights to health and treatment.

7- Social Determinants of Health:

The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. The determinants are represented in the social and economic conditions, which individuals are living under and determines their health. It is the “social risk conditions,” instead of being the individual risk factors, which can lead to the decrease or increase in the infection with a certain disease, such as, coronary cardiac disease or type II diabetes.

Executive Summary

Global levels of forced displacement have reached the highest recorded levels in recent years because of the wars, violence, instability, and natural disasters that currently affect many regions around the world. The United Nations Refugee Agency (UNHCR) estimates that in 2017, more than 71.4 million people were forcibly displaced by conflict, persecution, violence or human rights violations. Slightly more than half (55.8 per cent) of them were internally displaced (39.9 million), a quarter (19.9 million) were refugees, and 5 per cent were stateless (3.9 million). In addition, the Middle East and North Africa currently hosts 20 million of the world's registered refugees, asylum-seekers and internally displaced people (IDPs).[3]

The United Nations has declared the Syria crisis the worst humanitarian crisis of the 21st century. Since 2011, an estimated 5.5 million refugees have fled Syria, and are being hosted mainly in Lebanon, Jordan, Turkey, Iraq and Egypt.[4] In addition, the conflict in Yemen has left around 22.5 million out of a population of 27 million in need of humanitarian assistance[5] which has affected the country's infrastructure, including its medical facilities, and led to outbreaks of communicable diseases, with a particular impact on children.[6] Many other Arab states are facing similar crises.

The Members of the League of Arab States (LAS) are currently transitioning from the process of fulfilling the Millennium Development Goals (MDGs) to committing to the Sustainable Development Goals (SDGs). Arab states' attempts to meet the MDGs over the past decade have revealed various challenges, some of which persist or are aggravated due to the current turmoil in the region and its negative effects on development.

It is worth noting that the Arab states have made tremendous progress in health outcomes in recent decades, although with variation across countries. However, in lower and middle-income countries, the reformation process that is taking place has been hindered by the socio-economic and political instabilities that have hit the region, and the resulting forced displacements. The capacities and readiness of refugee-hosting countries to respond to such crises have been hampered, causing a lack of provision of food, shelter, and health services. Forced displacement movements have also put pressure on the health care systems of hosting countries, which have responded differently depending on their particular circumstances. This has led to a multitude of health concerns and problems that affect refugee communities, with a particular impact on the most vulnerable refugees.

Health issues affect refugee communities in various ways and are heightened by the lack of access to services, gender dynamics, existing health problems such as non-communicable diseases (NCDs) and aggravated by arising problems such as sexual violence and violence against women, early marriage, maternal and child health (MCH) complications, non-communicable diseases and others. Much work is needed in the area of public health services to meet the health needs of refugees and to ensure the integration of those needs and the related public health initiatives into an overall public health strategy, especially those that are not well-defined in original service delivery packages, yet constitute integral components of refugees' health care needs, e.g. mental health problems and services for those with disabilities.

3 United Nations High Commissioner for Refugees. 2017. "UNHCR Global Report". UNHCR. http://reporting.unhcr.org/sites/default/files/gr2017/pdf/GR2017_English_Full_lowres.pdf.

4 United Nations. 2015. "UN Report: Syria Faces Worst Refugee Crisis in Recent History". The International Committee of the Fourth International. https://www.wsws.org/en/articles/2015/07/10/syri-j10.html.

5 United Nations High Commissioner for Refugees. 2016. "Yemen Situation Regional Refugee and Migration Response Plan". United Nations High Commissioner for Refugees. http://data.unhcr.org/yemen/download.php?id=111.

6 Ibid.

The 2030 Agenda for Sustainable Development has taken shape in a set of SDGs seeking to eradicate poverty, promote inclusiveness and equity, and renew the global commitment to economic growth through environmental sustainability, protection and social development. The SDGs, which consist of 17 goals and 169 targets, are intended as a universal agenda for all people in all segments of the society in both developed and developing countries.[7] Health is both a precondition for and the outcome of policies that promote such sustainable development. The right to the highest attainable standard of health, the significance of good health to the enjoyment of dignity and human rights and the importance of healthy populations to sustainable development are essential.[8]

Although the SDGs do not explicitly include any targets relating to the health of refugees and asylum-seekers, they do include many provisions that are relevant to the rights of such groups. The success of the SDGs Agenda will likely be measured through the welfare promotion index and the capabilities of the groups most in need, those in exclusion and the most vulnerable in the society, presented in its principle promise to 'Leave No One Behind'. In fact, each of the goals, with their focus on equity and inclusiveness, will affect the status of refugees, both directly and indirectly.[9] For example:

- SDG 1: End poverty in all forms everywhere;
- SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agricultures;
- SDG 3: Promote well-being for all at all ages;
- SDG 5: Achieve gender equality and empower all women and girls;
- SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels.

Achieving the SDGs by 2030 will require further efforts from governments to address their needs in a way that supports the responsiveness of health systems.

The principle of "leave no one behind" addresses the issue of refugees, vulnerability and maintaining rights to health for all.[10]

The League of Arab States was founded in 1945 and is therefore the oldest regional organization in the world. It has 22 Member States: Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates, and Yemen. It was created to strengthen relations between Arab Member States and provide a platform for coordinating policy positions on matters of common concern and working towards common goals while preserving each state's independence and sovereignty.

Many Arab states have adopted resolutions that are relevant to the health rights of refugees, internally displaced people, and asylum-seekers pertaining national legislations (see annex for definitions). The Strategy will provide a regional framework applicable to all Arab states, but which may also be adapted to fit national realities and priorities.

7 Transforming Our World: The 2030 Agenda for Sustainable Development United Nations, 2015 A/RES/70/1.

8 Health in the Post-2015 Development Agenda: An Analysis of the UN-led Thematic Consultations, High-Level Panel report and sustainable development debate in the context of health. World Health Organization. ISBN 978 92 4 150596 3 (NLM classification: WA 530).

9 "The right to health of non-nationals and displaced persons in the sustainable development goals era: challenges for equity in universal health care," International Journal for Equity in Health, 2017. 16: 14 DOI:10.1186/s12939-016-0500-z.

10 "Reducing Humanitarian Needs and Vulnerabilities In The SDG Era | Center On International Cooperation". 2015. Cic.Nyu.Edu. https://cic.nyu.edu/blog/global-development/reducing-humanitarian-needs-and-vulnerabilities-sdg-era.

Vision and Scope of the Arab Strategy on Access to Public Health for Refugees in Asylum and Displacement Contexts.

"To improve the health outcomes of refugees, displaced persons and asylum-seekers in Arab states."

The Strategy aims to:

- Respond to the needs of refugees, displaced persons and asylum-seekers for health promotion, disease prevention, and care to reduce morbidity, premature mortality and disabilities, and adopting the universal health coverage (UHC) paradigm in alignment with the SDGs. This to be achieved through the empowerment, enhancement and mainstreaming of access to local primary health care services that are of high quality, including emergency services, referral to secondary and tertiary health care with relevant involvement of inter-related sectors, while ensuring their availability within national systems as far as possible.

- Support the necessary assistance for national health care systems to ensure its ability to respond to the health needs of refugees and host communities.

The Strategy provides a regional framework for Arab countries that can be modified to fit the local context and the priority of each country. The Strategy has come in time to pave the way for the developments necessary for the preparation of the Global Compact on Refugees, with respect to health (Page 29).

The Strategy suggests six strategic pillars and six main goals, necessary for creating an encouraging environment to support refugees and asylum-seekers in the Arab states, to obtain public health services and health care. The strategic pillars entail the following:

Strategic pillar (1): Supporting the legislative, political and regulatory environments that strengthen full health coverage for refugees and asylum-seekers.

Strategic pillar (2): Supporting the fair access of refugees, asylum-seekers and internally displaced persons, of high-quality primary, secondary and tertiary health care services, including the provision of health care as needed through the national systems, whenever feasible.

Strategic pillar (3): Addressing and processing refugee, displaced persons and asylum-seekers' vulnerabilities through protection responses.

Strategic pillar (4): Enhancing the national capacity of public health and infrastructure to respond to health needs of refugees, displaced persons and asylum-seekers, and host communities on both long and short terms.

Strategic pillar (5): Enhancing health information systems to allow gathering and acquiring of solid data in timely manner.

Strategic pillar (6): Coordinating medical sector response.

The Strategy is considered a dynamic process that presents a framework to specially prioritize public health needs of refugees, in line with the regional and national available capacities. The implementation of the Strategy is considered the responsibility of each country, while preserving the substantial role that is played by the League of Arab States and International Organizations to enhance and monitor the progress attained in this regard.

Chapter I

Methodology and Phases of The Strategy Development

A. General Plan for the Drafting Process of the Strategy

The "Arab Strategy on Access to Public Health Services in Asylum and Displacement Contexts during the period 2019 - 2024" comprises five chapters:

Below are brief descriptions of each of these chapters:

The First Chapter explains the approaches to be followed, while setting out the strategy. The Second Chapter includes an introduction that discusses the following:

1- Regional refugee context;
2- The Refugee situation in some Arab states;
3- The importance of drafting the "Arab Strategy on Public Health in Asylum and Displacement Contexts;"
4- Available opportunities for drafting the Arab Strategy on Public Health.

The Third Chapter entails the laws and policies of public health, and the international conventions relevant to refugees, these include the following:

1- International and Regional Human Rights Treaties and Instruments Relevant to Refugee Right to Public Health Services in the Arab Region;
2- Constitutional Rights in Asylum Contexts and Country Agreements Relevant to International Rights and Laws on Public Health;
3- Protection frameworks;
4- Gaps and challenges in the implementation.

The Fourth Chapter tackles the public health response concerning refugees, displaced persons and asylum-seekers in the region, and it includes the following:

1- Public Health Needs of Refugees, Displaced Persons, and Asylum-Seekers;
2- Public Health Interventions on Regional and National Levels;
3- Public Health Systems' Capacity;
4- Practical Experiences;
5- Case study on Cholera outbreak in Yemen;
6- Challenges of Access to Health Services, Mainstreaming and Sustainability.

The chapters from two to four are mainly concerned with the review and presentation of literature extracted from descriptive and analytical reports, and researches and studies performed on the current status of refugees, and the health services provided to refugees, displaced persons and asylum-seekers in the Arab states.

The Fifth Chapter is concerned with the theme of this document, as well as explaining the Strategy per se. It also includes the guiding principles and strategic approaches, which were laid out based on refugee right to health and public health principles that were derived from public health strategies on both local and regional levels. The chapter later explains the strategic priorities, the goals and procedures of priority, and lays out a plan of action.

The suggested strategic pillars include the following:

Strategic pillar (1): Supporting the legislative, political and organizational environment, which enhances the health coverage for refugees and asylum-seekers as feasible.

Strategic pillar (2): Supporting the fair access of refugees, displaced persons and asylum-seekers to high-quality primary, secondary and tertiary health care services, including the provision of health care as needed through national systems, whenever feasible.

Strategic pillar (3): Responding and processing of refugees, displaced persons and asylum-seekers' vulnerabilities through protection responses.

Strategic pillar (4): Enhancing the national capacity of public health and infrastructure to respond to health needs of refugees, displaced persons and asylum-seekers, as well as the host communities on both short and long terms.

Strategic pillar (5): Enhancing medical information systems to allow gathering and acquiring solid data in timely manner.

Strategic pillar (6): Coordinating medical sector response.

B. Strategy Layout

The Strategy was laid out through several steps, with the objective of using the best available data to establish a comprehensive framework that can be established across the Arab states.

Phase (1): Laying out the general plan and obtaining the unanimous consent of all concerned parties

The general plan was based on a number of strategies and gap analyses, concerning the understanding of refugee health conditions in the Arab states.

Phase (2): Literature Review

Published researches, reports, studies and surveys were reviewed, through a variety of sources. For example, TWINE system, the World Health Organization (WHO), United Nations International Children's Emergency Funds (UNICEF), the League of Arab States (LAS), the International Labor Organization (ILO) and the World Food Program (WFP). The literature review primarily included studies conducted in the period 2000 - 2017, with a focus on the reports published post the Arab Spring, and during the Syria crisis. The results of the research have shown a number of references of relevance, and also the gaps in research concerning refugees and national data. These gaps in available data and analyses, have resulted in gaps in the available information, for example, the data concerning refugees that are not registered with UNHCR or national governments, or those who are not part of the organized protection or health efforts. There has also been a gap in the available modern and detailed data that tackle the impacts of refugee influxes on the performance of health systems, with regards to the basic components of the systems of some Arab states.
Results:

- The draft was preliminarily reviewed by UNHCR, and it will be reviewed later with the concerned entities respectively.
- Procedures of priority will be adjusted based on the discussion with Member States at the League of Arab States.

Phase (3): Final adjustments of the Strategy

Below are the final stages that must be completed to conclude the drafting of the Strategy:

- Presenting the modified draft of the Strategy to the Member States for review;
- Including modifications based on the inputs and comments;
- Laying out the final Strategy;
- Adoption of the Strategy and the plan of action by the League of Arab States and its Member States;
- Layout of plans and frameworks by Member States.

Chapter II

Regional Context for Refugees, Displaced Persons and Asylum-Seekers

Introduction

Arab states are facing a number of challenges as a result of political, social and economic instability in some parts of the region and the wider impacts of this instability, as evidenced by the increased movement of refugees and asylum-seekers within the Arab world and Africa.

With regards to the effects on health, forced displacement within countries and between countries result in higher rates of morbidity and mortality from preventable causes, with particular effects on those made vulnerable by age or gender. In addition, there is a number of challenges regarding the provision of public health services in asylum contexts, including those related to policy, programmatic and institutional settings e.g. administrative difficulties, coordination, funding, weakened systems, the creation of sustainable interventions, among others.

A. Regional Refugee Context

The 22 Arab States located in North Africa, the Middle East and African countries represent a diverse group, ranging from oil-rich countries with good health indicators and less wealthy states with poorer health outcomes. With the exception of the oil-rich countries, Arab states approach the global averages in terms of poverty and inequality (World Bank data)[11,12]. The Arab world has life expectancy and infant mortality rates same or even better than the global averages.[13]

Refugee crises are not a new phenomenon in the Arab world. The region has experienced a number of waves of refugees and asylum-seekers, beginning in 1947 with the partition of Palestine and the subsequent 1948 war, and followed by waves of forced displacement prompted by conflict and instability in the region or in parts of Africa. The region has also witnessed many large-scale forced population movements that resulted from crises from the liberation of Algeria, the Lebanese civil war (1975-1991) until the invasion of Iraq in 2003 and the continued civil war.[14]

According to UNHCR's report on the global trends on forced displacement, conflicts and persecution have led to the increase in the percentages of forced displacement in 2017 to reach its highest recorded levels then. As the number of forcibly displaced persons has reached 71.4 million by the end of 2017, compared to 67.7 million persons in 2016, and 59.5 million persons in 2014. Additionally, the number of refugees globally, has reached to 19.9 million recording an increase of 5.5 million persons in comparison to those recorded in 2014, which has resulted in an increase in the refugee numbers to its highest peaks since the beginnings of the nineties. The numbers refer to the presence of one forcibly displaced person within every group of 113 persons around the world. Moreover, the Arab region[15] is witnessing the highest levels of forced displacement around the world. With a total of 71.4 million persons of concern to UNHCR in 2017, around 50 per cent are present in the region, taking into account the 5.3 million Palestinian refugees

11 "Indicators | Data". 2019. Data.Worldbank.Org. http://data.worldbank.org/topic.

12 Health in the Arab world: a view from within**.** Governance and health in the Arab world
Rajaie Batniji, Lina Khatib, Melani Cammett, Jeffrey Sweet, Sanjay Basu, Amaney Jamal, Paul Wise, and Rita GiacamanLancet. 2014 Jan 25; 383(9914): 343–355.
Published online 2014 Jan 20. doi: 10.1016/S0140-6736(13)62185-6

13 Ibid

14 Refugees and Displacement in the Middle East MARC LYNCH, LAURIE BRAND March 29, 2017 Project on Middle East Political Science. Carnagie Endowment for International Peace

15 The United Nations estimates that more than six million Syrians have fled their country, while another 10 million have been internally displaced. Statistics, performed under both IOM and UNHCR, show that around 2.755,916 individuals have become internally displaced in Yemen since the eruption of the last crisis at the end of March 2015.

registered with the UNRWA in its functional domains in Lebanon, Syria, Jordan, West Bank including East Jerusalem and the Gaza strip.

The current conflict in Syria has led over five million individuals (5.5 million refugees)[16] to flee as refugees to Turkey, Lebanon, Jordan, Iraq and Egypt. It has also led to the internal displacement of 6.15 million individuals, including 2.8 million children. The civil war in Yemen as well, which has erupted in 2015, has led, by the end of 2017, to 80 per cent of the civil population needing humanitarian assistance, especially food items, health assistance and shelter. In addition to that, there are around 280,692 refugees and asylum-seekers in Yemen. As well, around 165,000 Libyans were forced by the conflict to flee their homes in Libya. In Iraq, the current conflict has resulted in continuous waves of internal displacement, reaching 4.3 million and 249,000 Syrian refugees. A large number of refugees has crossed the Mediterranean Sea fleeing to Europe , resulting in a total number of 1.015,078 refugees and migrants coming through the sea in 2015, and more than 300,000 expatriates through the sea in 2016.[17] Taking into account the number of Palestinian refugees, the Arab region has the highest number of forcibly displaced persons in all geographic regions.

In addition to movements through the Gulf of Aden, a number higher than 172,301 persons have reached Europe through the sea in 2017, compared to 362,753 in 2016, and 1.015,078 in 2015 through irregular routes. Moreover, it has been reported that the majority have left through Libya. During the same period, 3,139 persons have lost their lives, or news have been delivered that they were lost in the Mediterranean Sea.

According to the World Bank, wars and conflicts in Syria, Libya, Yemen and Iraq have led millions of people to leave their homes to cross into countries suffering from economic burdens such as Egypt, Jordan, Lebanon, Djibouti and Tunisia, impacting the development progress in both the countries of origin and the host countries.[18]

Despite the assistance granted by the host governments and the international community, both refugees and host communities are exposed to dangers exponentially. The more refugees there are, the higher the percentages of poverty and risk exposure among these groups of refugees and asylum-seekers. 70 per cent of the Syrian families in Lebanon live below the local poverty line, while 90 per cent of Syrian refugees in Jordan, living outside camps are living below the poverty line.[19] Host countries are suffering due to overstretching of their limited resources. They often host refugees from multiple countries. Egypt, for example, is host to refugees from Syria and Iraq, as well as Eritrea, Somalia, Ethiopia, Sudan and other sub-Saharan African countries. Jordan, Lebanon, Sudan and Yemen also host diverse refugee populations. Iraq has between 300,000 refugees and asylum-seekers registered with UNHCR, including refugees from Syria, Palestine, Eritrea, Somalia, and Sudan, among others.

These rapid and substantial influxes of refugees and asylum-seekers create needs for assistance and protection. UNHCR and development organizations are working with host countries to create comprehensive refugee legislation addressing permanent and temporary status and granting basic rights and benefits to refugees and others needing humanitarian protection.

Of the total refugee population worldwide that are hosted by Arab states, only 15 per cent live in camps. The majority of asylum-seekers in Arab states live in urban and semi-urban settlements, mainly in lower

16 United Nations High Commissioner for Refugees. 2017. “Global Trends: Forced Displacement In 2017”. Geneva: United Nations High Commissioner for Refugees. https://www.uno-fluechtlingshilfe.de/fileadmin/redaktion/PDF/UNHCR/GlobalTrends_2017.pdf.

17 “Situation Mediterranean Situation”. 2019. Data2.Unhcr.Org. https://data2.unhcr.org/en/situations/mediterranean.

18 Quarterly Economic Report for MENA, January 2016: The effects of war and peace on the economy. World Bank

19 Opt. Cit.

and middle-income countries. Health care for camp residents is usually supported by programs through memorandums of understanding (MOUs) between UNHCR and local health ministries, national and international NGOs some of which are supported by UNHCR and other UN agencies, as the case in Jordan and Iraq. Refugees in urban and semi-urban areas receive health services through different systems (see Chapter IV). In some countries such as Mauritania and Jordan, refugees are distinguished by urban and camp caseloads, each receiving health services differently.

As of mid-2015, Lebanon has hosted the largest number of refugees, compared to the population, more than any country in the world, hosting approximately 986,242 registered refugees. In Jordan, of the 666,113 registered refugees, some 83 per cent live outside of refugee camps. Iraq hosts over 249,000 Syrian refugees, of whom 97 per cent in the Kurdistan region. In Egypt, more than 128,956 registered Syrian refugees live in urban neighborhoods.

Asylum-seekers and refugees in the region are moving – and will continue to do so, due to the persistence of the factors that prompt forced displacement– to countries geographically close to their country of origin. Wars and conflicts have forced people to flee their countries of origin, in the case of Arab states, and move to nearby low-income countries that open their borders and crossings to forced displacement. Attractive factors are still available in the form of hosts or transit stations that allow for further movement.

B. The Refugee Situation in some Arab States

Yemen

Since the beginning of the current conflict in March 2015, over 2.1 million people have been internally displaced and nearly 190,000 people have fled Yemen. An estimated 80 per cent of the population of 27 million are in need of humanitarian assistance.

Over 25 per cent of those who fled Yemen since the end of March 2015 are Somali nationals who had been recognized as refugees on a prima facie basis in Yemen. Many have returned to Somalia, but some have moved to other countries in the region, notably Djibouti and Ethiopia, where they are hosted as refugees. Nonetheless, despite the unstable security situation, Yemen continued to host some 280,000 refugees as of mid-2015 from Somalia and Ethiopia.

The Kharaz refugee camp, which opened in 1991, the only camp in Yemen, is home to approximately 18,000 refugees. Located in the Lahj governorate in the south of Yemen, the camp is isolated from urban areas. While UNHCR and partners are providing basic services including protection, food, shelter, health and education, protection from violence against women, child protection and community mobilization, refugees struggle with limited livelihood opportunities and harsh weather conditions.

Gulf countries have supported the Yemen situation. Saudi Arabia provided a six-month visa to more than 465,000 Yemenis to regulate their stay in the country, allowing the Yemenis to access basic health services, education and access to labor market. Syrians and Palestinians residing in Yemen were also provided with emergency entry visas. The Sultanate of Oman allows access to those with family links in the territory and transit for third country nationals.

Iraq

The situation in Iraq continued to have an impact on neighboring countries, with over 277,000 Iraqi refugees registered in the region. Half of those refugees were hosted in Turkey (105,900). Other host countries included Jordan (49,480), Syria (23,520), Lebanon (15,780), Egypt (6,760) and Iran (2,000). In 2015, there was a new internal displacement wave, with an estimated 1 million civilians displaced between January and mid-August 2015 reaching a total of 4.3 million displaced persons. The Kurdistan region hosts 27 per cent of the total internally displaced persons. In addition, Iraq hosts a considerable number of Syrian, Iranian, and Palestinian refugees[20].

Libya

There were 165,000 internally displaced persons in Libya as of the end of 2017, many of who were displaced again when new fighting started. More than 37,000 refugees and asylum-seekers were registered with UNHCR in Libya. More than half of them were from Syria and the rest were from other countries. As a result of the instability in the country, Libya continued to be the main transit and departure point for mixed migration movements by sea from North Africa to Europe.

Syria

The Syrian conflict has entered its seventh year, resulting in 6.15 million internally displaced and over 5.5 million refugees, the latter of which are hosted in Egypt, Iraq, Jordan, Lebanon and Turkey. Several areas of the country are markedly in need of humanitarian assistance, e.g. Aleppo, Homs, Deir El-Zor, El-Hassaka, etc. On a related note, safe and sustainable humanitarian access without hindrance within the country remains extremely difficult, with 13.5 million people in need of humanitarian assistance, including 5.47 million people living in besieged and hard-to-reach areas. Many refugees in host countries have exhausted their savings and are now getting poorer.

Djibouti

The refugee situation in Djibouti dates before other countries mentioned in the draft, as Djibouti has lived with refugees and displaced persons since its independence in 1977. It also continues to live with them to date, with refugees mainly concentrated in three main districts: Ali Atta comprises of 15,257 refugees, Halhal 3,755 and Obock 1,649. In addition to these, three times the numbers live irregularly in the capital in residential neighborhoods and are all benefitting from the basic services.

Mauritania

There are around 1,200 refugees and asylum-seekers in urban Nouakchott, mainly residing in four areas/ districts. They have been integrated into the public primary health care services since April 2015. Fifty thousand Malian refugees are currently hosted in Mbera Camp.

20 UNHCR Country Operation Profile: Iraq, UNHCR, http://www.unhcr.org/cgi-bin/texis/vtx/page?page= 49e486426&submit=GO

C. Importance of Drafting the Arab Strategy on Public Health

Refugees and asylum-seekers usually suffer from increased morbidity and mortality, mostly from preventable causes due to higher risk exposure and increased vulnerabilities that affect their physical, mental, and social well-being. At the same time, the influx of new arrivals puts pressure on host countries, which face immediate challenges in meeting the increasing health needs of refugees and asylum-seekers. Although universal health coverage is high on the global agenda, its implementation health systems are overstretched, with increased demands leaving the most vulnerable behind.

Health care provision for refugees in most Arab states is therefore a challenge on both the demand and supply sides. On the demand side, epidemiological, demographic and safety issues have led to a high burden of both communicable and non-communicable diseases and mental illness among refugee populations, combined with a burden of common diseases related to poor determinants of health, social status and lack of access to basic health services. On the supply side, access to health care is hampered by weakened health systems that also vary widely across countries in the region. As a result, public health resources are unable to meet either the emerging short-term public health needs or the long-term demands imposed in asylum contexts. Public health adaptations are therefore required for a sustained response.

The situation underscores the significant need for the development of a comprehensive and integrated regional public health strategy, not only to support the needs of the refugees, but also to strengthen and support public health and health care systems in host countries. This Strategy aims at increasing the resilience, capacity, and preparedness of health care systems to allow a sustained response that addresses the public health needs of refugees and the general public.

Despite the need to draft a strategy for public health for refugees adopted by the Arab League, countries' characteristics and variations should be taken into account in the development and implementation of the strategy, and will be based on the local legal context of each country, while ensuring refugee rights to health care. This is an opportune time for revision of the relevant legal frameworks.[21]

D. Opportunities for Drafting the Arab Strategy on Public Health

Arab states stand at a crossroads between maintaining and building on previous achievements, responding to changing socio-political stresses, and looking forward to a phase of transformation that will reform all development initiatives. Similarly, the Arab states are transitioning from the process of achieving the Millennium Development Goals to committing to the Sustainable Development Goals. The Sustainable Development Goals emphasize universal health coverage as a priority for sustained development. Given the commitment to global movements, the League of Arab States is reviewing the Arab States Primary Health Care Strategy (2011-2016), in addition to drafting the 2017-2021 strategy in alignment with the SDGs.

As outlined above, the Arab states host a considerable number of refugees and asylum-seekers, and the changing situation of the Arab world and the health stresses imposed by the refugee crisis underscores the need for a unified public health strategy that is connected to all development strategies drafted at the regional level.[22]

21 UNHCR Strategic Plan for Public Health 2014 – 2018. http://www.unhcr.org/530f12d26.html Public Health and Nutrition Strategy for Syrian Refugees.

22 Examples to the development strategies are the SDGs 2030 and "Forcibly Displaced: Toward a Development Approach Supporting Refugees, Internally Displaced Persons and Their Hosts," produced in close partnership with UNHCR; The Middle East and North Africa and OECD: A mutually beneficial partnership.

Refugees and asylum-seekers represent a diverse group, more than half of whom are women and children. Women and girls are more exposed to risks related to early marriage, pregnancy and childbirth, and sexual and gender based violence, enhancing gender differences. On the other hand, refugee children are subject to an increased risk of morbidity and mortality due to the conditions in which they live. The new strategy should link to and draw from existing protection strategies drafted by UNHCR/LAS, which already form integral parts of public health strategies. For example, the Arab Child Protection Strategy, which supports children rights to health, could be incorporated where relevant into the strategy, as could the UNHCR/LAS Arab Strategy on SGBV for Protection of Women in asylum context.

There is also an opportunity to draw a link between the 2030 Agenda for Sustainable Development, which aims to address some of the consequences of forced displacement, and LAS public health strategy, to translate the SDGs into policies that ensure inclusion of refugees' and asylum-seekers' health needs in development policies' framework.

Another timely consideration is the Global Compact on Refugees that UNHCR proposed to the General Assembly in 2018. The Compact will be comprised of a comprehensive refugee response framework, as well as a programme of action for UN Member States and other stakeholders. The proposed framework has four objectives: (a) ease pressures on host countries, (b) enhance refugee self-reliance, (c) expand access to third-country solutions or their resettlement, and (d) support conditions in countries of origin for return in safety and dignity.

The New York Declaration for Refugees and Migrants also provides an opportunity to develop principles and guidelines on the treatment of refugees which should govern the regional situation to complement national efforts to protect and assist refugees.

The World Bank is also involved in supporting host countries to meet the needs of refugee populations through the Global Concessional Financing Facility. It aims to expand a previously launched program to global reach through coordination with partners to ensure a coordinated international response to refugee crises in middle-income countries. The World Bank has pledged with countries and the European Commission to provide a range of grants, concessional loans and guarantees to support Syrian refugees and their host communities in Jordan and Lebanon, as well as economic recovery and reconstruction across the region.

Chapter III

Laws, Policies and International Conventions on Public Health

Introduction

The right of every refugee and asylum-seeker to enjoy the highest attainable standard of physical and mental health is embedded in the World Health Organization (WHO) constitution of 1948, which has been supported by multiple international human rights treaties and conventions, to protect the rights of migrants and refugees, including the right to health.

Refugee protection laws and policies in the Arab region should promote coherence between policies that affect the ability of refugees and asylum-seekers to access health care services across Arab states.

A. International and Regional Human Rights Treaties and Instruments Relevant to Refugee' Right to Public Health Services in the Arab Region

In view of the health implications resulting from the global refugee movement[23] and the resulting situation, which impact the host communities as well as the refugees themselves, it is necessary to identify the legal frameworks for protection of refugees' health and health care provision in light of conditions that have room for improvement in the Arab states.

International human rights instruments recognize the enjoyment of the highest attainable standard of health as a fundamental right of every individual, regardless of race, religion, political belief, economic or social condition or immigration status. The right to health extends to include other determinants necessary to the existence of a life of dignity, equality and well-being, mainly safe water and adequate sanitation, and other underlying determinants of health. These health-related rights are expanded in international instruments and are laid out in many national constitutions and laws. This is important since the rights of refugees and asylum-seekers to health are mainstreamed across several conventions and declarations.

Arab states are signatories and have ratified many of the relevant international and regional laws governing human rights and accordingly rights of refugees and their health and care, with some variation between Member States. These resolutions and agreements set the foundation for generous policies and are basis for a comprehensive framework for the rights of refugees that can be redrafted to protect the rights of refugees in the region.

Only Nine Arab States (Algeria, Djibouti, Egypt, Morocco, Somalia, Sudan, Tunisia, Mauritania and Yemen) out of the 22 Member States are party to the 1951 Refugee Convention, which is the primary international treaty governing the status and rights of refugees around the world. In such cases where countries have not acceded to the international convention, the countries' national laws concerning foreign nationals govern the legal status of asylum-seekers and refugees.

All Arab States have signed the Universal Declaration of Human Rights except the Kingdom of Saudi Arabia; however, on 30 June 2000, the Kingdom of Saudi Arabia, as a member of the Organization of Islamic Cooperation, officially resolved to support the Cairo Declaration of Human Rights in Islam, an alternative document that states that people have "freedom and right to a dignified life in accordance with the Islamic Sharia, without any discrimination on grounds of race, color, language, sex, religious belief, political affiliation, social status or other considerations."[24] In addition, 14 Member States have acceded to

23 See Glossary on Migration, loc cit. n. 4 and Master Glossary of Terms, UNHCR, June 2006.

24 Adapted from MENA HPF/UNFPA ASRO SRH mapping report.

the Arab Charter of Human Rights, prepared by the Arab Summit in Tunisia in May 2004.[25]

The right to health has been explicitly secured in several conventions. The International Covenant on Economic, Social and Cultural Rights (ICESCR)[26] of 1966 upholds the most authoritative definition of the right of all persons to the enjoyment of the highest attainable standard of physical and mental health, which could be interpreted broadly to cover the status of refugees and asylum-seekers (UN 1966). It has been ratified by all Arab States except the Kingdom of Saudi Arabia, Qatar and the Sultanate of Oman. The Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (CMW) was ratified only by Algeria, Egypt, Morocco, The Union of the Comoros, Syria, Libya and Mauritania. The right to health was also recognized in Article 5 of the International Convention on Eradication of Racial Discrimination (1966).

An experts meeting was held in Cairo in November 1992 on the "Protection of Refugees and Displaced Persons in the Arab World," which was organized by the Institute for International Humanitarian Law, the Faculty of Law in Cairo University and the General Secretariat of the League of Arab States and sponsored by the United Nations High Commissioner for Refugees. It has called for exerting further efforts from the League of Arab States side to adopt an Arab Convention on Refugees". The League of Arab States has later adopted the Arab Convention on Regulating the Refugee Situation in the Arab region in September 1994.[27] This Convention did not come into force since then, and it is now under update process within the joint Arab Justice - Interior Ministers Councils.

Refugees' and asylum-seekers' original nationalities and legal status may determine their entitlement to special treatment; and accordingly, their access to health services in host countries. This may result in inequity in access to health services, preventing universal coverage. This is shown in the case of Palestinians and the League of Arab States' Protocol for the Treatment of Palestinians in Arab States (the Casablanca Protocol) since 1965,[28] according to which, Palestinians are accorded special rights that are not given to refugees of other nationalities. Many Arab states have incorporated these rights into their national laws, and many have drafted policies in this regard, such as MOUs between international organizations and hosting governments to ensure universal access of refugees to essential health care services.

25 http://www.refworld.org/docid/3ae6b38540.html [Arab Charter].
Cairo Declaration on Human Rights in Islam, Aug. 5, 1990, U.N. GAOR, World Conf. on Hum. Rts., 4th Sess., Agenda Item 5, U.N. Doc. A/CONF.157/PC/62/Add.18 (1993) League of Arab States, Arab Charter on Human Rights, May 22, 2004, reprinted in 12 Int'l Hum. Rts. Rep. 893 (2005), entered into force March 15, 2008.

26 The Committee on Economic Social and Cultural Rights' General Comment No. 14 on Article 12 of the Covenant lists, in a non-exhaustive catalogue, the steps States Parties shall take to this end. They include the improvement of: child and maternal health; environmental and industrial hygiene; prevention, treatment and control of epidemic, endemic, occupational and other diseases; and medical services in the event of sickness. The Committee considers that "the highest attainable standard of health" take into account both the individual's biological and socio-economic preconditions and a State's available resources. Consequently, States Parties with the resources to implement Article 12 cannot lawfully decide to refrain from taking the necessary steps to implement the said article. The States with insufficient resources are, nonetheless, under an obligation of progressive realization.

27 Regional Refugee Instruments & Related, Declaration on the Protection of Refugees and Displaced Persons in the Arab World, 19 November 1992, available at: https://www.refworld.org/docid/452675944.html [accessed 13 October 2019].

28 http://www.refworld.org/docid/460a2b252.html [Casablanca Protocol]. The Casablanca Protocol allows for Palestinians to retain their Palestinian nationality, grants the right of employment where refugees reside, allows Palestinians the right to leave and return to host countries, and grants travel documents upon request.

1. Recent declarations and frameworks of action

◆ In the United Nations' 2030 Agenda for Sustainable Development, the needs of refugees, internally displaced people and migrants are recognized. The agenda promotes good health as a core for development. The Member States are committed to work towards its full implementation with the pledge that "no one will be left behind", and all segments of society will be included. Pursuing the health-related goals and their relevant targets will help the Member States and partners to address multiple economic, social and environmental determinants of the well-being of refugees and migrants.

◆ On 19 September 2016, the United Nations General Assembly adopted the New York Declaration for Refugees and Migrants, setting out commitments to enhance the protection of both refugees and migrants, since recognized that the number of persons who had been forcibly displaced from their homes was at a historically high level. The 193 Member States pledged to increase the number of resettlement slots for refugees, expand humanitarian assistance, provide additional funding for development aid, and work towards conflict prevention and assistance to host communities, etc. In adopting the Declaration, the 193 States, members of the United Nations declared profound solidarity with persons who were forced to flee, and reaffirmed their obligations to fully respect the human rights of refugees and migrants; and, pledged robust support to countries affected by large movements of refugees and migrants (this was important given that this idea has been contested in recent years). The two annexes of the Declaration paved the way for the development of the Global Compact on Refugees and the Global Compact for Safe, Orderly and Regular Migration in 2018.

◆ According to the New York Declaration, the States should specifically:

- Reaffirm the importance of adhering to the International Protection Regime (1951 Refugee Convention, Human Rights and Humanitarian Law);
- Acknowledge that protection of refugees and assistance to host countries are a shared international responsibility;
- Pledge to strengthen and facilitate a well-funded emergency response and a smooth transition to sustainable approaches that invest in resilience of both refugees and local communities;
- Commit to providing additional and predictable humanitarian funding and development support;
- Commit to wider avenues for refugees to be admitted to third countries, including through increased resettlement programs;
- Pledge to support the development and application of a Comprehensive Refugee Response Framework for large displacement movements including protracted ones;
- Commit to working towards the adoption of a Global Compact on Refugees in 2018.

◆ In May 2017, the 70th World Health Assembly drafted a framework[29] of priorities and guiding principles to promote the health of refugees and migrants. The priority framework and guiding principles are directed by ongoing discussions between Member States and involved partners in the development of the Global Compact on Refugees and the Global Compact on Safe, Orderly and Regular Migration to ensure that the health aspects of refugees and migrants are adequately addressed. This framework will also be used as a basis for the development of a draft global plan of action on the health of refugees and migrants, which is to be submitted to the 72nd World Health Assembly in 2019. Furthermore, the Member States can consider this framework when addressing the health needs of refugees and migrants, in alignment with the Sustainable Development Goals and other global and regional policy frameworks as appropriate to their contexts, priorities and partners.

29 This framework was requested in January 2017 by the Executive Board at its 140th Session, to be considered during the Seventieth World Health Assembly.

2. Internal displacement laws and policies

Five countries in the Arab region have specific national laws or policies on internal displacement. Many of those instruments contain specific provisions articulating the definition of internally displaced people, their rights and anti-discriminatory statements that protect internally displaced persons. In many instances, however, the responsibility of governments to address and enact laws for internally displaced persons is hindered by a lack of governmental capacity due to limited resources and continuing causes of displacement, leading to significant gaps in implementation.

Sudan has internal displacement laws drafted from the Doha Document for Peace in Darfur in 2011. The interim constitution was amended in January 2015 to add a new article, Article 226, which stipulates that: "In what does not contradict previous clauses, the Doha Document for Peace in Darfur becomes an integral part of this Constitution."[30] The law covers all three settlement options. A national policy for internally displaced persons that emphasizes their rights was adopted in 2009.

Lebanon has a long history of displacement, beginning with its civil war. The country has a national legislation in respect to internal displacement (Law 190) that was adopted in 1993. The law is not supported by any official text, decree or bylaw to specify the beneficiaries of its policies.

Iraq's 2008 national policy on internal displacement recognizes the government's primary responsibility to protect and assist internally displaced persons and returnees, and pledges to address displacement with the support of the international community. This policy also states that the government will adopt policies in line with Iraqi law, International Humanitarian and Human Rights Law, the Guiding Principles on Internal Displacement, and the UN principles on housing and property restitution. Its list of specific internally displaced persons' rights was drawn from the Guiding Principles, which are supported by the Ministerial Decree 262 and Prime Ministerial Order 101 to facilitate property recovery in the Baghdad governorate, and Order 58, which extends those measures to the Diyala governorate.

The government of Yemen drafted a national policy on internal displacement in June 2013. It recognizes that the Government of Yemen has primary responsibility for the assistance and protection of internally displaced persons, and also aims to prevent forced displacement, and supports both internally displaced persons and host communities, and creates the required conditions for durable solutions. The policy states the rights of internally displaced persons, and identifies roles and responsibilities of government institutions towards them.

Somalia has three policies in respect to internally displaced persons. A policy framework on displacement within Somalia was adopted in 2014. Under this policy, internally displaced people were broadly defined as "persons or groups of persons who are evicted from internally displaced settlements especially in urban areas, as part of the recovery of public buildings and urban development, and who are not receiving an adequate housing and/or alternative land or both, nor appropriate compensation allowing them to restore their lives in an adequate manner". The policy covers all causes of internal displacement. The Somali provisional Constitution, adopted in August 2012, sets out rights and freedoms for all Somalis, including internally displaced persons, without discrimination. In addition to this, in September 2012, the President issued the "Six Pillars" Policy, setting out priorities to alleviate Somalis' suffering, and create effective State institutions in this regard.

30 UNHCR Sudan, IDMC-UNHCR national laws and policies survey, 23 November 2015.

Table 1: Summary of Arab states with laws or policies on internal displacement

Country	Laws	Policies	Other Instruments
Sudan	1	1	1
Lebanon	1		1
Yemen		1	1
Iraq		1	1
Somalia		3	1
Libya	In process		

B. Constitutional Rights in Asylum Contexts and Country Agreements Relevant to International Rights and Laws on Public Health

At national levels, policies and strategies to manage the health consequences of migration and displacement have not kept up with the speed and diversity of modern migration and internal displacement.[31] The right to equality and non-discrimination are both specifically mentioned and safeguarded in all Arab states' constitutions. The right to health care is guaranteed by constitutions of all countries except Lebanon and Palestine.[32] It could be argued that this provision requires, among other things, that the government enact comprehensive legislation related to refugees and asylum-seekers.

The Iraqi government has drafted legislative instruments related to refugees in the country. Law 21 of 2003 establishes the Ministry of Migration and Forcibly Displaced, which provides assistance and services to both internally displaced persons and refugees inside Iraq. The Political Refugee Law of 1971 addresses political refugees only and establishes benefits such as the right to work and access to the same health and education services as Iraqis. However, it does not apply to refugees who have fled their countries for other reasons. To facilitate the voluntary return of internally displaced persons to their places of origin, the Iraqi Council of Ministers issued Decree 262 of 2008, which authorizes the Ministry of Migration and Forcibly Displaced to provide monetary awards to Iraqis who were forced to leave their homes because of sectarian violence. Ministerial Resolution 202 of 2001 provides Palestinian refugees with all the benefits to which Iraqi nationals are entitled.

Section B of the Preamble of the Lebanese Constitution stipulates the following: "Lebanon is a founding and active member of the United Nations Organization and abides by its Covenants and the Universal Declaration of Human Rights. The Government shall embody these principles in all fields and areas without exception."

Refugees in Lebanon are mainly governed by the Law on entry, stay, and exit of foreigners in Lebanon, which was enacted in 1962 to facilitate the process of asylum seeking. A new residency policy was announced in 2017 that would drop the annual residency fee of $200 for Syrian refugees residing in Lebanon, provided that they had been registered with UNHCR before January 2015 or had received residency by UNHCR certificate at least once during 2015 or 2016. The refugee status is at present determined mainly by the provisions of a MoU signed between Lebanon and UNHCR.

31 WHO, 2017.

32 Adapted from MENA HPF /UNFPA ASRO mapping study 2016.

Egypt is a party to both the 1951 Refugee Convention and the 1969 Organization of African Unity Refugee Convention. Egyptian authorities have, as such, adopted several local legislative initiatives to regularize the legal status of refugees. The Egyptian Constitution of 2014 provides protection to refugees and asylum-seekers. Article 91 prohibits the extradition of political refugees. The Constitution also enshrines the right to health services for citizens. A comprehensive instrument that provides the legal framework for the treatment of refugees is a Memorandum of Understanding signed between the Ministry of Health and Population and UNHCR in 2016 to promote accessibility of primary health care services and referrals to refugees and asylum-seekers in Egypt (MoU document, 2016). In 2012, the Ministry of Health and Population issued a decree enabling Syrians access to health services through governmental hospitals at an equal stepping as Egyptian citizens.

Jordan's Constitution provides protection against extradition for political asylum-seekers (Article 21(1)). Jordan has not enacted any national legislation to deal with refugees, and it is not a party to the 1951 Refugee Convention nor its 1967 Protocol. The legal instrument that provides the legal framework for the treatment of refugees is a Memorandum of Understanding signed between Jordan and UNHCR in 2014. In the absence of special legislation addressing their status, refugees and asylum-seekers are subject to Law 24 of 1973 concerning Residency and Foreigners' Affairs.[33] This law applies to all foreigners without distinction between refugees and non-refugees. The law refers to refugees in some of its articles but does not define them as a separate category. For example, Article 4 refers to a travel permit issued to refugees by the country of their residence as a valid documentation allowing them to enter Jordan.

Morocco has recently drafted a new immigration policy in the form of an operation work plan. This policy builds on the 2011 Constitution, which guarantees the rights of Moroccans living abroad and of foreign nationals residing in Morocco. In its Preamble, the Constitution upholds "the principles, rights and obligations set out in its Charters and Conventions. It affirms its link to human rights as they are universally recognized." The Constitution pledges that Morocco would continue to work:

- "To protect and promote the mechanisms of Human Rights and of International Humanitarian Law and to contribute to their development within their indivisibility and their universality;"
- "To ban and combat any discrimination whenever it encounters it, for reason of sex, color, beliefs, culture, social or regional origin, language, and/or disability, or whatever personal circumstance that may be;"
- "To comply with the international conventions legally ratified by Morocco, within the framework of the provisions of the Constitution and other Laws derived of the constitution and the Kingdom' laws, within respect for its immutable national identity, and on the publication of these conventions, [their] primacy over the internal legislation of the country, and to harmonize in consequence the pertinent provisions of national legislation."[34]

Sudan has also ratified international conventions relevant to the right to health services. Sudan has a generous refugee policy[35], as well as a refugee law enacted in 1974, and the Regulation of Asylum Act, a model derived from the 1969 OAU Refugee Convention dealing with the situation of African refugees. The implementation of the law was hindered in some regions of the country in view of the economic challenges faced. The interim constitution of Sudan, endorsed in 2005, also includes several statements relevant to health and care. It recognizes human rights, including the right to life, dignity, and personal safety,

33 "Refugee Law and Policy: Jordan". 2019. Loc.Gov. https://www.loc.gov/law/help/refugee-law/jordan.php.

34 Kingdom of Morocco constitution, 2011.

35 Karadawi, Ahmed 1999. Refugee policy in Sudan, 1967-1984. New York. Berghahn Books.

and it affirms that all rights and freedoms enshrined in international conventions and treaties ratified by Sudan shall be considered part of the constitution. The right to health is also referenced in the constitution, including the obligation of the State to provide free primary health care services.

Tunisia has finalized the draft of a national law related to the protection of refugees that is aligned with international standards in this regard.

C. Protection Frameworks

Several instruments relating to special rights for specific categories of individuals exist: the 1979 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) which relates to the defense of human rights, gender equity, the elimination of violence against women (VAW), and advancement of health; and the Convention on the Rights of the Child (1989). All Arab states except Sudan have ratified the Convention on the Elimination of All Forms of Discrimination against Women.[36] It aims at eliminating discrimination against women in health care to ensure access to health care services, including those related to family planning, pregnancy and postnatal care, on the basis of equality between men and women. On the other hand, many countries have registered reservations to the treaty on several aspects related to health and sexual and reproductive health. For example, the Kingdom of Saudi Arabia registered a reservation noting that in case of contradiction between a term of the Convention and the norms of Islamic Law, the State shall abide by the provisions of the Islamic jurisdiction. All other states recorded reservations on some articles (such as Articles 2, 9, 15 and 16), especially those related to family laws and nationality laws, with the exception of Tunisia, which is the only Arab State that had no reservations to CEDAW.[37]

In addition, Arab states have ratified many international conventions that address the principle of non-discrimination, which also applies to refugees and their rights to health care, including:

- The International Convention on the Elimination of All Forms of Racial Discrimination (1965), ratified by all Arab States except Somalia;
- The International Convention on the Rights of Persons with Disabilities, (2006), ratified by all Arab States except Lebanon, Libya and Somalia;
- Declaration on Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992).

1. Child protection and marriage

Given the fragile context in many countries in the Arab region, it is relevant to note that the impact of child marriage (such as interrupted education, early pregnancy, higher rates of maternal and child mortality, and an increased risk of domestic violence) is exacerbated in humanitarian crises. The birth rate per 1,000 women aged 15 to 19 ranges from 7 in Tunisia to 102 in Sudan.

The issue of child marriage is particularly salient in some vulnerable refugee and asylum-seeker communities, e.g. among Syrian refugees in Jordan and Lebanon.[38] The Convention on the Rights of the Child (CRC) and CEDAW recommend 18 as the minimum age of marriage. All states have ratified the revised Convention

36 CEDAW aims to eliminate discrimination against women in health care in order to ensure, on a basis of equality between men and women, access to health care services, including those related to family planning, pregnancy and post-natal care.

37 Opt. Cit.

38 "To Protect Her Honour": Child Marriage in Emergencies, Care International, 2015; Gender-Based Violence and Child Protection among Syrian Refugees in Jordan with a focus on Early Marriage, Inter-agency Assessment, UN Women, 2013.

on the Rights of the Child and, as noted above, all states except Sudan have ratified the Convention on the Elimination of All Forms of Discrimination against Women. According to the Committee on the Rights of the Child's observations on periodic reports from a number of states, legislative frameworks often lack provisions protecting children, especially girls, from the phenomenon of child marriage.

Some countries, including Syria, are working to rectify the disparity in the minimum age of marriage for boys and girls by raising the legal age of marriage of girls from 17 to 18. In Jordan, Morocco, and Syria, the actual age of marriage can be as low as 13 years. In 2014, the legal age of marriage for Egyptians was raised to 18. In Jordan, the Council for Family Affairs has issued a legal guide for marriage based on personal status law, which bans marriage under age 18. It also prohibits marriage if there is a difference of over 20 years between a man and a woman under 18. Egypt and Sudan both developed draft national strategies for child marriage in 2015. Legislation in some Arab states grants judges the right to lift the condition of minimum age for marriage at their discretion, e.g. Jordan. This creates a gap in the legal framework that allows for underage marriage.

2. Protection for mentally affected individuals

International human rights conventions play a key role in protecting the rights of individuals with mental illness. They define the principles of protection of individuals with mental illness and improve psychological health care, as a useful tool for applying international standards to groups in need of care. These principles have important links with the rights contained in the International Covenant on Civil and Political Rights and the Declaration on the Rights of Persons with Disabilities.[39]

3. Protection of people living with HIV/AIDS

Asylum-seekers and refugees have often been stigmatized due to their perceived higher risk of HIV/AIDS. Humanitarian crises do increase the vulnerabilities of those experiencing them to sexual violence, food and housing insecurity, human trafficking and other human rights violations - all this has potential implications for the HIV epidemic and managing it.

Hence, the priority is to ensure that these populations have access to essential prevention and treatment services, through partnerships and technical support to countries and humanitarian organizations. This can be done through effective implementation of a Global Fund to Fight AIDS, Tuberculosis and Malaria through the regional grant, implemented by the Middle East Response Initiative targeting Yemen, Lebanon, Jordan, Syria and Palestine.

Many Arab states have joined as parties to the 2001 Declaration of Commitment on HIV/AIDS to Eliminate All Forms of Discrimination against People Living with HIV or the Arab AIDS Strategy (2014-2020)[40]; yet, many have restrictive policies which do not comply with WHO standards or guidance from the Joint United Nations Program on HIV/AIDS.[41,42,43]

39 Office of the United Nations High Commissioner for Human Rights. (1991). Principles for the protection of persons with mental illness and the improvement of mental health care. Retrieved 13th July 2010, from http://www2.ohchr.org/english/law/principles.htm.

40 The 10 goals of the Arab Strategy (2014-2020) include: To reduce HIV incidence among key populations at higher risk of infection by more than 50%; to eliminate new HIV infections among children; to increase HIV treatment coverage to 80%; to address stigma and discrimination; to improve AIDS financing; to address the special vulnerability of women and girls; and to review the policies around travel restrictions.

41 Annon, J and Todrys, K 2008: "Fear of foreigners". Journal of International AIDS Society :1-6

42 WHO 1987 report of the consultation on international travel. HIV infection/WHO /SPA/GLO,787.1

43 Joint United Nations Programme on HIV/AIDS (UNAIDS) 2002. UNAIDS/02.31E (Original version, June 2002) ISBN 92-9173-190-0

All states in the conflict-affected Arab region need to act and monitor the implementation of the Security Council Resolution on HIV/AIDS (1983), with a focus on sexual violence in conflict situations, and the provision of basic HIV services through partnership with peacekeeping missions, and capacity development of standardized services provided with regard to human rights, HIV and gender.

On 10 June 2016, the UN General Assembly adopted, by consensus, the 2016 Political Declaration on the Fast-Track to End AIDS in the age of Sustainable Development. The new Declaration encourages the Member States to address the vulnerabilities to HIV and the specific health care needs experienced by migrants and mobile populations, as well as refugees and crisis-affected populations, and to take steps to reduce stigma, discrimination and violence, as well as to review policies related to restrictions imposed on entry, based on HIV status with a view to eliminating such restrictions and the return of people on the basis of their HIV status, and to support their access to HIV prevention, treatment, care and support.[44]

Table 2: International treaties ratified by Arab states

Year[45]	International treaty	Relevance to health of refugees	Countries ratified
1948	Universal Declaration of Human Rights	Recognizes the role of states in the defense of human rights and the right to health.	All countries except the Kingdom of Saudi Arabia
1951	Convention Relating to the Status of Refugees	-	Algeria, Djibouti, Mauritania, Egypt, Morocco, Somalia, Sudan, Tunis and Yemen.
1965	Convention on the Elimination of All Forms of Racial Discrimination	Ensures that state parties respect the right of non-citizens to an adequate standard of physical and mental health by, inter alia, refraining from denying or limiting their access to preventive, curative and palliative health services.	All countries except Somalia

44 70/266. Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030 General 22 June 2016.

45 Table adapted from MENA HPF/UNFPA mapping study.

1965	Protocol on the Treatment of Palestinians, (Casablanca Protocol) adopted by the League of Arab States	Establishes a solid framework for temporary protection in the Arab states hosting Palestinian refugees. Under the Casablanca Protocol, Arab states agree to accord Palestinians the same treatment as their nationals with regard to employment; freedom of movement between the Arab host countries; the right to leave and return to the territory of their state of residence; issuance and renewal of travel documents; and security of residence and employment in the state of residence. In many ways, the Casablanca Protocol' provisions are more generous than those of the 1951 Refugee Convention, particularly with regard to employment and freedom of movement. Many of the Arab states have incorporated these standards into their national laws.	Jordan, Sudan, Syria, Algeria, Iraq, Egypt and Yemen. Kuwait, Lebanon and Libya have also ratified it with reservations on some points.
1966	Covenant on Civil and Political Rights	Recognizes political rights	All countries except the Sultanate of Oman and Qatar.
1966	International Convention on Eradication of Racial Discrimination (1966)	Recognizes the right to health	All countries except Somalia.
1966	International Covenant on Economic, Social and Cultural Rights (ICESCR)	Enshrines the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."	All countries except Qatar, the Sultanate of Oman and the Kingdom of Saudi Arabia.
1979	Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	Among other issues, establishes a framework against sexual violence.	All countries except Sudan. Other countries have registered reservations.
1986	Declaration of the Right to Development	Recognizes the role of states to ensure that women have a role in development.	All countries.
1989	Convention on the Rights of the Child (CRC)	Guarantees the rights of all children without discrimination in any form. Also recognizes the girl child.	All countries.

1990	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW)	Provides for the right to equal treatment regarding access to social and health services for regular migrant workers and members of their families and nationals. In addition to this, Article 28 recognizes the right to emergency medical treatment for all migrant workers and members of their families regardless of whether their stay or employment is irregular.	Algeria, Egypt, Morocco, Comoros Islands, Syria, Libya and Mauritania.
1994	Commitment to the ICPD Program of Action, commitment to be renewed in Nairobi Conference in 2019.	Prohibition of discrimination.	All countries, except the Kingdom of Saudi Arabia and Sudan.
2000	Millennium Declaration	Recognizes gender equality, mental health, and the fight against HIV/AIDS as axes of sustainable human development.	All countries.
2001	Declaration of Commitment on HIV/ AIDS	Describes commitments regarding the fight against HIV/AIDS and links them to inequalities and rights.	All countries except Palestine.
2006	Convention on the Rights of Persons with Disabilities.	Recognizes that women and girls with special needs are often at greater risk, inside and outside their homes, injury or abuse, and exploitation. They have the right to physical and mental health.	All countries except Somalia (Lebanon and Libya are signatories but have not yet ratified).
2014-2020	Arab AIDS Strategy (2014-2020)	-	All countries.
2015	Sustainable Development Goals (SDGs)	Universal health coverage for all.	By consensus.
2016	Political Declaration on the Fast-Track to End AIDS in the age of Sustainable Development.	Fast track to end AIDS	By consensus.
2016	New York Declaration for Refugees and Migrants	Reaffirms the importance of adhering to the International Protection Regime (1951 Refugee Convention, Human Rights and Humanitarian Law)	By consensus.

2016	World Humanitarian Summit (WHS), Istanbul 2016	Preparedness of health systems to provide services to refugees and displaced, and to document the lessons learnt from the services provided to refugees and displaced, while exchanging expertise.	By consensus.
2019	Arab Strategy for ageing, adopted by the Summit.	-	All countries.
2019	Multi-sectoral Arab Strategy on women, children and adolescents' health with specific objectives (2019-2030)	-	All countries.

D. Gaps and Challenges in Implementation

A number of Arab states are carrying out successful case studies on improving the refugee situation. Nevertheless, there are clear gaps, within the region as a whole, in the implementation of international conventions and treaties, as well as national laws and policies with regard to the protection of the right to health of refugees, displaced persons and asylum-seekers. This has been demonstrated by the inability of countries to fully comply with their responsibilities in providing basic health needs for this group of individuals. This situation is exacerbated by the escalating situation in the region and the increased influx of refugees, displaced persons and asylum-seekers, mainly to lower and middle-income countries.

Fragmented legislative policies on refugees and asylum-seekers should be consolidated into comprehensive legislation based on international and regional protection and rights frameworks. New strategies and ways of dealing with refugees, asylum-seekers, internally displaced persons and returnees must be developed and codified into national laws.

Given the results of the mapping exercise (for 2014), it has become evident that there is a need for the revision of laws on health and protection of refugees and asylum-seekers to expand and materialize the rights of this group in alignment with international instruments and national laws and regulations. The most apparent gap lies in the non-applicability of international refugee instruments where a country has either not acceded to them or records reservations to its provisions.[46] Refugee policies in several host countries also suffer from a lack of consistency in relation to a number of elements.

It must be emphasized that effective protection of health care rights depends on the commitment of States to implement the protection instruments, both individually and through international cooperation, to ensure universal application and to expand access.

Legal frameworks need to be developed for particular refugees and asylum-seekers to secure specific health rights, including health care and services for women, children, elderly, persons with disabilities, and for mental health.

46 Volker Türk and Rebecca Dowd. The Oxford Handbook of Refugee and Forced Migration Studies. Edited by Elena Fiddian-Qasmiyeh, Gil Loescher, Katy Long, and Nando Sigona. 2014. DOI: 10.1093/oxfordhb/9780199652433.013.0024

Host countries rely on solidarity in their response to refugees and asylum-seekers, and this is advocated for by the New York Declaration for Refugees and Migrants, and it is a principle of the Sustainable Development Goals. These instruments mandate responsibility-sharing and sustainable, implementable and rigorous solutions supported by policies implemented in Arab states.

Arab states, therefore, need to develop a regional public health framework to ensure responsibility-sharing, protection and health care arrangements within the framework of universal health coverage and international refugee conventions, while addressing gaps in implementation. This requires revision and modification of Arab countries' protection laws and policies, to be inclusive of the needs and demands of refugees, displaced and asylum-seekers. Resilience and strengthening of health systems should be an integral part of each country's transformational strategy.

Chapter IV

Public Health Response to Refugees, Displaced Persons and Asylum-Seekers

Introduction

Health care and its outcomes in the Middle East region have improved over recent decades, with some variation between different countries. Health indicators improved overall, but in some countries have worsened due to the various instabilities and challenges in the region, which has undergone significant improvements including increased life expectancy and reductions in child mortality.[47,48] Some states lagged behind on important Millennium Development Goals, especially those pertaining to hunger, poverty, food insecurity, lack of access to water, child and maternal mortality, and lack of improved sanitation in rural areas. Sudan, Yemen, Djibouti and Somalia have the poorest health indicators, while Gulf Cooperation Council countries showed marked improvements. In addition, the Arab region is experiencing a period of demographic and epidemiological transition. The youth population is the biggest in decades, accounting for almost 50 per cent of the population in 2016. The increase in non-communicable diseases coupled with the increase in life expectancy has triggered those changes, yet many Arab states face the dual burden of communicable and non-communicable diseases.[49]

The impact of forced displacement on health occurs at both individual and population levels, and such impacts also affect the health sector service provision within host countries at large. Governments face immediate challenges to meet the health needs of refugees and asylum-seekers, and even those of internally displaced persons. Although universal health coverage is high on the global agenda, it is facing challenges, as health systems are overstretched, with increased demands leaving the most vulnerable behind. As such public health resources are unable to meet the emerging short-term public health needs and longer-term demands imposed in asylum contexts while supporting effective emergency responses.[50]

A. Public Health Needs of Refugees, Displaced Persons, and Asylum-Seekers

At the global, regional and national levels, policies and strategies have been put in place to manage the consequences on health due to forced displacement. Due to the urgency and diversity of needs imposed by rapid influxes of large numbers of refugees and asylum-seekers, these attempts are not always capable of keeping up with the increasing health needs and demands.[51] Multiple international, regional and national organizations are seeking ways to improve aspects of refugee health, including by providing access to health services and addressing issues of equality and the social determinants of health which are markedly challenged since the population influxes are mainly in lower and middle-income countries, which already face challenges due to their limited resources.

The relationship between refugees and public health has ethical implications, considering the unequal access to health care, the inadequate quality of care, the incurred costs to the refugees, and the burden placed on the health systems of host countries.[52] Establishing a regional pattern of public health needs

47 Mokdad AH, Forouzanfar MH, Daoud F, Mokdad AA, El Bcheraoui C, Moradi-Lakeh M, et al. Global burden of diseases, injuries, and risk factors for young people's health during 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. Lancet. 2016;387(10036):2383–401. pmid:27174305

48 Kadri N, Agoub M, Assouab F, Tazi MA, Didouh A, Stewart R, et al. Moroccan national study on prevalence of mental disorders: a community-based epidemiological study. Acta Psychiatr Scand. 2010;121(1):71–4. pmid:19681770

49 World Health Organization. 2010. "Global Status Report on Non-Communicable Diseases". Geneva: World Health Organization.

50 World Health Organization. 2016. "Health in the Context of Migration and Forced Displacement". Geneva: World Health Organization. https://www.who.int/migrants/publications/UNGA_SideEvent_Report.pdf?ua=1.

51 WHO, 2017A70/24. Promoting the health of refugees and migrants. Draft framework of priorities and guiding principles to promote the health of refugees and migrants.

52 WHO/EMRO 2015. Refugees and internally displaced persons in the Eastern Mediterranean Region: A Health Perspective.

and regional public health cooperation is important since they will add value to all public health efforts planned at the national levels. However, the variability among refugee groups in terms of age, gender, health conditions, susceptibility to health issues, and prior experiences must be considered in terms of the need for more robust, continuously updated data collection which is only able to handle this diversity, including the diversity of health systems in host countries. This is particularly important given the need to understand the impact of various determinants on the health needs of refugees, including their conditions before fleeing their homes, their displacement experiences during their journey to host countries, the conditions within the host country, their legal status and access to healthcare, the language they speak and their cultural norms, among other factors.[53-54]

Arab states are, in light of the impacts of large-scale forced migration, currently facing an urgent need to address the public health consequences of the increased numbers of refugees, asylum-seekers and internally displaced persons within the region, both in the short-term and the long-term.[55] Changing population demographics and disease epidemiology, coupled with increasing rates of the determinants of poor health among refugees in host communities, require sustainable interventions that strengthen the resilience of health care systems, and humanitarian programs that meet the immediate and the longer-term needs of affected populations.

Mass movements of people often result in extremely high rates of morbidity and mortality, generally from preventable causes that are associated with poverty and poor living conditions. Emergencies have a disproportionate effect on the poorest and most vulnerable refugees, particularly women, children, the elderly and the disabled.[56] For example, the highest maternal mortality ratios in the world and highest neonatal mortalities occur in fragile circumstances and related to current conflicts or recent humanitarian emergencies. Sexual and reproductive health (SRH) is a significant public health need for those facing emergencies.[57] Emergencies linked to forced displacement, food insecurity and poverty increase vulnerability to HIV and negatively affect the lives of those already living with HIV.[58] The major causes of death in asylum contexts and complex emergencies have been identified as undernutrition, measles, diarrhea, pneumonia, and malaria, which are particularly evident in children (the same major causes of death in countries with the highest child mortality rates).[59,60] Accordingly, the priority activities to address these causes of morbidity and mortality include the provision of adequate food, water, shelter, sanitation, and immunization.[61]

Communicable diseases, such as cholera, polio, etc., can spread in different forms, increasing the risk of outbreaks. The prevalence of these diseases is usually linked to poor sanitary conditions, such as lack of adequate sanitation, poor hygiene practices, and unsafe water and food[62]. Vulnerable groups (children, pregnant women and elderly) are the most susceptible. Moreover, crowded places may increase the risk of

53 WHO, 2017A70/24. Promoting the health of refugees and migrants. Draft framework of priorities and guiding principles to promote the health of refugees and migrants.

54 Side event report, UN General Assembly high level meeting to address large movements of refugees and migrants: Health in the Context of Migration and Forced Displacement, 22 Sept 2016.

55 WHO, 2017A70/24. Promoting the health of refugees and migrants. Draft framework of priorities and guiding principles to promote the health of refugees and migrants.

56 as Opt. Cit 3

57 WHO/integrating SRH into health emergency and disaster risk management. October 2012 www.unfpa.org/sexual-reproductive-health

58 "Sexual & Reproductive Health". 2019. Unfpa.org. https://www.unfpa.org/sexual-reproductive-health.

59 Black RE, Moris SS, Bryce J. Where and why are 10 million children dying every year. Lancet 2013:361:2204-9.

60 Communicable diseases in complex emergencies: impact and challenges. Lancet series Volume 364, Issue 9449 December 2004 /react-text: 68, Pages 1974-198.

61 Georgetown University Centre for Immigration Policy and Refugee Assistance. Declaration on Health Care for Displaced Persons and Refugees : Conc. On progress WDC 1988.

62 UNHCR. 1995. "Refugee Health refugee Health EC/1995/SC.2/CRP.29". https://www.unhcr.org/excom/scaf/3ae68bf424/refugee-health.html.

vector-borne diseases such as malaria.[63,64]

Tuberculosis (TB) poses a public health problem among refugee populations. The risk of being affected by the disease depends on its incidence in the country of origin, access to health services, and the socio-economic environment of refugee settlement conditions. The incidence of tuberculosis in the countries of origin varies from as low as 17 new cases per 100,000 people in the Syrian Arab Republic to 338 in Nigeria. WHO's strategy to eradicate "tuberculosis" by 2030[65] aims to eradicate the tuberculosis epidemic, emphasizing the need for cross-border cooperation to address the needs of vulnerable communities and the threats posed by multidrug resistance. The same risk is perceived for malaria in malaria affected countries.

Many refugees are subject to psychological and social pressures leading to psychological stress and mental illness, with increasing demand for mental health and psychosocial support services, which have not been adequately developed in many host countries. If these diseases are not well treated, they may become physically ill, as shown in a study on Iraqi refugees[66]. A study quantifying the burden of mental disorders in the Eastern Mediterranean Region (EMR) found that in 2013, such disorders contributed to 5.6 per cent of the total disease burden in the region.[67]

Women bore a greater proportion of the burden of psychological disorders than did men of equivalent ages, except for those under 18 years of age. A study found that Palestinians bear the brunt of the unrest. Almost all countries in the Eastern Mediterranean Region suffer more from the burden of psychological disorders than the average level of the same burden globally.[68]

Non-communicable diseases (NCDs) represent another challenge to the needs of both refugee and host communities, due to the high burden and complexity of managing these conditions.[69]A periodic research in 2014 indicated a high incidence of non-communicable diseases among refugees in urban areas in the Middle East[70]. The 10 countries identified by UNHCR as the largest source of refugees in 2015 all have significant non-communicable disease burdens, accounting for 19-62 per cent of total mortality (Figure 1) and the prevalence of high blood pressure ranging from 23 to 32 per cent amongst adults.[71]

63 UNHCR. 1995. "Refugee Health refugee Health EC/1995/SC.2/CRP.29". https://www.unhcr.org/excom/scaf/3ae68bf424/refugee-health.html.

64 UNHCR WASH Manual. 2019. Ebook. Geneva: UNHCR. Accessed October 14. http://wash.unhcr.org/Public_Health.pdf.

65 Resolution WHA67.1 (2014).

66 Maten FJ, Carone M, Nyce S et al 2012. Neurological disorders in Iraqi refugees in Jordan: data from United Nations Refugee Assistance Information System. J Neural 259:694-701.

67 DALYs (disability-adjusted life years) allow assessment of both premature mortality (years of life lost–YLLs) and nonfatal outcomes (years lived with disability–YLDs). DALYs are computed by adding YLLs and YLDs for each age-sex-country group. In 2013, mental disorders contributed to 5.6% of the total disease burden in the EMR (1894 DALYS/100,000 population): 2519 DALYS/100,000 (2590/100,000 males, 2426/100,000 females) in high-income countries, 1884 DALYS/100,000 (1618/100,000 males, 2157/100,000 females) in middle-income countries, 1607 DALYS/100,000 (1500/100,000 males, 1717/100,000 females) in low-income countries. See Charara R, Forouzanfar M, Naghavi M, Moradi-Lakeh M, Afshin A, Vos T, et al. (2017). The Burden of Mental Disorders in the Eastern Mediterranean Region, 1990-2013. PLoS ONE 12(1): e0169575. https://doi.org/10.1371/journal.pone.0169575.

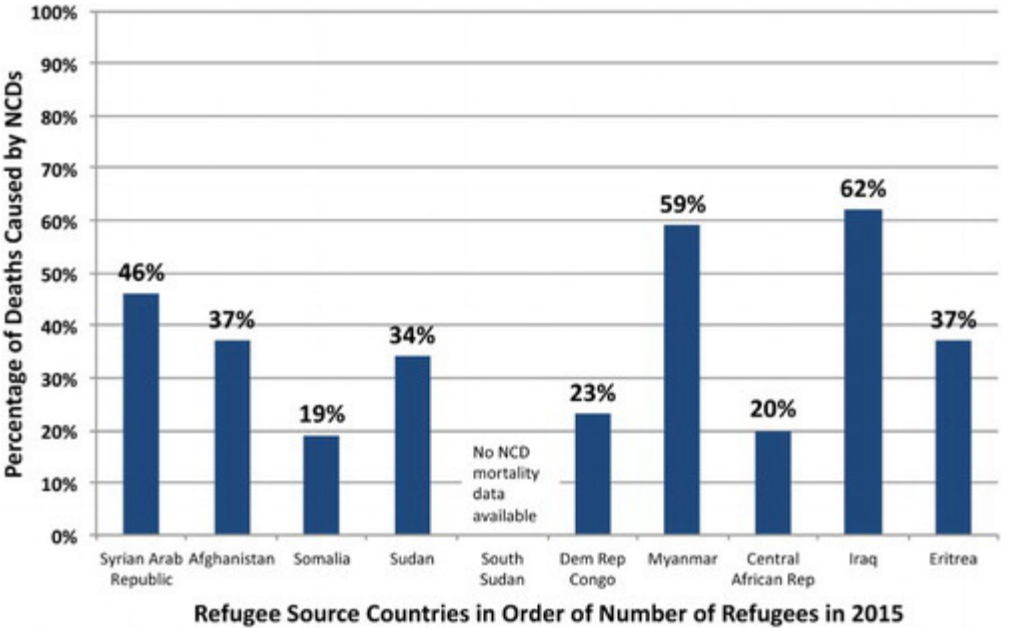
68 Charara R, Forouzanfar M, Naghavi M, Moradi-Lakeh M, Afshin A, Vos T, et al. (2017). The Burden of Mental Disorders in the Eastern Mediterranean Region, 1990-2013. PLoS ONE 12(1): e0169575. https://doi.org/10.1371/journal.pone.0169575.

69 Twenty-two percent of consultations in Zaatari in 2014 were for NCDs (diabetes constituted 19%, hypertension 21% and asthma 12%). A prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon study (2016) found over half (50.4 %) of refugee and host community households (60.2 %) reported a member with one of the five NCDs. Care-seeking for NCDs among refugees and host community households was high across all conditions with 82.9 and 97.8% respectively, having sought care in Lebanon for their condition. Shannon Doocy, Emily Lyles, Baptiste Hanquart, The LHAS Study Team and Michael Woodman Conflict and Health 2016 10:21DOI: 10.1186/s13031-016-0088-3).

70 Amara, A. H., & Aljunid, S. M. (2014). Non communicable diseases among urban refugees and asylum-seekers in developing countries: A neglected health need. Globalization and Health, 10(24), 1–14.[PubMed].Most studies were conducted in the Middle East and indicated a high prevalence of NCDs among urban refugees in this region, but in general, the prevalence varied by refugees' region or country of origin. Hypertension, musculoskeletal disease, diabetes and chronic respiratory disease were the major diseases observed. In general, most urban refugees in developing countries have adequate access to primary health care services. Further investigations are needed to document the burden of NCDs among urban refugees and to identify their need for health care in developing countries.

71 WHO. (2015). Non-communicable disease country profiles. Retrieved 31 March 2016, from http://www.who.int/nmh/countries/en/)

Figure 1: Percentage of total deaths caused by non-communicable diseases in the largest source countries of refugees in 2014



Adapted from: WHO NCD Country Profiles and UNHCR Mid-year trends of 2015. December 2015, UNHCR, Geneva.

1- Women and their dependents

The current situation in the region has increased the vulnerability of particular groups of refugees, including women and children, who constitute more than half of the world's refugee population, to diseases.[72] Women who are separated from their communities and families often face a higher risk of exploitation and abuse. The problem is further exacerbated by weak legal protection, low awareness among women of their rights and, in many cases, cultural attitudes. [73]

Women and girls are exposed to vulnerabilities which are gender-induced, increasing their risk exposure consequently infected by diseases and maternal mortalities. Repeated un-spaced pregnancies and births, and a lack of trained birth attendants, and lack of sanitary conditions, combine to make pregnancy and childbirth risky. Generally, health services sometimes overlook reproductive health needs, such as access to gynecological care and family planning services. As a result, serious problems such as sexually transmitted diseases go undetected, which in this case is assumed to be recognized as even more prevailing.[74]

Refugee children face similar health problems as their peers in host countries; however their situation is exaggerated due to their vulnerable experiences and hardships faced during travel and new living circumstances, leading to higher morbidities due to prevalence of deficiency diseases and communicable diseases.[75,76] Vaccination against childhood diseases is an essential item of all refugee response and an

72 https//www.apha.org/health of refugees and displaced persons: A Public Health Priority.1992.

73 www.un.org/pga/70/wp.../10/.../21-Apr_Refugees-and-Migrants-21-April-2016.pdf

74 The Health of Refugees and Displaced Persons: A Public Health Priority, Jan 01 1992 Policy Number: 9212 APHA.

75 Refugee health. EC/1995/SC.2/CRP.29 By UNHCR | 11 September 1995.

76 Communicable diseases in complex emergencies: impact and challenges Máire A Connolly, Michelle Gayer, Michael J Ryan, Peter Salama, Paul Spiegel, David L Heymann Lancet, 2004 364: 1974–83 Spotlights on Health and Rights: Forced Migration -- Basic Facts: healthandrights.ccnmtl.columbia.edu/forced_migration/basic_facts.html

indicator of access and outreach services for those targeted.[77] A review of individuals' vaccination status is essential and vaccination be offered in accordance with national guidelines.[78] It should be noted that refugee children constitute a good proportion of psychologically affected population groups; and thus, should be warranted special care and management in relation to psychosocial diseases.[79]

According to UNICEF, in Yemen alone there are 10 million children in need of humanitarian assistance, including half a million children suffering from severe malnutrition. In Iraq, internal displacement has shown increasing cases of grave violations of children's rights. According to UNICEF, 3.6 million children in Iraq – one in five children in the country – are at serious risk of death, injury, sexual violence, abduction and recruitment into armed groups.[80] A child protection strategy for Arab States in asylum context is being developed in close coordination between the League of Arab States and UNHCR, and in consultation with all relevant partners working in the field of child protection. This strategy includes the provision of protection, health services, education, psycho-social support, as well as the provision of required documents that enable refugees to register all civil events, such as, birth, marriage, divorce and death.

Sexual violence and violence against women is a significant problem in all crisis interventions, and comes in many forms, including forced and early marriage, and increased vulnerability to sexually transmitted diseases. Many refugees face a lack of access to HIV prevention, testing, care and treatment services.[81] Despite being extensively addressed by UNHCR and development partners, the resulting impact of sexual violence on health services for women and girls is not given adequate resources or attention and gaps in assessing the actual needs of adolescent girls still exist.[82] In Jordan, UNFPA estimates that girls under the age of 18 account for 5 per cent of all new births in Zaatari refugee camp, and that 30 per cent of new marriages registered in Jordan involved a girl between the ages of 15-17.[83] Work must be done to address the gaps and to decrease the risks of sexual violence and violence against women that refugees are subjected to and to enhance the efforts undertaken in this regard.

2- People with disabilities and the elderly

People with disabilities and elderly persons constitute a relevant proportion of refugee groups in need of health services.[84,85] The types of disability and the need for continuity of care due to the chronic nature of the conditions makes it cost-effective, to consider developing special service programs for their health problems.[86,87] This group face specific barriers to accessing health services including financial barriers at health centers, lack of understanding among staff regarding their health concerns, and long distances to

77 Improving child health in post conflict countries. Can the World Bank contribute. http://siteresources.worldbank.org/INTCPR/Resources/ImprovingChildHealthInPost-ConflictCountries.pdf

78 ecdc.europa.eu/.../Expert-opinion-irregular-migrants-public-health-needs-Sept-2015....

79 Health of refugees /BU School of Public Health. Psted Sept.2015/Dean's note.

80 UNICEF. 2015. "Learning Under Fire: How Conflict In The MENA Region Leads To Children's Lack Of Schooling". Geneva: UNICEF. https://www.unicef.org/mena/Education_Under_Fire.pdf.

81 UNHCR. 2019. "Refugees And HIV". Geneva: UNHCR. Accessed October 14.

82 Vu A, Adam A, Wirtz A, et al. The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis. PLoS Currents. 2014;6:ecurrents.dis.835f10778fd80ae031aac12d3b533ca7. doi:10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7.

83 Peace and Security Occasional Paper Series, January 2016.

84 https://www.un.org/evelopment /desa/disabilities/refugees_migrants withdisabilities.html

85 UNHCR's policy on older refugees. April 2000. https://www.refworld.org/docid/47036b502.html.2014

86 Women's Commission for Refugee Women and Children June 2008 ISBN: 1-58030-072-3.

87 data UNHCR.org/Syrian refugees/download php health sector humanitarian response strategy –data unhcr.org

health care centers, coupled with the high cost of transport.[88] According to the Handicap International/ HelpAge International assessment (2014),[89] 22 per cent of Syrian refugees in Jordan and Lebanon have an impairment (physical, visual, auditory, intellectual/cognitive and/or mental).

3- Access to health services

Access to health care services for refugees and asylum-seekers is not only a problem of acute provision during the initial phases, but also an issue of the care that should be provided for chronic as well as acute health needs, as required. The organization of health care systems themselves and the limitations of the governance structures further impede access of refugees to the services available.[90]

Levels of service delivery and accessibility vary greatly depending on the host country, public laws and policies governing service delivery to refugees and asylum-seekers, and whether a refugee lives in a refugee camp or in a non-camp setting, including urban or informal settlements. The legal status of refugees and asylum-seekers, and their country of origin, may also affect the accessibility of health services, including reproductive health services.[91,92]

While national public health systems in most of the countries hosting Syrian refugees have formally integrated Syrians into their health systems to varying degrees, significant barriers remain in place due to overloaded services, a lack of quality services, rising health costs, a lack of financial sustainability, inequitable access, a lack of necessary services, and supply shortages, leading in some instances to increased out-of-pocket expenditures and the discontinuation of needed services.

Table 3: Summary of living conditions and access to services in selected Arab states

Hosting countries	Living conditions	Access to health services
Algeria	Camps	Refugee camps are located in remote areas relying on humanitarian assistance. The health services are provided in five camps and include 27 primary health care clinics, five hospitals, and a central hospital.

88 "Disability And Health". 2019. Who.Int. https://www.who.int/en/news-room/fact-sheets/detail/disability-and-health.

89 Handicap International/HelpAge International. Hidden victims of the Syrian crisis: disabled, injured and older refugees. 2014.

90 Ager A. Health and forced migration. In: Fiddian-Qasmiyeh E, Loescher G, Long K, Sigona N, editors. The Oxford handbook of refugee and forced migration studies. Oxford: Oxford University Press; 2014.

91 Jane Freedman. (2016) Sexual and gender-based violence against refugee women: a hidden aspect of the refugee "crisis". Reproductive Health Matters 24:47, pages 18-26.

92 Survey on Public Health Services and its use among African and Iraqi refugees in Egypt, 2016.

Egypt	Urban	Syrians were granted access to the public health system at equal footing as Egyptians. The integration process for Syrian refugees in public primary health care services started early in 2014, in addition support and training were provided for selected primary health care centers in the governorates where refugees are more concentrated. This has been expanded to all refugees since 2016. In addition to this, health partners are providing health care services with a focus on child health, women's health, non-communicable diseases, psychological health and disabilities.
Iraq	About 60 per cent not living in camps	Specific services offered to select registered refugee populations.
Jordan	Majority in non-camps including urban or informal settlements; 15 per cent of refugees are camp based, mostly in Zaatari and Azraq camps.	Syrian refugees (registered with UNHCR) can access to public health system. Opportunities for integration are difficult for other refugee nationalities based on current policy environment. Camp-based refugees do not have access to Ministry of Health Services and if referred to these services, they are charged the foreigners' rate and paid by UNHCR.
Lebanon	Urban areas and informal settings.	UNHCR registration is required for Syrian refugees to access primary health care services.
Yemen	Urban areas and camps.	Refugees continue to have access to primary health care; however, as a result of the current conflict, some of the refugees and asylum-seeking communities have been displaced or their access to health care has been hindered. In June 2014, UNHCR mainstreamed the health care for urban refugees into the national health system, to allow access to primary health care services similar to nationals, with support from UNHCR and partners for delivery of other specialized services, psychological health services, and sexual violence and violence against women response. Refugees are charged for services at similar rates to nationals at two primary health care facilities, while UNHCR covers the fees for vulnerable groups. Currently, public health services lack operational funding and adequate human resources, which is challenging for refugees as well as nationals, limiting refugees' access to quality services.

Libya	Only 35 per cent of migrants (as stated by IOM[93,94]) are currently living in private accommodation, while the rest are staying in informal settings, market places, transport points or unfinished buildings. Another 4 per cent live in detention centers. Men make up 89 per cent of the migrant population, mainly from Niger, Egypt, Ghana and Mali.	Refugees and asylum-seekers have been provided with UNHCR-supported primary health care services managed by partners at the UNHCR-supported Community Development Centers (CDCs). UNHCR partners also facilitate refugees' referral to secondary and tertiary health services when necessary.

B. Public Health Interventions at Regional and National Levels

1- Emergency response

The rapid influx of large numbers of refugees poses a pressure to health systems that are developed to certain targets and that may already be overburdened by the pressing health needs of the existing population. In addition, emergency responses are often overwhelmed by the rapidity of refugee influxes. Emergency response mandates mobilizing needed resources to support health needs and demands while responding to urgent health needs and screening for serious mental health and other chronic conditions.[95]

Humanitarian assistance is required and is usually provided in a coordinated manner by UNHCR and the host country's Health Ministry, with support from different organizations and NGOs. Preparedness for assistance provisions is essential, given the ongoing situation in the MENA region, and requires planning, burden-sharing and coordination among partners. It should be noted that, while immediate and emergency response may be the same in hosting countries and across borders, yet variability among different refugee groups may pose administrative challenges depending on the government policies and health system management that affect access to services and care.

Emergency preparedness strategies developed by UNHCR focus on risk assessments, collaborative and localized planning, and protection. UNHCR introduced the high alert list for emergency preparedness (HALEP) as a key diagnostic tool for early warning, monitoring of displacement risks, and assessing the readiness and response capacity of the organization.

93 «Libya». 2019. DTM. http://www.globaldtm.info/libya/

94 Labor, transit, or forced migration.

95 http://www.who.int/healthinfo/global_burden_disease/estimates/en/index2.htmlMental health and psychosocial wellbeing of Syrians affected by armed conflict.

Table 4: Overview on health priorities and related interventions in emergency situations

Overview on health priorities and related interventions in emergency situations[96]	
Reducing mortality and contributing to the fulfilment of international standards for shelter, nutrition, water, sanitation, health and education.	◆ Ensure access to primary health care. ◆ Communicable disease surveillance and disease control. ◆ Monitoring of nutrition situation and ensuring of timely response. ◆ Provide health care services if needed (identify needs, partners and resources). ◆ Ensure access to maternal and newborn care as part of essential health care. ◆ Ensure referral to confidential medical care and ensure timely access thereto, it, including preventive treatment after exposure to HIV infection. ◆ Implement appropriate screening and programming for the treatment and prevention of malnutrition. ◆ Establish WASH infrastructure to provide sufficient quantity and quality of water and sanitation facilities. ◆ Conduct proper site assessment and site planning and set up shelter priorities and strategies.
Community-based protection: Promoting participation of people of concern in the emergency response.	◆ Involve persons of concern when identifying needs, capacities and priorities. ◆ Support persons of concern to establish leadership and management structures. ◆ Undertake participatory assessments, set up feedback and complaints mechanisms. ◆ Support peaceful co-existence. ◆ Strengthen self-protection mechanisms.
Solutions-orientation: Laying the foundation for solutions at the onset of the emergency	◆ Ensure links to and integration in local, national and existing services. ◆ Facilitate resettlement in emergency critical health conditions. ◆ Identify opportunities for self-reliance. ◆ In situations of internal displacement, involve early recovery actors (including government and civil society) in developing solutions from the onset of an emergency' perspective.
Protection from violence and exploitation: Reducing protection risks of women, men, boys and girls, notably risks related to sexual and gender-based violence (SGBV) and specific risks faced by children.	◆ Identify service providers and implement referral pathways for access to services. ◆ Coordinate information dissemination about services; include sub-working groups. ◆ Provide or facilitate child protection and SGBV case management. ◆ Facilitate/ put in place family tracing and prevention of family separation. ◆ Facilitate identification and screening - identify and screen children who have specific needs or those at risk.

96 "UNHCR|Emergency Handbook". 2019. https://emergency.unhcr.org/entry/81389/emergency-priorities-and-related-indicators.

2- Regional strategies

A global public health strategy for refugees and asylum-seekers was developed by UNHCR for 2014-2018, mandating improved access to quality primary health care programs, decreased morbidity from communicable diseases and epidemics, improved childhood survival, facilitated access to integrated prevention, control of non-communicable diseases, including psychological health services, ensuring rational access to specialist referral care, ensuring access to national health services, and exploring health financing mechanisms.

A regional public health strategy for Syrian refugees was also developed, stemming from the global strategy of 2014 - 2015 for countries affected by fragility in the Middle East region. It emphasizes 10 main objectives:

- Objective 1: Support adequate triage, health screening and age-appropriate immunization of new arrivals.
- Objective 2: Support access to comprehensive primary health care.
- Objective 3: Decrease morbidity from communicable diseases and outbreaks.
- Objective 4: Support childhood survival and expanded programs for immunization.
- Objective 5: Support integrated prevention and control of non-communicable diseases and mental health.
- Objective 6: Support access to comprehensive reproductive health services.
- Objective 7: Support access to nutrition services.
- Objective 8: Support access to secondary and tertiary health care.
- Objective 9: Maintain and expand health information systems including information on access, uptake and coverage of services.
- Objective 10: Coordination.

The Regional Refugee and Resilience Plan (3RP) was drafted by UNHCR in response to the Syria crisis and includes five refugee-hosting countries. It combines an adaptive humanitarian response, aided by multiple partners, which aims to address basic needs and prevent large numbers of refugees from becoming impoverished, with an emphasis on strengthening the resilience of refugee and host communities and at the same time, strengthening capacities of national systems.

The focus of the 3RP health strategy is twofold: strengthening the capacity of public health infrastructure to cope with the large caseload of Syrian refugees and providing direct and targeted support to the most vulnerable populations who lack access to critical health services. This is done by implementing interventions for emergency and short-term needs through support for primary, secondary, and tertiary health services both in camps, rural and urban areas and national health system capacity strengthening. The emphasis is on the provision of equitable reproductive and neonatal health services, routine immunization, dealing with trauma and rehabilitation, care for the disabled, psychological health problems, outbreak control, management of non-communicable diseases and nutrition services.

Table 5: 3RP beneficiaries

Countries	Registered Syrian Refugees (01/12/2017)[1]	Estimated number of Syrians[2]	Expected Syrian Refugees by December 2018[3]	Number of affected communities (directly benefitted) 2018[4]	Expected Syrian Refugees by December 2019	Number of affected communities (directly benefitting 2019)
Egypt	126,027	50,000	131,000	368,300	126,000	368,000
Iraq	246,592	246,592	245,000	158,110	240,000	158,110
Jordan	655,056	1.380,000	602,000	520,000	560,000	520,000
Lebanon[5]	1.001,051	1.500,000	1.000,000	1.005,000	1.000,000	-

Table sourced from Health Sector Humanitarian Response Strategy, UNHCR.

1- Regional total of 5.379,644 registered Syrian refugees on 01 December 2017 includes 30,104 Syrian refugees accommodated in countries in North Africa.
2- Total estimated number of Syrians of 6.947,406 according to Government estimates, including registered Syrian refugees, unregistered Syrian refugees as well as Syrians residing in the host countries under alternative legal frameworks. Total estimated number of Syrians in Jordan is based on the national plan (2018 - 2020) presented by the Government of Jordan.
3- The expected number of registered Syrian refugees is 5.311,217, which represents the planned number in the Regional Plan (3RP), and the expected number of registered refugees in the mentioned countries by 31 December 2017. The total number of registered Syrian refugees expected in Jordan was based on UNHCR's analysis on trends in return to Syria and departure for resettlement in third countries, as well as based on birth, mortality, and new arrivals.
4- Members of affected communities (direct beneficiaries) represent affected individuals in host communities who will be directly targeted for assistance in accordance with the Regional Plan (3RP).
5- This figure does not include the 277,985 Palestinian refugees in Lebanon and Palestinian refugees from Syria targeted in the Lebanon Crisis Response Plan.

One point that requires further monitoring is what will happen to the numbers of refugees not included in the targeted beneficiaries? How will this targeting affect their health outcomes?

3- Community-based interventions

Community-based interventions that reach out to refugees as well as the host community are essential to ensure awareness of the provided services, thus improving accessibility and continuity of care, particularly for the vulnerable groups. They also work to increase the opportunities of refugee health care access among host communities. In addition, these interventions can be utilized to promote good health, for example by including nutrition and health awareness and addressing underlying causes of morbidities and mortalities. Other interventions may focus on refugees and host communities' economic needs.

For example, social cohesion has been operationalized in the Lebanon National Response Plan (Health Sector), targeting 242 vulnerable communities throughout 2014-2016. This includes the establishment of its very own sector working group in the Lebanon response with dedicated resources and capacity for mitigating tensions, preventing future conflict by ensuring the equipment of refugees and vulnerable local

populations with the skills that the markets demand. This allows refugees to increase their capabilities to help increase the development and diversify local economies.[97]

Training refugee volunteers and outreach workers to carry out community activities related to health can also empower refugee communities. The type of interventions and responsibilities of community workers must be adapted to the actual needs of the community, and can focus on raising awareness and changing behavior related to morbidity and mortality causes, e.g. lack of immunization in children, the promotion of antenatal and post-natal care, delivery facilities and early neonatal care.[98]

In some cases, for example in Egypt, targeted assistance to Syrian refugees by UNHCR has shifted from geographical and social-group targeting to household-based socio-economic assessment. In Lebanon, a network of Outreach Volunteers (ORV) conducts information sessions and refers refugees who need official documents as well as children-at-risk, and individuals with serious medical conditions. They also take part in over 160 homework support groups. More than 24,000 individuals benefited from their work in 2016.[99]

In 2016, UN partners started a home-based care program in Jordan whereby post hospitalization follow-up care is provided by 24 trained Syrian volunteers.[100] In addition, continuous efforts have been undertaken to support outreach efforts to raise awareness among Syrian refugees about access to health services and comprehensive services for vulnerable groups. This was done in response to the assessments results that had shown that refugees' knowledge of available subsidized and free services is limited, which makes many refugees turn to private services at full expense. A study conducted by UNHCR showed that 39 per cent of households in the study suffer from non-communicable diseases, and about a quarter of them are unable to afford treatment. The study showed similar results with regard to antenatal and postnatal services[101].

There is a need for greater access of refugees to information and enhanced refugee participation and engagement in identification of health and disability-related needs, provision of information and linkages with health and rehabilitation services as shown in the surveys on access to and use of health services. Participatory mechanisms for refugees have been strengthened in Jordan by providing hotlines where refugees can get responses to their questions and concerns regarding assistance and protection.[102] At the same time, this service is used to get feedback and seek ideas from refugees relating to a number of services, thus empowering refugee communities.

4- Health system-based interventions

There is a strong history of developing parallel standard packages of services, and prioritizing emergency response programs in cases of forced displacement.[103] As refugees become dispersed all over host countries, instead of being housed in camps, it is essential that health systems expand their services and strengthen their capacities to mainstream refugee health needs and their absorption into national health

97 Action Document for EU Trust Fund to be used for the decisions of the Operational Board.

98 Ideally the community-based workforce will consist of one community-based health worker for 500-1,000 persons (depending on geographical distribution and expected tasks).

99 data.unhcr.org/syrianrefugees/download.php?id=12854Dec 31, 2016 - Regional Refugee and Resilience Plan (3RP)

100 "Document - Regional Public Health And Nutrition Strategy for Syrian Refugees - Egypt, Iraq, Jordan, Lebanon and Turkey - 2014-2015". 2015. Data2.Unhcr.Org. https://data2.unhcr.org/en/documents/details/40687.

101 UNHCR 2016 Health Access and Utilization Survey among Syrian Refugees in Lebanon,

102 data.unhcr.org/syrianrefugees/download.php?id=12854Dec 31, 2016 - Regional Refugee and Resilience Plan (3RP)

103 http://www.who.int/migrants/publications/UNGA_SideEvent_Report.pdf?ua=1Health in the context of migration and forced migration.

systems, and thus serve both host and refugee populations.[104]

Coordinated humanitarian responses have been developed by UNHCR in Lebanon in response to the Syria crisis through an inter-agency mechanism in coordination with the Government of Lebanon. Health assistance for Syrian refugees is based on a primary health care strategy, subsidizing primary health care services for refugees in existing primary health care centers across the country's governorates.[105] A private sector third-party administrator manages referrals for secondary and tertiary services, which predominantly cover life-saving emergencies, pregnancy and birth, and care for newborns[106]. Supporting access to health services for refugees and vulnerable groups of the population is important in order to reduce inefficiencies and strengthen the health system for universal health coverage, which requires sustainability.[107] In Lebanon, the new health strategy integrates universal health coverage as a key principle redefining the benefit package for refugees.[108]

In Jordan, the Ministry of Health has prioritized strengthening health systems and encouraging short-term interventions that would redeploy general practitioners and nurses from hospitals to primary health centers in the regions that have absorbed the greatest number of refugees. In the long term, the Ministry invests to support in-service training and professional development system that will upgrade the skills of the health workforce, while enticing health workers to remain in the country with professional development opportunities.[109]

In Egypt, the health sector has continued to support access to comprehensive health services in coordination with partners. The Ministry of Health (MoH) decree 601/2012 allowed Syrian refugees access to Ministry of Health services under the same regulations as Egyptians. This was supported by a 2016 MoU between the Ministry and UNHCR which provided services to all refugees. The health sector strategy supported by UN partners was to establish a balance between strengthening the national system and delivery of quality services, while ensuring sustainability and stressing key components of care e.g. maternal and child health care, NCDs, psychological health, sexual violence and violence against women and emergency preparedness.[110]

In response to these health needs and in order to provide refugees' health needs and services within the national health system, since August 2016, 281 community health workers and 1,554 primary health care staff have been trained; 112 primary health care facilities have been established in targeted communities; 35,000 referrals to secondary and tertiary care have been made; 5,000 refugee patients with chronic conditions have benefitted from care; and 80,000 primary health care consultations for women, girls, boys and men have taken place, representing an output achievement rate of between 80 and 293 per cent. Since 60 per cent of health care costs are borne by Egyptian patients, and to avoid the cost burden on refugees and asylum-seekers, UNHCR supports secondary and tertiary care, including emergency care, in a private network of health facilities. The League of Arab States[111] also attaches great importance to humanitarian

104 World Bank. 2017. Forcibly Displaced: Toward a Development Approach Supporting Refugees, the Internally Displaced, and Their Hosts. Washington, DC: World Bank. doi:10.1596/978–1-4648–0938–5. License: Creative Commons Attribution CC BY 3.0 IGO.

105 United Nations Office for the Coordination of Humanitarian Affairs (OCHA). Lebanon Crisis Response Plan 2015–2016: Sector Plans. https://docs.unocha.org/sites/dms/CAP/2015-2016_Lebanon_CRP_Sector_Plans_EN.pdf. Accessed 4 Sept 2015.

106 Frenk J. Leading the way towards universal health coverage: a call to action. Lancet. 2015; 385: 1352–8.

107 Ammar W. Towards Universal Health Coverage: Universal Community Health Coverage for Preventive and Essential Outpatient Care. Beirut: Ministry of Health; 2010.

108 Amnesty International. Agonizing choices: Syrian refugees in need of health care in Lebanon. London: Amnesty International; 2014.

109 http://blog.chemonics.com/ James Griffin, The Refugee Crisis Presents a Global Challenge to the Health Workforce. Posted on June 20, 2016.

110 Primary Health Mainstreaming of Syrian Refugees in Egypt, 2015.

111 UNHCR Regional Refugee Resilience Plan 2017-2018 Egypt.

crises through its mechanisms of specialized Arab organizations and specialized Arab ministerial councils, such as the Council of Arab Ministers of Youth and Sports, the Council of Arab Ministers of Social Affairs and the Council of Arab Ministers of Health, which works to support the health sector in the Member States of the Arab League.

In this regard, the Council of Ministers of Health adopted a number of resolutions that provide technical and material support during crises to alleviate the suffering of those affected. The Technical Secretariat of the Council has worked to implement these resolutions, including the dispatch of a joint mission from the League of Arab States and the Organization of Islamic Cooperation through which support was given to the health sector (2011). Another support was given to make necessary vaccinations and serums available to the Libyan Ministry of Health (2017). The Council has also adopted a resolution to send a multi-specialization medical convoy to Sudan, and to make the necessary medications and equipment available to the accompanying medical team (2011). And with the start of the Syrian humanitarian crisis, the Arab Health Ministers Council has adopted a resolution to support the health sector inside Syria, and collaborated to execute these decisions with the World Health Organization to provide the urgent medical needs to inside Syria (2012). The Council has also provided support to Syria's neighboring countries and host countries (Hashemite Kingdom of Jordan, Republic of Lebanon, Republic of Iraq, the Arab Republic of Egypt and Turkey) during 2013, 2014 and 2015. The Council, in addition, supported the health sector in the Union of Comoros (2012), and it has also issued a resolution to support the health sector in the Republic of Yemen, upon which the efficiency of the health sector was raised with the collaboration between the Yemeni Ministry of Health, the League of Arab States and the World Health Organization (in 2012 and 2015). In 2011, 2017 and 2018, the Council provided support to the Somali Ministry of Health. The Council of Arab Health Ministers always engages to alleviate the health and humanitarian sufferings of those affected by crises.

C. Capacities of Health Systems

What is really needed is to ensure that health systems are strengthened so they are capable of providing universal health coverage and access to quality health services for all refugees. This entails support to the resilience of health systems and their capacity to sustain response to crises, both short and long-term, to meet the needs of all, especially the most vulnerable, such as children, pregnant women, the elderly, people with disabilities and victims of sexual violence and violence against women. In addition, continuity of care is integral for those with specific health needs such as patients suffering from NCDs, HIV, tuberculosis, psychological health problems, and other chronic health conditions. The expansion of the health system would ensure the provision of routine services to the general population at large. [112,113]

Most of the challenges in providing effective health care to refugees and displaced persons are programmatic and institutional rather than technical.[114] Logistical and administrative difficulties, lack of planning and coordination, lack of adequate funding and lack of capacity to support a sustainable response are the major challenges. In some cases, national health systems have been put under great pressure by the conflicts and insecurity in the region, which have damaged healthcare facilities or negatively affected healthcare workers. The increasing pressures due to population movements may also strain health care systems.

Despite governments' efforts to support health service delivery for refugees, a number of challenges

112 World Bank. 2017. "Forcibly Displaced: Toward a Development Approach Supporting Refugees, the Internally Displaced, and Their Hosts" (Overview). World Bank, Washington, DC. License: Creative Commons Attribution CC BY 3.0 IGO.

113 Health Sector Humanitarian Response Strategy - UNHCR Data Portal: data.unhcr.org/syrianrefugees/download.php?id=9943

114 The Health of Refugees and Displaced Persons: A Public Health Priority. https://www.apha.org/...health.../the-health-of-refugees-and-displaced-persons-a-publi...

hinder the accessibility of such services, particularly to those with increased vulnerability. Health access and utilization surveys have been conducted by UNHCR in several Arab states to monitor access to and utilization of basic health services among Syrian, Iraqi and African refugees living in Egypt, and Syrian refugees in Jordan. The surveys highlighted the particular challenges related to health services access, including communication challenges affecting refugees' knowledge of their rights to free or subsidized health care at governmental facilities or through UNHCR, a preference for the private sector, and a lack of needed services.[115,116]

In recent years, the health care sectors of many Arab states have witnessed development and reform, through the implementation of modern networks of health infrastructure, an increasingly skilled health workforce, and deployment of modern technologies. However, these gains have not been equally distributed among the countries of the region, and gaps and disparities in health outcomes also exist within countries. The Eastern Mediterranean Regional Office of the World Health Organization (WHO-EMRO) in 2012 attempted to categorize countries in the region according to the capacities of health systems, based on population health outcomes, health system performance and the level of health expenditure.[117] The results highlighted the differences in capacity between countries in the three different tiers, and even among countries in the same tier. In addition, it is clear that countries mainly affected by major population movements are in group 2 (middle-income countries) and group 3 (low-income countries); thus, excluding Gulf Cooperation Council countries in tier number one.[118]

According to the same study, out-of-pocket spending is highest in group 3 countries (around 70 per cent of all spending on healthcare); nevertheless, equity problems also exist in group 2, where out-of-pocket spending reaches 50 per cent. The high share of out-of-pocket payments in these groups exposes households to the risk of financial catastrophe and impoverishment, due to lack of compatible health financing and coverage schemes.

Inequities in access to health services, rising exposure to health risks, increasing health care costs and unacceptably low levels of access to quality health care represent the most important challenges facing many countries. Universal access to health services is almost 100 per cent for group 1 countries; varies between 83 and 100 per cent for group 2 countries; and is between 44 and 97 per cent for group 3 countries. The coverage of primary health care services differs by type of services among countries in the three groups; there is full or near- full immunization coverage, but incomplete provision of services for non-communicable and psychological diseases within primary health care services. Many countries have relatively high coverage for basic services such as immunization, maternal and child health services, and health awareness; yet are missing the more costly elements of chronic disease care and management, and related services, including referral systems.[119]

115 Health Access and utilization Surveys-HAUS Egypt 2016, Jordan 2015.

116 The majority of participating Ethiopians do not vaccinate their children against infantile paralysis and measles (88 per cent have not received the vaccine for infantile paralysis, the same percentage have not received the vaccine for measles), followed by Somalis (60 per cent have not received the vaccine for infantile paralysis and 80 per cent have not received the vaccine for measles), South Sudanese (54.4 per cent have not received the vaccine for infantile paralysis and 54.5 per cent have not received the vaccine for measles), Eritreans (50 per cent have not received the vaccine for infantile paralysis and 33 per cent have not received the vaccine for measles). In Jordan, the protective coverage against measles presented to children has decreased for children below five years old, from 87 per cent in 2014, to 82 per cent in 2015, according to personal surveys.

117 WHO EMRO Annual report 2012. http://www.emro.who.int/annual-report/2012/strengthening-health-systems.html.

118 Group 1: Bahrain, Saudi Arabia, Kuwait, Oman, Qatar, United Arab Emirates; Group 2: Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, Syrian Arab Republic, Tunisia; Group 3: Djibouti, Somalia, Sudan and Yemen.

119 Int J Qual Health Care. 2005 Aug; 17(4):331-46. Epub 2005 May 9. Quality of primary health care in Saudi Arabia: a comprehensive review.

Health coverage in group 2 countries suffers from fragmentation and duplication, and the extent of population eligible for coverage varies. In the absence of well-established social health insurance schemes and the presence of underfunded public sector health services, coverage is largely restricted to a formal organized sector, and large segments of the population remain uncovered by prepayment schemes. In group 3 countries, and while in principle, governments are supposed to cover all nationals, coverage is primarily available for public sector employees.

The existence of health infrastructure and a health workforce, which are proxy measures for service provision, show marked variation among countries between the three tiers and between countries in the same group. Poorer countries suffer from a lack of recruitment, deployment and retention strategies, emigration of skilled health personnel, and an absence of reliable data on human resources for health, hindering improved policy formulation and decision-making. The existing workforce is often misaligned across specialties, regions, and sectors. Over 88 per cent of physicians in Egypt and over 70 per cent in Lebanon are specialists, as compared to general practitioners.[120] Human resources for health also tend to be concentrated in urban areas, which may not always match population need. In Yemen, approximately 70 per cent of all health workers were concentrated in areas where only 35 per cent of the population resides.

From the above, it becomes clear that the greatest challenge in strengthening health systems to support universal health coverage to leave no one behind lies, to a large extent, in some countries in group 1 and 2, and in all countries of group 3.

D. Practical Experiences

Iraq

Given the importance of mental health in humanitarian contexts, UNHCR has taken the lead to improve access to mental health and psychological support for refugees in Iraqi camps. UNHCR is addressing mental health through its mainstreaming into camp-based primary health care services by building the capacity of the general health workforce in refugee camps to assess and prioritize mental health conditions, under the supervision of mental health professionals (psychiatrists). The process has its own challenges, e.g. retention of trained staff (which makes the training an ongoing process), availability of psychotherapy at primary health care (PHC) level (national regulations are not very clear in this area), and the motivation of general health staff to provide mental health services. The second axis is through strengthening of non-specialized but trained community workers for mental health care. This is achieved through directing psychological interventions that are susceptible to scaling and development to be developed by community workers, and healthcare staff and establishing referral pathways between psychological health and psychosocial support actors, and PHC units in camps.

Lebanon

Expanding provision of primary health care to all refugees at the same level as nationals, is done through 200 health-ministry affiliated PHC units, where refugees can access comprehensive PHC services free of charge or by nominal fees. In addition, in around 100 PHC units, humanitarian actors provide additional subsides support to reduce the user fee. Support of disaggregated data collection by nationality is undertaken, yielding more reliable data, although the system needs to be further strengthened.

120 (Jabbour et al., 2012). Jabbour, S., Giacaman, R., Khawaja, M., Nuwayhid, I. (Eds.), 2012. Public Health in the Arab World, 1st ed. Cambridge University Press.

Jordan

UNHCR provides primary health care services to Syrian, Iraqi and other nationalities if they are unable to access Ministry of Health facilities or cannot afford to access (based on vulnerability criteria). These services are available through UNHCR's implementing partner clinics of the Jordan Health Aid Society (JHAS). They have five static clinics and one mobile medical unit serving out-of-camp refugees in the urban setting. Services available through the above clinics include general practice and specialist consultations, dentistry, and provision of medications on prescription, health education and referrals for secondary and tertiary health care services.

Syrian refugees had free access to Ministry of Health facilities from March 2012 until November 2014. As of November 2014, the Government of Jordan ceased free access to health services. Syrian refugees now have to pay the same rate as non-insured Jordanian when they use all types of health services provided by the Ministry of Health. The non-insured Jordanian rate is the subsidized rate that is used for Jordanians who do not have government health insurance and is about 35-60 per cent of what non-Jordanians (foreigners) pay. The non-insured Jordanian rate is normally affordable for non-vulnerable individuals, especially at the primary health care level, but is expected to cause considerable hardship for many refugees. All registered refugees are encouraged to access Ministry of Health facilities at non-insured Jordanian rates (already subsidized and affordable for some). Pregnant Syrian women with a valid card from the Ministry of Interior have free access to the basic antenatal care and childcare for children up to 5 years of age. Normal vaginal delivery, caesarean section and secondary health care for pregnant women are charged at the non-insured Jordanian rate.

Djibouti

A refugee contingency plan has been drawn up, and was updated in February 2017, following the resurgence of the Oromo crisis in Ethiopia. The purpose of this plan is to define the general line and coordination mechanisms that should be set up in the event of an influx of refugees from Ethiopia. A simulation exercise was created with the support of external experts under the leadership of a UNHCR protection officer, two staff from the Government's National Office for Refugees and Victims of Disasters and two UNHCR field sector focal points (water, sanitation and hygiene; health; and shelter).

There is also a plan for preparing and responding to epidemics in Djibouti that targets the outbreaks most likely to appear: cholera, bloody diarrhoea and measles. In addition, health partners, including staff from the Ministry of Health in refugee hosting areas, have been trained on outreach volunteers.

A network of community health workers is in place in the three refugee camps. Capacity building is ongoing. As part of the complementarity process, UNHCR and the Ministry of Health work towards harmonization of management of community health workers in refugee camps and those in host communities. Most community health workers are from refugee communities, as are 90 per cent of health personnel working in refugee programs. The implementing partner is funded mainly by UNHCR, and therefore has less margin to recruit more qualified health staff, and more refugees are accordingly recruited.

Sudan

Advocacy efforts that were in place for few years have finally paid off through a high-level agreement to include urban refugees within the same health insurance scheme as nationals. This started as a pilot project covering all Yemenis that were 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 assessment of health insurance coverage and utilization was prepared, lessons learned were documented, and best practices for upgrading the service were documented, which will directly support the new intellectual outlook for service delivery, according to the Forum for Peace for Human Development led by the Federal Ministry of Health.

Health and nutrition provisions are implemented through inter-agency sectorial approach considering the mixed population context. In order to highlight the plight of refugees, UNHCR advocated and succeeded in convincing the government and partners for a special forum to discuss technical issues. As a result, a Technical Advisory Group was created. UNHCR co-leads with the Federal Ministry of Health the refugee-specific Health and Nutrition Technical Advisory Group meetings in Khartoum. On the other hand, in the same area within States hosting refugees, WHO co-leads with the State Ministry of Health through the regular sector approach. In order to clearly define roles and responsibilities amongst health and nutrition UN sister agencies, a memorandum of understanding has been signed with UNICEF and another one is being finalised with WHO.

Almost 60 per cent of health personnel working in refugee camps in Sudan are refugees. Implementing partners are continuously advised to hire available and technically qualified personnel from the refugee communities. The only challenge is that resistance to recruit from the refugee community has been encountered in one of the governorates, but UNHCR will continue to advocate and promote for recruiting technically competent refugees.

E. Yemen Cholera Outbreak Case Study

Refugees and asylum-seekers in Yemen, numbering 280,421, as of 31 July 2017, continue to live in an unstable situation. Conflict, coupled with a steady deterioration of the country's economic conditions and a persistent lack of livelihood opportunities, dramatically increases the risks of the persons concerned. Maintaining protection remains difficult, and ongoing conflicts put refugees at great risks. Protection activities, including individual case management, specialized child protection, sexual violence and violence against women services, as well as financial assistance for high-risk situations, ensure a safety net for refugees and asylum-seekers since Yemen is on the brink of a crisis.

Since March 2015, the health system has come under considerable strain. Lack of resources, war-damaged premises, unpaid staff salaries for health workers, rising operational costs in health clinics, coupled with fuel and electricity shortages, is taking its toll. The United Nations in Yemen estimates only 45 per cent of facilities reported as functioning to some degree. The main causes of avoidable deaths in Yemen are communicable diseases, maternal, prenatal and nutritional conditions, and non-communicable diseases. The crisis in Yemen has been further compounded by the outbreak of cholera in April 2017, which has put much of the population at risk, including persons of concern to UNHCR. The outbreak is now considered the largest cholera crisis globally, and has taken hold at a frightening rate, aided by the erosion of critical water and sanitation, along with health response infrastructure. Widespread hunger has exacerbated the

crisis, as diarrheal diseases, including cholera, are particularly dangerous for those with weakened immune systems due to malnutrition. As of August 2017, over 550,000 suspected cases were registered and 2,000 attributable deaths recorded across 20 out of 21 governorates.

While UNHCR cholera activities began in October 2016, in response to the current outbreak, it has worked to confront the epidemic as part of a system-wide response led by authorities, and cluster leads UNICEF (WASH) and WHO (Health). UNHCR's primary responsibility has been the well-being of persons of concern, along with Yemeni host communities living in areas with high concentration of refugees in Sana'a, Kharaz camp and Basateen.

Efforts have largely focused on placing the community at the center of prevention efforts, empowering high-risk communities with accurate information on the spread of cholera, coupled with early case detection and surveillance, and the timely referral of suspected cases to UNHCR-supported health and community centers. Critically, UNHCR tailored the cholera response to suit the setting including distinguishing between urban settings (Sana'a and Basateen) and camp settings (Kharaz) where water and sanitation play a larger role in prevention.

UNHCR has also initiated an awareness campaign through the community-based protection network volunteers in five northern governorates. The UNHCR-led Protection Cluster boosted cholera prevention efforts through the community-based protection network, including training for volunteers. Training has now been completed, with volunteers being provided with printed materials, to communicate and assist communities in 25 districts far from areas, where the refugee population is located. The prevention information activities are taking place in public places including mosques, schools, hospitals and markets and are carried out in close coordination with entities, and WASH and health clusters.

UNHCR has largely been successful in protecting persons of concern, including both refugees and asylum-seekers, from the latest cholera epidemic, despite facing significant challenges including problems of access to services and funding shortages. The epidemic has led to tragic and preventable deaths of over 2,000 people in Yemen, none of them refugees. Considering the nature of the disease and the ease in which it spreads in dire conditions such as in Yemen, this figure could have been significantly higher. Refugees and asylum-seekers are undoubtedly among the most vulnerable communities in Yemen and will continue to face great personal risk as the war continues.

In order to ensure the highest level of care for persons of concern, UNHCR engaged communities through expanded outreach efforts for prevention and early detection of suspected cholera cases. Training and equipping community mobilizers has resulted in accurate information shared among the community, with knowledge of symptoms allowing for speedy referral and appropriate response in the home such as rehydration and cleaning of contaminated surfaces. By boosting the capacity of clinics and health staff, the medical response was also expanded to handle the additional pressure as cholera sweeps across the country. Finally, by reaching out and engaging the community-based protection network volunteers, families outside of UNHCR's area of operation have also been reached with prevention messages.

While figures for the epidemic suggest that the infection rate is beginning to slow, UNHCR's activities continue in order to confront cholera. Conditions in Yemen, including widespread malnutrition, breakdown in medical, water and sanitation services, along with ongoing hostilities, emphasizes that this country will remain a breeding ground for epidemics in a manner that can be described as man-made but avoidable.

F. Challenges of Access to Health Services, Mainstreaming and Sustainability

Forced displacement affects different countries in different ways because of its effects and challenges. It is important to plan for all possible refugee types, and to monitor the impact on health systems and health outcomes to identify any health-related challenges.

Limited resources affect the capacity of the government to adequately finance the health sector and to expand the supply and the comprehensiveness of the services provided, as the case in many Arab states affected by forced displacement. Superadded factors include a lack of mechanisms for financial risk protection, for equitable access to quality services, and for inclusion of vulnerable groups. This requires strengthening health financing and budgeting systems, which is essential for proper budget allocation and should be supported by proper planning, monitoring and evaluation to identify priorities and support efficiency and effectiveness in addressing demand from refugee groups, and those at risk. Financial gaps should be assessed to determine their implications on service delivery for priority-setting. Funding contributions should also be assessed, developed and coordinated to ensure they do not fall short of need.[121]

To promote sustainability, adequate funding and health financing systems relevant to the health services accessed by refugees and to the specific context of each country should be guaranteed. Any health financing schemes, including insurance schemes, need to be combined with a mechanism to financially protect the poor and other potentially vulnerable persons and groups to enable them to access health services.

Mainstreaming access of refugees to such health systems in urban environments is a more efficient use of limited resources than setting up separate services and doing so benefits both refugee communities and the public health system as a whole on the way to universal health coverage. It, therefore, makes sense to augment the capacity of these systems, either directly, where funding is available, or indirectly, by encouraging the engagement of various donors and other actors. To this end, an inclusive policy must be in place, and the health sector must have the capacity to support the extra demand for health services, particularly in areas of great need, to ensure responsiveness, accessibility and acceptability. This means strengthening the delivery capacity in terms of infrastructure, technology and supplies, health workforce, quality, and services.

Refugees and asylum-seekers' epidemiological patterns and demographics must be considered when planning for public health strategies. A concentration of women, children, youth and the elderly, with their increased vulnerabilities, makes people-centered health system approaches more relevant to fulfil their public health needs. Strengthening of health systems should focus on prevention, primary care, public health and clinical referrals when needed. This includes expansion of the provided services at the primary level of care, given the increased vulnerabilities of refugees to morbidities and mortalities due to increased prevalence of communicable diseases, non-communicable diseases, psychological disorders, reproductive health disorders, disabilities, improper continuity of care; it also requires coverage of needed health services. This entails that the provided services are age, gender and disease-vulnerability sensitive, while considering the economic and social determinants for all refugees, particularly those in the most vulnerable situations, such as children, pregnant women, the elderly, persons with disabilities, and victims of torture and those of SGBV.

121 As of 31 January 2017, UNHCR's budget for the MENA region for 2017 stood at $2.05 billion, including the responses to the Iraq, Syria and Yemen situations. This represented $116.3 million less than the budget of $2.17 billion approved by UNHCR's Executive Committee at its 67th session in October 2016. This will affect life-long, protection assistance for refugee families in dire need and will also have an effect on life -saving secondary and tertiary health care interventions.

The challenge of achieving universal health coverage remains high on the development agenda and requires effective interventions including antenatal and postnatal care, safer deliveries, breastfeeding support, micronutrient supplementation and routine immunization against preventable diseases, while optimizing investments and enhancing accountability to improve the health and nutritional status of women and children.

All levels of public health services, such as preventive health and therapeutic health promotion services, including emergency care, should be strengthened in accordance with carefully developed local guidelines supported by epidemiological surveillance, according to data collected, and follow-up systems to cover information gaps that hinder overall response. Conducting systematic and comprehensive efforts to determine the numbers, whereabouts and needs of displaced persons is therefore essential.

All public health interventions for refugees and asylum-seekers must focus on bridging gaps in health equality, as these gaps affect them significantly, as well as other vulnerable groups. Reducing patient expenses by modifying and expanding health insurance schemes and improving access to services are essential. Evidence-informed policies and the alignment of strategies and plans are the foundation from which progress can be made towards universal health coverage. These are sometimes missing in countries with weakened health systems.

The situation of health workers continues to pose challenges in terms of staff availability, equitable distribution, specialization and retention. The lack of quality health care services at the primary health care level and the unregulated expansion of the private health sector present other challenges. All these factors affect the overall performance of health systems, impede refugee health programs, and hinder progress towards universal health coverage in a number of countries.

Refugee health care services cannot be planned without taking into account the social determinants of health, which are considered integral components for risk mitigation.

Developing mechanisms and programs to share country experiences and best practices will help many countries to adopt effective interventions. Participation and commitment by all stakeholders is also crucial to develop and implement a local and regional public health framework that works at all levels when trying to adjust and harmonize procedures in different countries to take on shared responsibilities.

Chapter V

The Strategy

Introduction

This Strategy has been developed based on situation assessments and previously developed global, regional and national public health and resilience strategies, particularly those addressing Syrian refugees in the Arab states most affected by the situation, while considering the Sustainable Development Goals 2030, the New York Declaration (2016) and rights to health of refugees according to international instruments. This strategy addresses key public health priorities and actions that are necessary to meet current and ongoing health needs and to overcome barriers to universal health coverage in the context of asylum.

The scope of the strategy is broadened, to accommodate and respond to the health needs of refugees and asylum-seekers and vulnerable groups and to ensure universal health coverage in accordance with the principle of making essential services available, accessible, affordable and of high quality, while considering the social determinants and the risk of exposure to multiple health hazards induced by the living context.

The Arab Strategy on Access to Public Health Services in Asylum Context aims to ensure solidarity and shared responsibility between countries, and at the same time, to support national health systems in consolidating interventions at the national level, to support the health needs of refugees and asylum-seekers in camps, rural and urban areas and to strengthen the capacity of national health systems for service delivery.

It should be noted that, although the strategy proposes the creation of a regional public health framework on health and health care in asylum context, the implementation of this framework may vary according to each country's context, readiness, capacities, and the specifics of the refugee and asylum-seeker communities it hosts.

The public health strategy will support interventions needed to meet the short, medium and long-term health needs of refugees, while also strengthening health systems and promoting resilience for sustained response.

A. Vision and Scope of the Arab Strategy on Mainstreaming of Public Health Services to Refugees in the Arab Region "To improve the Health Results of Refugees, Displaced Persons and Asylum-Seekers in the Arab States"

The Strategy aims to:

- Respond to the needs of refugees for health promotion, disease prevention, and care to reduce morbidity and premature mortality, while adopting the universal health coverage paradigm and in alignment with the SDGs. This to be achieved through enabling, supporting and improving access and availability to quality national primary health care services including emergency services, referrals to secondary and tertiary care with relevant involvement of inter-related sectors.

- Supporting the needed assistance for national health care systems to ensure the possibility of responding to medical needs of refugees and host communities.

B. Guiding Principles

- Protection and non-discrimination: The well-being and dignity of refugees and asylum-seekers should be safeguarded, and services should be provided depending on need, and underpinned by human rights principles.
- Appropriateness: The Strategy prioritizes evidence-based and effective interventions in public health to strengthen effectiveness and efficiency that depend on available resources and local context of each country.
- Equity and access: Refugees and asylum-seekers should be ensured equitable access to similar health services to nationals in host countries, with special care for the most vulnerable.
- Sustainability: To ensure sustainability, public health services for refugees should be provided by or included within national systems wherever possible. Sustainable health financing opportunities should be capitalized on to address needs.
- Age, Gender and Diversity (AGD): Gender equality should be supported and the rights of all refugees and asylum-seekers, of all ages and nationalities, must be respected. Special measures should be taken to mitigate risk and reduce vulnerabilities of particular groups, including women, girls and boys, the elderly, the youngsters, and persons with disabilities (principle of non-discrimination).
- Primary health care principles: Provision of health care should be anchored in the principles of primary health care, to ensure that both prevention and curative care are provided.

C. Strategic Approaches

- Partnership and coordination: Support for coordination and inter-sectoral collaborations between different stakeholders, including government bodies, UN agencies, international organizations, NGOs, private sector organizations or other partners involved with the response to refugees and asylum-seekers, in order to ensure complementarity, and to better meet the health needs of refugees.
- Capacity enhancement: Increasing institutional and local capacities of all stakeholders, to ensure their capabilities are strengthened and overall public health services in host countries benefit.
- Community empowerment: Ensuring social accountability and community involvement and participation; support for community-level health programming as an essential component of public health care programs.
- Supporting health information systems (HIS): Rigorous data collection and health information systems should be supported in order to generate timely data, which can then be utilized for evidence-based decision-making.
- Integrated approaches: Consider the public health needs of refugees in other relevant public services or in refugee protection priorities within national systems, where possible.
- Innovation: Utilizing creative solutions to improve the well-being of refugees and asylum-seekers; continuous modernization and updating of working methods and application of new and innovative technologies; new approaches to developing sustainable, effective and quality health services; creating and strengthening links with research and academic institutions to facilitate this.
- Monitoring and evaluation: Continuous and periodic assessment to ensure improvement.

D. Key Considerations

- Collaborative effort between the League of Arab States and the United Nations High Commissioner for Refugees.
- Adopting a human rights-based approach.
- Adopting a universal health coverage model, in alignment with the Sustainable Development Goals.
- Adopting the New York Declaration for Refugees and Migrants framework (2016).
- Responding and prioritizing different health needs of refugees and asylum-seekers: mental health care, sexual violence and violence against women response, non-communicable diseases, reproductive health, etc.
- Supporting solidarity and responsibility-sharing among Member States.
- Acknowledging that national legislation and policies differ from country to country, however, all support human rights.
- Considering the readiness and capacities of health services to respond to increased demands, both short and long-term.
- Removing political barriers in accessing primary health care services.
- Considering the role of civil society, private sector and whole-of-government approach.

Targeted Groups
All refugees, asylum-seekers, displaced and stateless persons in asylum and displacement contexts in the Arab League Member States (regardless whether resident in refugee camps, settlements, or rural and urban out-of-camp populations). (See annex for the numbers of persons of concern in the Arab states).

E. The Concerned Parties for Implementation

- The League of Arab States.
- Governments, including relevant line ministries and host communities.
- UNHCR, other UN agencies, international organizations, development banks and multilateral funds at all levels and within all sectors.
- Donors.
- Parliamentarians.
- Refugees and asylum-seeking communities through needs assessment, awareness raising and communication with competent authorities.
- Partnerships, networking and exchange of information among Member States regarding experiences in implementing the provisions of the Conventions.
- National and international NGOs by working through the societal role, which supports the governmental one, especially in remote areas.
- Academic and research institutions by conducting field researches concerned with health and suggesting practical solutions to overcome health and social issues that threaten public health.
- The private sector through supporting the implementation of the Strategy with the agreed roles, including financing and the complementary role of government and community.

F. Strategic Pillars

The Strategy is based on six strategic pillars, which are vital to create a conductive environment that supports the access of asylum-seekers and refugees in Arab states to public health services and health care.

- SP1: Supporting a legislative, policy and regulatory environment that fosters universal health coverage for refugees and asylum-seekers.
- SP2: Supporting equitable access of refugees and asylum-seekers to quality primary, secondary and tertiary health care, including the provision of health-care needs in national health systems, where possible.
- SP3: Addressing refugees and asylum-seekers' vulnerabilities via protection responses.
- SP4: Strengthening the capacity of public health systems and infrastructure to respond to health needs of refugees, asylum-seekers and their host communities in both short and long-term.
- SP5: Strengthening health information systems to allow for reliable and timely data collection and monitoring.
- SP6: Coordination of health sector response.

Strategic pillar 1: Supporting a legislative, policy and regulatory environment that fosters universal health coverage for refugees and asylum-seekers

It is evident from the results of the mapping exercise (see Chapter IV) that despite a number of successful examples of Arab states supporting and safeguarding refugee rights to health, many refugees in the Arab world at present lack access to health services including national services at the same level as citizens. Such access depends in part on the commitment of states to ratify the international instruments that protect these rights, and to fully implement them within domestic law and national policy.

Many Arab states have ratified International Human Rights Conventions to protect the rights of refugees and asylum-seekers, including their right to health, but others have yet to do so, or record reservations to their provisions. Likewise, several regional Arab conventions have also been developed, but have not yet been fully implemented or reflected in national legislations. In addition, laws and policies on refugees and asylum-seekers in Arab states are in many cases fragmented or inconsistent.

Most recently, the 2016 New York Declaration for Refugees and Migrants, which encourages responsibility-sharing and sustainable, actionable and rigorous solutions, depends on states reviewing and enhancing their commitments to refugee rights. Taking advantage of this opportunity, requires countries to incorporate the principles of international refugee law into their own national legislation to ensure that targeted groups see their rights safeguarded.

The large-scale forced population movements within the Arab world in recent years have highlighted these gaps in implementation of international instruments at the national level, as host countries have been unable to fully respond to the health needs of refugees, asylum-seekers and host communities.
In order to safeguard these local communities, and in order to ensure that their rights to access health

services are protected, domestic laws and policies on these issues should be revised and expanded so that they are fully in alignment with international and regional frameworks.

Legislation and policy at the national level must also be reviewed, and where necessary consolidated and unified. The needs of vulnerable groups, including women, children, the elderly, persons with disabilities, and those in need of mental health services, must also be addressed at the legal and political level.

Accordingly, this Strategy proposes the development of a comprehensive regional policy framework on health in asylum context, to support the harmonization of policies and laws at the regional and national level.

Objective 1: Developing and supporting the implementation of the updated health policies established by the League of Arab States through its mechanisms of action in specialized Arab councils that take into account the health needs of refugees and asylum-seekers, which respect and promote their rights to access to equitable, quality and affordable basic health care; in line with international and regional conventions, which guide the development of national health laws, frameworks and practices for Arab states.

Priority actions:

- The Strategy and action plan constitute an Arab policy framework that provides health care in the context of asylum and displacement to prioritize shared responsibilities, complementarity within public health systems, a framework for universal health coverage, and supports international and regional refugee conventions.

- Revising and amending the relevant laws and policies of the Arab states to include the health rights and needs of refugees and asylum-seekers adopted by the New York Declaration for Refugees and Migrants. This will be done by analyzing relevant laws and trends in each country and working towards the practical implementation of these laws in terms of access to and provision of health services. Such new legal and policy frameworks should be comprehensive, including in particular the needs of the most vulnerable groups of refugees and asylum-seekers such as women, children, the elderly, persons with disabilities and mental health.

- Harmonization at regional level of Arab states' policies on refugees and asylum-seekers and non-discriminatory access to health services, while also taking into account their national context. This requires the development of mechanisms that promote coherence between policies in Arab states, to facilitate the ability of refugees and asylum-seekers to access health care services across the region.

- Development of a set of indicators to be adopted by states to monitor the progress towards achievement of coverage and equity, reflecting commitment to this goal; this also entails government interventions, as appropriate, to ensure enforcement of supportive legislation that promotes transparency and accountability.

Strategic pillar 2: Supporting equitable access of refugees and asylum-seekers to quality primary, secondary and tertiary health care, including the provision of health-care needs in national health systems where possible

According to international conventions and standards, refugees and asylum-seekers should be entitled to access to preventative and curative health care services with equal opportunities to nationals.

Despite improvement of access of refugees and asylum-seekers to health care due to a coordinated humanitarian response, gaps still exist due to technical, financial, geographic, cultural, and administrative barriers. Inaccessibility may also differ for different refugee groups, depending on their legal status or their country of origin.

Financial hardships represent one of the main barriers to access to health care services in asylum context. To promote financial risk protection, fees for accessing health services should be similar to those paid by nationals. Refugees and asylum-seekers with increased vulnerabilities should be identified and provided with suitable financial support to ensure continuity of care, e.g. cash-based funding or insurance coverage.

Communicable diseases constitute a major concern and are main causes for increased morbidity and mortality - among several other causes - due to vaccine shortages in countries of origin, gap in vaccination coverage during the responses and poor living conditions. Diarrhea and respiratory diseases are major causes of morbidity; also measles, malaria and cholera may spread, depending on the overall epidemiological situation of each country. Tuberculosis morbidity continues to be a problem exacerbated by weak surveillance systems, protection and prevention mechanisms. The spread of infectious diseases can take many forms and depends on the strength of surveillance systems and the availability of preventive measures. The cholera outbreak in Yemen is an example of high morbidity and mortality from poor living conditions and the lack of preventive and curative services. In 2013 a polio outbreak in Syria threatened the introduction of the disease to the region. The need for protection against communicable diseases extends to members of the host communities, as public health measures exert pressure on the existing health services.

Non-communicable diseases and their management represent a burden and a high risk to refugees and asylum-seekers, affecting morbidity and mortality, particularly cardiovascular disease, diabetes mellitus, cancer, and mental illness. Data on service utilization show limited access of cases to health promotion, disease prevention and care for complicated conditions, including the lack of response of health services to ongoing and extended care, including the financial burden, which is a barrier to access.

The impact of morbidity and mortality from reproductive health is among the major problems facing refugees and asylum-seekers. Like all societies, refugees and asylum-seekers need access to appropriate preventive and curative HIV/AIDS services, as well as ensuring that people diagnosed with the disease do not have adverse effects, including rejection of asylum-claim, their right to services, care and non-exclusion. Relevant services are essential to improve health outcomes and should be provided within integrated services that ensure reproductive and maternal health, neonatal health services, HIV treatment services, protection systems and societal engagement.

Essential health care packages help to promote universal health coverage and equity through increasing availability of services and efficient resource distribution, and availability of medicines. Essential and basic health services that are part of the specific health needs of refugees and asylum-seekers should be part of a modified and comprehensive basic benefits package and should be accessible free of charge

or included under financial schemes, depending on the country context. These may include childhood vaccinations, reproductive health services, communicable and non-communicable disease control, mental health services, and emergency care.

Although attempts to mainstream refugees and asylum-seekers into national health systems have been attempted to various degrees, barriers still exist due to overloaded systems, increasing costs, lack of needed services and resources and inequitable access, leading to increased out-of-pocket expenditures and discontinuation of care.

Objective 2: Ensuring refugees and asylum-seekers' access to needed services at all levels of care in similar ways and at similar costs to those of nationals, thus fulfilling their health needs.

Specific objectives 2.1: Providing essential and accessible primary health care services of high quality to refugees and asylum-seekers.

Priority actions:

- Promoting an effective legal environment (see Strategic pillar 1).
- Developing a basic benefit package for essential health care services that defines cost-effective, evidence-based, comprehensive integrated primary and essential health care interventions; the package should support expanded immunization programs, reproductive health and HIV/AIDS care, nutrition support, communicable disease management, non-communicable disease management and referral, psychological health services, and support for those with disabilities.
- Vulnerable groups should be targeted based on criteria and a suitable safety net provided for them to ensure access to needed health services.
- Health service delivery points should be equitably distributed and equipped in impacted areas to facilitate accessibility.
- Exploring Financing options to support refugees and asylum-seekers with health needs, e.g. cash assistance and insurance schemes should be analyzed and appropriate options selected and implemented.[122] The full range of available financing mechanisms including insurance schemes and cash-based financing should be examined, to assess how to protect vulnerable refugees and asylum-seekers and other potentially vulnerable groups and to enable them to access health services.
- Supporting the continued access to care, and availability of and access to essential medicines.
- Raising awareness of refugees about available services.
- Monitoring system for refugees and asylum-seekers' access to services.

122 A careful cost-analysis is needed to compare direct payment for services with health insurance payments, and to ensure that insurance schemes are not exclusive of people with existing illnesses or for people under or over certain ages.

Specific objective 2.2: Improving access and quality of secondary and tertiary health care services in impacted areas.

Priority actions:

- Development of a unified national standard operating procedures and guidelines for case detection and referral to secondary and tertiary health care.
- Referral system should be strengthened to ensure timely access and equitable for specialist care and quality services whenever possible, depending on each country's context and capacity.
- Establishing special assistance arrangements for refugees at risks and individuals with specific needs so that they can access services equitably and to ensure the continuity of care.
- Establishing a referral mechanism to deal with serious cases among Arab states as part of humanitarian rescue through complementary pathways.
- Raising refugees' awareness of available services.
- Establishing a comprehensive health system to follow up on the provision of services to refugees and asylum-seekers like registration and health records at the health provision centers.

Specific objective 2.3: Sustaining public health services for refugees and asylum-seekers by ensuring they are mainstreamed within national systems.

Priority actions:

- Connecting refugees and asylum-seekers to national health systems in a way that guarantees the mainstreaming of their health needs.
- Identifying a monitoring system to record the impacts of refugees on national health systems.
- Continuous monitoring and assessment of provided services and filling the gaps in implementation.
- Coordinating efforts with partners.
- Ensuring sustainable financing systems and mechanisms through investment of social refugee protection systems and the attempt to reduce the challenges they encounter to receive the needed services.
- Enhancing capacities and resilience of the health system.

Strategic pillar 3[123]: Addressing refugee and asylum-seekers' vulnerabilities via protection responses.

Women, children and adolescents are disproportionately affected in both sudden and slow-onset emergencies. They suffer multiple human rights violations in situations far beyond their control such as violence, early marriage, abuse and more. The evidence clearly demonstrates the intimate relationship between health, peace and security.[124]

Addressing vulnerabilities to ill health among refugees should be part of a collective response from different sectors, since health issues are inextricably bound up with other parts of refugee life and may fall under the purview of sectors providing shelter, education, sanitary services, nutrition, and food security. The health sector therefore needs to support and be supported by other relevant sectors, and should work to ensure implementation of policies and laws which support refugees.

Social, economic and environmental factors are important determinants that affect refugees and asylum-seekers' vulnerability to health risks. Different refugee populations have different risk factors, as do different host country environments, and these local specificities should be identified and incorporated into coordinated policy responses by agencies and governmental entities.

Some groups of refugees are particularly vulnerable or have particular health care needs; women and girls may face increased risk of sexual violence, or other negative health effects due to gender inequality. Children may require protection mechanisms, as well as a range of specialized health services. The elderly, the disabled and those with mental health problems may also have particular needs and vulnerabilities that should be accommodated.

The provision of health services to refugees and asylum-seekers in the national health systems of host countries increases the chances of mitigating risk factors and negative determinants. However, more needs to be done to meet the needs and address the specific concerns and experiences of different refugee subgroups, including their legal status in the host community. The involvement of refugees themselves in identifying and designing the necessary interventions is essential to ensure a sustainable response.

Stigmatization and discrimination must also be addressed, where present, as these issues can severely exacerbate the problems of vulnerable groups, such as those with HIV/AIDS or those experiencing sexual violence and violence against women. Accordingly, more should be done to prevent and combat stigmatization and discrimination by programs that address the needs of refugees and asylum-seekers.

The General Secretariat of the League of Arab States, in collaboration with UNHCR, has developed refugee and asylum-seeker protection strategies that could provide a framework of action on these points, for example the Arab Strategy for Protection of Refugee children in Asylum Context, and the Arab Strategy for the Prevention and Protection from all Forms of Violence, especially Sexual Violence in Asylum and

123 Public health is declared by universal human rights and principles. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). These rights to health, nutrition and water are also outlined in the Universal Declaration of Human Rights, 1948, Article 25: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family," and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) which reinforce the right to food, health and living conditions, further highlighting these in the General Comments on the right "to adequate food" (No. 12) and to the "highest attainable standard of health" (No. 14). General Comment 15 on the right to water (2002) urges state parties to ensure that "Refugees ... have access to adequate drinking water whether they stay in camps or in urban areas."

124 WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Trends in maternal mortality: 1990 to 2015. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf, Accessed 1 May 2017).

Displacement Contexts. Implementation requires coordination with all stakeholders.

Objective 3: Supporting positive health outcomes through the implementation of protection mechanisms across relevant sectors for all refugees and asylum-seekers, with emphasis on the most vulnerable.

Priority actions:

- Development of gender-sensitive mechanisms that allow data collection and processing.
- Assessment of the different social, economic, and environmental determinants of health among refugees and asylum-seekers, and how they affect health outcomes.
- Identification of the relevant sectors that are responsible for the main social determinants of refugee health and specific areas for interventions. (e.g. WASH)
- Supporting mechanisms that strengthen coordination between stakeholders on the different risk factors refugees face, and corresponding protection mechanisms and appropriate responses that tackle these risks.
- Providing groups at risk including women, girls, persons with disabilities, etc., with needed information, support and care.
- Responding and enhancing full implementation of child protection and sexual violence and violence against women' standard operating procedures.
- Strengthening national protection systems to prevent, respond to, and mitigate the risks which refugees and asylum-seekers are exposed to.
- Cooperating with the community to develop formal and non-formal education, social and economic programs to decrease refugees' and asylum-seekers' vulnerability to health risks.
- Mainstreaming protection policies into public health policies to support the best interest of refugees including age at marriage, child protection and registration.
- Providing support to host communities to help them to better prevent and respond to violence, abuse, and discrimination against refugees.

Strategic pillar 4: Strengthening the capacity of public health systems and infrastructure to respond to health needs of refugees, asylum-seekers and their host communities in both short and long-term.

International rights conventions and standards, the SDGs and other international instruments provide a context that guides the response of health systems to health needs in asylum context and propose a framework for action to ensure the health and well-being for all, while also protecting the rights to health of refugees and asylum-seekers, supporting and strengthening the resilience of national health systems is an integral part of the Strategy.

The capacities of national health systems in the Arab region vary widely in terms of their ability to adopt a universal health coverage approach in which primary health care is a corner stone. Health outcomes show variability between and within countries and in the response to the refugees and asylum-seekers' public health needs (see annex for tables summarizing systems in selected countries on selected public health service indicators).

In addition, the needs of refugees and asylum-seekers create additional challenges for health care systems, and the impact of these communities on host countries' health systems is widely varied. It is essential, therefore, that different national contexts are taken into consideration.

The capacity of national health systems in the region should be strengthened and expanded to include provision of health care for all, with the emphasis on the most vulnerable. Issues relating to sexual and reproductive health, maternal and child health, sexual violence and violence against women, mental health, non-communicable and communicable disease prevention and care, should be prioritized.

Health systems should be sensitized to refugee and asylum-seekers' health needs and should support access to quality, equitable and comprehensive primary health care and coverage for essential secondary and tertiary care whenever possible. This requires that health systems have adequate capacity, and therefore, supporting and ensuring cooperation and coordination within and among countries is essential.

Objective 4: Supporting the strengthening of national health systems to increase capacity of response to current and future public health needs and care in asylum and displacement contexts, with special attention to those at heightened risks.

Priority actions:

- Evaluating and coordinating efforts at the regional level by activating the role of the League of Arab States Emergency Health Committee, established by the Arab Ministers of Health Council with the capacity to support and monitor progress in implementing regional and local public health strategies and policies, and to provide health needs for refugees and asylum-seekers and supports coordination among Arab States. Leadership and governance are required to ensure appropriate policy and strategic frameworks, accountability and partnership.
- Developing a regional legal framework to support the provision of health services to refugees and asylum-seekers in the Arab region.
- Fulfiling the health needs of refugees and asylum-seekers in local and regional public health plans.
- Assessing the capacity and response of health systems to provide a guaranteed minimum of essential health care interventions that ensure the public health needs of refugees in host countries.

- Using the manual to evaluate and expand the basic services package for refugees and asylum-seekers, with a view to ensuring that the needs of these groups are met. (This requires mechanisms to support service delivery, and to improve access to comprehensive primary health care for refugees and asylum-seekers at all levels of care).
- Developing preparedness plans at the local and regional levels.
- Appropriately allocating the required resources and developing the necessary tools to strengthen capacities,including:
  - Health infrastructure, services and equipment needed to deliver effective, universal, integrated and quality health interventions: primary health care, referral systems, health centers, hospital beds, basic medical equipment, vaccinations, technologies and community health programs.
  - Strengthen the balance within the health workforce with special focus on areas most affected by refugees. Enhance adequate numbers, guide capacity building, training and support tools to ensure that health systems and human resources can implement appropriate interventions that take into account refugee needs. A balance must be struck between the production, distribution and use of the health workforce by the health system on the one hand (regardless of the public or private sector) and the needs of refugees, asylum-seekers and affected communities on the other hand.
  - Provide modern health information systems that work efficiently to prepare updated data and analyze disaggregated data, including: monitoring morbidity and mortality rates, epidemiological surveillance, surveys of communicable and non-communicable diseases, and establishing an observatory for Arab States for monitoring and evaluation, with the preparation of data disaggregated by country, social determinants, age and gender.
  - Provide sustainable health financing systems to ensure that all groups most in need of access to services, reform the health financing system to improve access to quality health services, ensure health services for refugees and asylum-seekers in local systems, and reduce out-of-pocket spending. Also, to develop a social protection mechanism for the poor, using available global and regional expertise, implement cash financing, free access to primary health care and emergency services, and reallocate financial resources to targeted needs.

Sub-objective 4.1: Strengthening systems to ensure adequate preparedness and emergency response

Priority actions:

- Creating an effective epidemiological surveillance system for data collection and forecasting on the national level.
- Establishing a monitoring and reporting system to ensure rapid response to the urgent needs of refugees and asylum-seekers.
- Developing case management guidelines for emergency refugee needs and responses for example, injuries, disabilities and mental health issues.
- Effective coordination and collaboration between and within countries, as well as between sectors and different stakeholders to support system functioning.

Sub-objective 4.2: Strengthening universal health care services at its three levels: primary, secondary and tertiary health care (completion of the strategic pillar 2)

Priority actions:

- Strengthening of infrastructure and human resources to support access to services, and to support the decision makers to fulfil the needs of public health of refugees and asylum-seekers through provided services.
- Establish standards of practice and guidelines for primary health care, emergencies and high-risk cases.
- Creating a responsive referral system, financial support, medicines and supplies especially immunizations, essential chronic disease drugs, TB and HIV/AIDS care, mental health care, care for persons with disabilities, sexual violence and violence against women, and community-based interventions.
- Building the capacity of health workforce, communities, stakeholders on needs, management and care of refugees and asylum-seekers.

Sub-objective 4.3: Strengthening the capacities of health systems to prevent, protect and address communicable diseases at national and regional levels

Priority actions:

- Updating epidemic surveillance system and enhancing data collection on refugees, including cross-border surveillance.
- Supporting effective interventions including immunization and synchronized vaccination efforts across host countries and countries of origin.
- Strengthening Health systems to support adherence to developed national disease management protocols for communicable diseases; workforce should be trained, community interventions and treatment provided, and screening improved.
- Establishing a preparedness and response system in case of outbreaks, including the prevention and treatment of common communicable diseases, such as:
  - Malaria: prevention program, treatment and vector control, which include rapid diagnostics, treatment and preventive treatment during pregnancy, proper treatment of acute malaria and proper pest control through long-term spraying of confined spaces and long-term pest control nets.
  - Tuberculosis (TB) services: prevention, treatment and response including rapid diagnosis, multi-drug treatment and programs targeting those infected with a treatment-resistant strain.
  - Diarrheal and respiratory system diseases: early diagnosis and treatment during emergencies, and long-term care to provide basic services.
- Supporting the abundance of needed vaccines and medications.
- Supporting the continuation of care and inclusion of cases in the relevant national programs, for example, tuberculosis and malaria.
- Performing a comparison between countries and data collection on regional levels with a continuous follow-up.

Sub-objective 4.4: Supporting integrated prevention and control of non-communicable diseases and mental health problems

Priority actions:

- Expanding the basic services package to include prevention, investigation and containment of non-communicable diseases (cardiovascular diseases, oncology, diabetes, chronic respiratory diseases) and psychological health.
- Ensuring an abundance of capacities for diagnosis and containment during emergencies, and linkage to continuous treatment.
- Enhancing epidemiological surveillance capacity, which includes refugee data, including risk factors to strengthen surveillance and follow-up on disease outcomes.
- Promoting health literacy.
- Mainstreaming operational policies, strategies and action plans for the prevention and reduction of heart disease, diabetes, oncology, etc. and dealing with risk factors and disease determinants such as stress, lifestyle and smoking in national health policies and strategies within the same framework as citizens.
- Establishing referral mechanisms supported by tools and guidelines:
  - Regular follow-up, referral, and ongoing treatment for people with chronic diseases including epilepsy, diabetes, high blood pressure, asthma, Chronic Obstructive Pulmonary Diseases (COPD), and heart diseases.
  - First-line psychological health interventions for patients with mental and neurological illnesses and addiction, including referral for psychosocial support.

Sub-objective 4.5: Strengthening childhood public health programs

Priority actions:

- Expanding health system capacity to complete coverage, with expanded vaccination programs, surveys, and improved diagnosis and treatment of infectious diseases among children. This will be achieved through the use of modern clinical protocols and linkages with local strategies to ensure integrated management of child health care and diseases.
- Improving the skills of health care workers to deal with cases.
- Strengthening linkages between nutrition and sexual and reproductive health programs, which are essential for the survival of infants, and other elements of health-care systems.
- Following up and evaluating health services provided to children.

Sub-objective 4.6: Strengthening the provision of reproductive health services and HIV/AIDS treatment and care

Priority actions:

- Supporting minimum essential interventions during the early stages of emergencies.
- Supporting the integration of quality reproductive health services to improve access to services, including maternal and child programs including antenatal, pregnancy and childbirth care, nutritional support, emergency obstetric and referral, family planning, and neonatal and postnatal care.
- Including sexual and reproductive health services for easy access to quality integrated maternal and child programs, including antenatal services, pregnancy and childbirth care, nutritional

support, skilled birth attendance, emergency obstetric care, referral and postnatal care for mothers and newly born.
- Including reproductive health services for young people and adolescents in primary health care programs.
- Preventing and treatment of sexually transmitted diseases for all ages.
- Strengthening the capacity of health systems including standard operating procedures for screening and referral to contain cases of sexual violence and violence against women.
- Enhancing national HIV/AIDS programs to contain cases including screening, transmission and protection.
- Ensuring effective response to HIV and reproductive health in emergencies.
- Ensuring that HIV/AIDS screening is voluntary and accompanied by counselling and informed consent while linking these services to care and treatment, and ensuring that there are no negative outcomes for those who show positive results.
- Emphasizing policies that promote the provision of HIV/AIDS prevention, care and treatment services to refugees and asylum-seekers in national health programmes and HIV/AIDS programs.
- Affirming the availability and accessibility of preventive interventions including mother-to-child transmission and clinical responses to sexual violence, including post-exposure prevention.
- Ensuring the availability of appropriate prevention, care and treatment services for groups most at risk and linking them to national programs.
- Supporting universal access to viral treatment in accordance with national protocols.
- Raising awareness of refugees and asylum-seekers of available services.

Sub-objective 4.7: Improving access to food-assistance services

Priority actions:

- Ensuring access to nutrition programs including screening for acute malnutrition and nutritional rehabilitation through supplementary and outpatient or inpatient treatment programs.
- Ensuring access to nutrition-enhancing services, nutritional supplements and food security support; including infant and child nutrition and the promotion of exclusive breastfeeding.
- Including nutrition services with other related services such as breastfeeding programs, family planning, maternal and child health, etc.
- Supporting the surveillance system to monitor coverage and measure results.
- Supporting community interventions

Strategic pillar 5: Strengthening health information systems to allow for reliable and timely data collection and monitoring

A robust health information system is one of the key elements needed to operate a robust health care system that performs efficiently. Appropriately analyzed data reveal disparities in health and risk exposure among different groups and allow analysis of the impact of policies on health outcomes. Accordingly, such systems are necessary to establish targeted evidence-based interventions.

Quality, well-functioning health information systems are also essential in the context of asylum, as assessing data can ensure timely implementation of appropriate policies, which is essential in emergency situations that require rapid responses in particular. Data systems can identify important health determinants (socio-economic, environmental, behavioral and genetic factors) and the contextual environments within which refugees and asylum-seekers live; thus, identifying their risk exposure.

Priorities include improving the collection and accessibility of information on the health status of refugees and asylum-seekers, as well as on their risk-adjustable behavior and access to health care. The provision of quality data should cover all categories and identify specific and planned health needs and actions to address these needs, while identifying costs where possible. Disaggregation and comparability of data is required, in order to assess variances by gender, age, nationality, place of residence etc.

Data collection methods and tools such as population surveys and specialized tools used by UNHCR (e.g. the web-based platform Twine[125] and WASH follow-up systems), expanded standardized nutrition surveys, and health access and use surveys (HAUS) in urban areas should be widely disseminated to allow for monitoring the progress.

At the regional level, data collection and analysis should allow for the identification of trends and comparison among states, in terms of preparedness, capacity and response. Where possible, cooperation should be established between countries of origin and host countries for the collection of health-related data.

Objective 5: Ensuring the adequacy, accuracy and timeliness of national and regional refugee health and asylum data and records to facilitate policy development and following up on the implementation of existing interventions while retaining non-disclosure.

Priority actions:

- Strengthening health information systems for improved data collection on the health of refugees and asylum-seekers and the health services[126] available to them at the local and regional levels.
- Ensuring that refugees and asylum-seekers are integrated into existing information systems for data collection and monitoring.
- Developing guidelines on the collection, prioritization and use of relevant data from refugees and asylum-seekers.
- Supporting data collection in multiple ways.

125 The Twine web platform allows UNHCR and partner staff to collect and explore public health, water-sanitation and nutritional data, from health facility level in about 40 countries.

126 To improve health information systems it is important to monitor their performance and have benchmarks against which countries can identify their relative strengths and weaknesses. The WHO recommends the health information system performance index (HIS-PIX) for the assessment of country health information systems. This tool assesses country capacity to collect relevant data at appropriate intervals, periodicity, timeliness, contents of data collection tools and availability of data on key indicators, as well as country capacities for synthesis, analysis and validation of data. HIS-PIX is, however, focused on low- and middle-income countries, and is applicable to national systems and populations rather than to inequalities within populations.

- Capacity-building for data collection by all stakeholders.
- Coordinating data collection bilaterally and regionally, and following up through the establishment of a regional data observatory under the umbrella of the League of Arab States with technical and material assistance from the United Nations High Commissioner for Refugees, which will allow for follow-up on changes, trends and prediction of outcomes, while ensuring that data is available and used for all.
- Drafting of regional and national reports.
- Promoting scientific research, data collection and analysis, including equity data, with a view to raising standards for communicable and non-communicable diseases control, and providing an opportunity to measure the progress achieved hereof.
- Strengthening monitoring, accountability and evaluation systems for the provision of public health and primary care services.
- Organizing a regional academic forum to promote scientific research in the Arab region.
- Ensuring that ethical considerations should be taken into account during data collection.

Strategic pillar 6: Coordination of health sector response

The multiplicity of actors in the humanitarian sector means that it is important to strengthen coordination of the health sector response with all other stakeholders, to ensure coherence and avoid fragmentation and duplication. This is particularly critical during the transition from short to medium- and long-term planning.

Consolidated actions are important for coordinating inter-sectoral and multi-sectoral collaboration together on matters that may involve more than one entity, such as social solidarity, water and sanitation, protection, nutrition and food security. There may be positive effects for many stakeholders in the non-health sector in areas that directly and indirectly affect health and its outcomes, such as those dealing with sexual violence and violence against women, education, livelihoods, etc.

It is imperative for all stakeholders to coordinate to ensure the availability of public health services for refugees and asylum-seekers at both the national and regional levels. However, national and regional leadership is essential to ensure complementarity in planning, resource allocation, implementation and data collection.

Coordination mechanisms need to be developed, monitored and evaluated. The health sector should identify all development initiatives and examine the relationship between emergency response and development efforts in order to create long-term plans.

Coordination mechanisms should also not overlook the capacity of each country and its health system in terms of service delivery, in order to provide an opportunity to bridge the gaps in responses through collaborative interventions.

Objective 6: Enhancing coordination and cooperation among all stakeholders in responding to public health needs of refugees and asylum-seekers

Priority actions:

- Establishing and strengthening a national coordination mechanism to support the health sector response and ensure response in asylum context through this mechanism.
- Ensuring the participation of the Ministry of Health, and other competent government departments, international and non-governmental civil society organizations, along with United Nations agencies and the private sector in response to asylum situations.
- Supporting the Ministry of Health to play an active role in coordinating the response in asylum situations through capacity building and development of necessary tools (guiding principles, instructions, follow-up mechanisms, etc.)
- Ensuring methodology for the exchange of information between the national coordination mechanism and the lateral coordinating agencies, and promote reporting between these mechanisms and with the main national mechanism.
- Developing or adapting information systems for coordination such as activity tracking mechanism.
- Using the coordination mechanism to update and refine the health sector response strategy, develop response plans to mobilize financial resources, advocate for political changes, address gaps through evaluation, data collection and monitoring.
- Ensuring the engagement of the private sector in assisting resilience and developing updated approaches for cooperation.

- Establishing and strengthening a coordination mechanism between countries of origin, transit and host countries to ensure the continuity of treatments for certain diseases, such as tuberculosis or malaria.
- Developing and promoting a national coordination mechanism between the Ministry of Health, civil society and non-governmental organizations, which provide assistance to refugees, displaced persons and asylum-seekers to collect and share data with other competent authorities.

Conclusion

The 22 Member States of the League of Arab States include high, middle and low-income countries, and countries with varying social, economic and political circumstances. As a result, national health sectors vary widely in the level of development and capacity among Member States.

However, a common feature is that all states experience the regional instability and its implications on development. Health services across the region are affected by this instability; and in conflict-affected countries such as Iraq, Libya, Somalia, Syria and Yemen, health care provision may be severely curtailed or ceased altogether by violence, while existing public health issues may be exacerbated or worsened by harsh conditions.

In other Arab states, forced displacement, exacerbated by regional unrest, has put pressure on host countries' health care systems, imposing new demands and stretching their capacities. This Strategy aims to develop a dynamic framework whereby these new demands and needs can be met, taking into account regional and national specificities and experiences.

Health-care policy and service provision to refugees and asylum-seekers in host countries should be underpinned by a human rights framework that seeks durable solutions in line with regional and national public health policies, taking into account the context of each host country, and should also work towards achieving the objective of universal health coverage.

Universal health coverage is a dynamic process based on primary health care delivery, requiring strong and effective health systems, capable of managing priorities and opportunities, and assessing preparedness for service delivery. Arab states are at varying stages of transition towards universal health coverage, which requires constructed and sustained efforts to strengthen the technical, financial and administrative capacities of national health systems. This process may take some time, depending on the capabilities, experiences and context of each country. However, service delivery should rotate around people-centered health systems that focuses on prevention, primary care and public health.

In order to develop responsive and resilient health care systems in countries hosting refugees and asylum-seekers, there is a need to support these countries in order to have the necessary material and human resources; there must be, also, an improved readiness to change and an increased ability to expand the supply of priority services to large numbers of patients. Linkages should also be established or, where necessary, strengthened with water, sanitation, nutrition and security sectors.

Health responses to forced displacement of populations have emphasized emergency needs and urgent demands that humanitarian responses typically highlight. Nevertheless, given the regional context and the potential endurance of many of these challenges, a transition is needed from emergency response to long-term management of the situation.

All these elements require a well-formulated, long-term public health strategy, which addresses the specific needs of refugees into a more comprehensive package of services, which include addressing vulnerability by situation and encompassing all relevant sectors of response and recovery.

Spending on the health sector in the Arab states varies widely. However, the costs of treatment are generally high for individuals, resulting in increasing inequality in access to services for refugees and other vulnerable groups, and impacting health outcomes. Therefore, the Arab states should establish public health financing systems and strategies to maintain sustainability while improving service delivery.

A considerable number of refugees are women, children and youth. Their vulnerabilities should not be overlooked when assessing their health needs. For example, reproductive health services must be taken into consideration when providing health care to refugee communities. The international community aims to ensure universal access to sexual and reproductive health services to reduce maternal mortality worldwide, among other goals. Accordingly, these services must be integrated into national and regional strategies, policies and programs.

There is a growing need for a clear leadership and accountability system to coordinate national, regional and international health care responses, as well as with development partners, local civil society and the private sector. Such coordination is essential for developing collaborative, effective and sustainable responses, consistent with regional and national refugee strategies. The Technical Secretariat of the Arab Ministers of Health Council is responsible for coordination and cooperation between Arab states as well as between donors and stakeholders; this is essential for building a conductive environment to support refugees' rights to health care. Mechanisms for cooperation at the regional level must therefore be developed and recognized.

Implementation of this framework will require high-level commitment and engagement from all stakeholders regionally and nationally. Their efforts are essential to many key elements of the Strategy, including improved dissemination of evidence-based programs, policy reorientation, more effective use of legal instruments, comprehensive monitoring of progress, and fostering health systems that take into account the diversity of the groups they serve.

The Strategy suggested the recommended priorities for countries. However, it must be emphasized that these standards need to be adjusted at the level of each State, to take into account the capacity of their health systems and the diversity of the populations they serve.

The progress achieved by the Arab states in universal health coverage is uneven between refugees and host countries at large. In many cases, health systems in the Arab world face serious challenges, such as lack of adequate financial resources, infrastructure, policies and appropriate national health systems. The nature and magnitude of these challenges require greater commitment from governments to place health care at the top of the national development agenda. The inadequacy of the health workforce in some countries, or the lack of skills to deal with the specific health needs of refugees, can also affect the provision of health care. As a result, human resources development plans should be developed to overcome the shortage of key personnel in the workforce. Many of these issues can be better addressed through increased regional cooperation among Arab states, enhanced integration and, where appropriate, shared responsibilities. In addition, building mechanisms and platforms to share national experiences and best practices will help the states to develop more comprehensive, efficient and integrated health care interventions.

Regional strategies and programs aim at reducing the burden of communicable and non-communicable diseases affecting refugees, such as HIV/AIDS, tuberculosis and malaria, should be fully integrated into all other attempts to provide universal health coverage to refugees.

Furthermore, it is necessary to support and strengthen a refugee database and collection of data periodically, to analyze data collected across countries. This requires a standardized framework for data collection and monitoring, and will address gaps in service delivery, to help ensure that refugee needs are met in national programs, including the most vulnerable groups. There should also be a focus on using new technologies and evidence in order to foster innovation and uncover creative solutions to the challenges faced by health

sectors in responding to refugees' needs.

This Strategy should be envisioned as a dynamic process that provides a framework for prioritizing refugee public health needs in line with regional and national contexts and capacities. The responsibility for implementing the proposed Strategy rests within each state, although Member States and relevant international institutions will also perform a key role in promoting, monitoring and following up on the implementation of the Strategy.

Thus, sharing of responsibilities, as agreed by the Member States in the New York Declaration, is achieved through an understanding of those responsibilities agreed upon by the Arab states, in order to establish relevant mechanisms for implementation among the Arab states.

Finally, it is important to develop a plan of action to identify mechanisms by which refugee health needs can be met through national health plans. This will depend on the level of development within each country and the specific needs of the refugees it hosts. Implementation requires the development of frameworks for action, monitoring and follow-up at the regional and national levels, and should be supported by a well-defined and long-term financial plan.

Annex

Table 6: 3RP beneficiaries - Syrian refugees and members of local communities

Country	Registered Syrian Refugees 30/11 /2016	Total estimated number of Syrians	Local Communities	
			Direct	Indirect
Egypt	115,204	400,000	34,550	5.734,324
Iraq	227,971	235,000	47,941	2.397,033
Jordan	655,833	1.266,000	138,150	2.632,994
Lebanon	1.017,433	1.500,000	336,000	1.422,000

Table 7: Selected health indicators (Twine)

Country	Health tilization rate*	Measles overage %	U5 Mortality Rate **	Skilled BA %	Acute Malnutrition Rate***
Mauritania	2.4		0.25	100	5.9
Jordan	5.4		0.35	100	1.8-2.7
Djibouti	3.1	100%	0.32	90	
Yemen	1.3	60%	0.80	100	
Sudan	1.9	89%	0.26	95	7.4-21
Iraq	3.7	80%	0.07	100	
Algeria					3-6.2

*New visits /person/year Standard 1 - 4
**Deaths /1000/month standard less than 1.5
*** Range of proportion from surveyed sites standards less than 10% GAM

Table 8: Achievement of the five HIV indicators

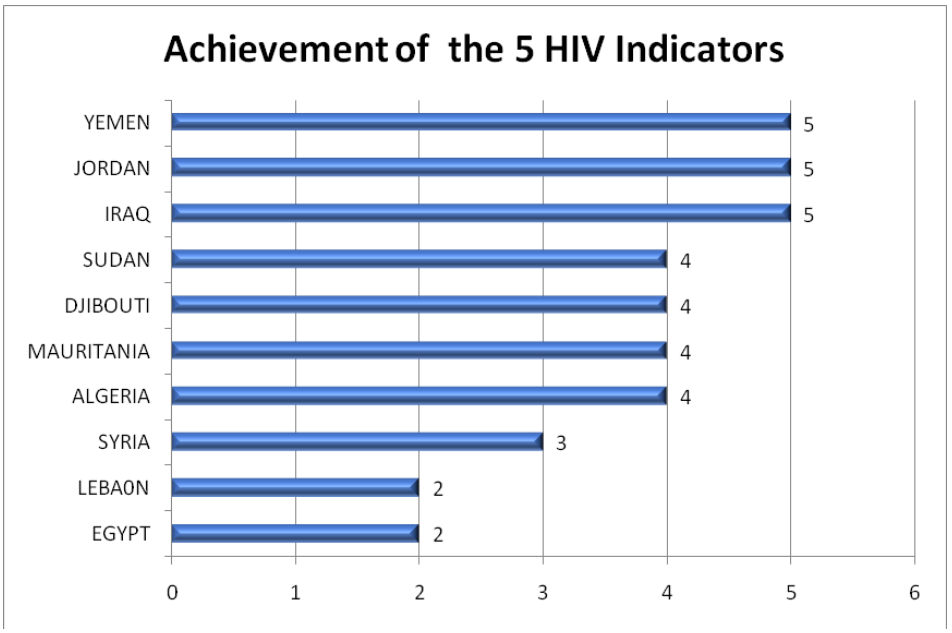


Table 9: Achievement of the eight reproductive health indicators

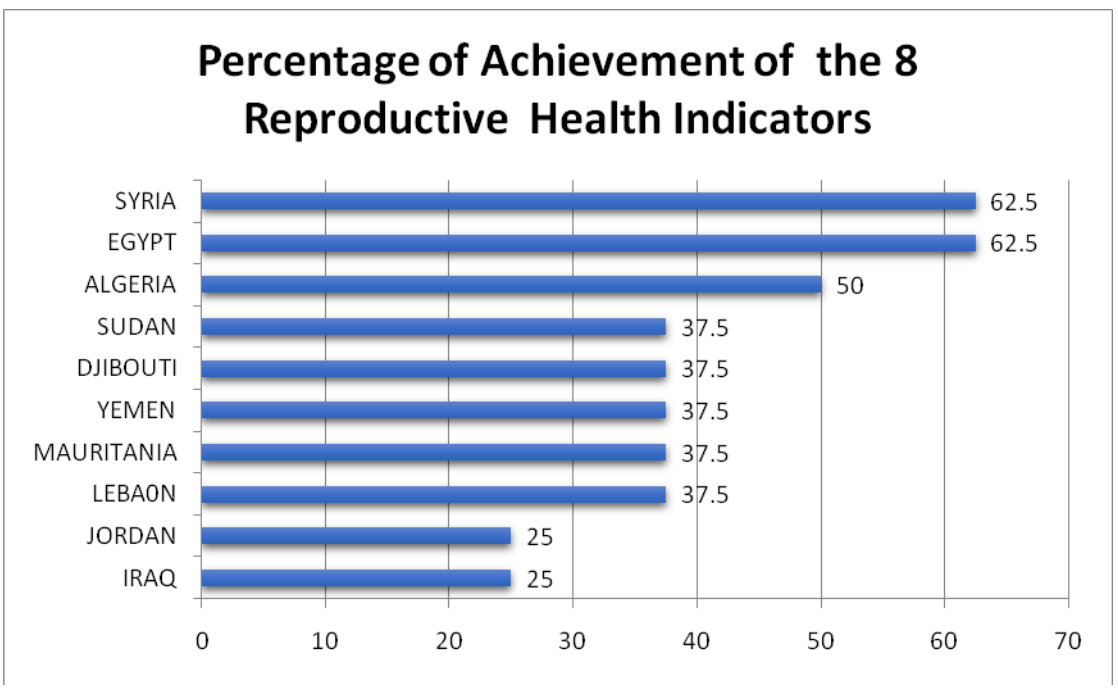


Table 10: Achievement of the five mental health indicators

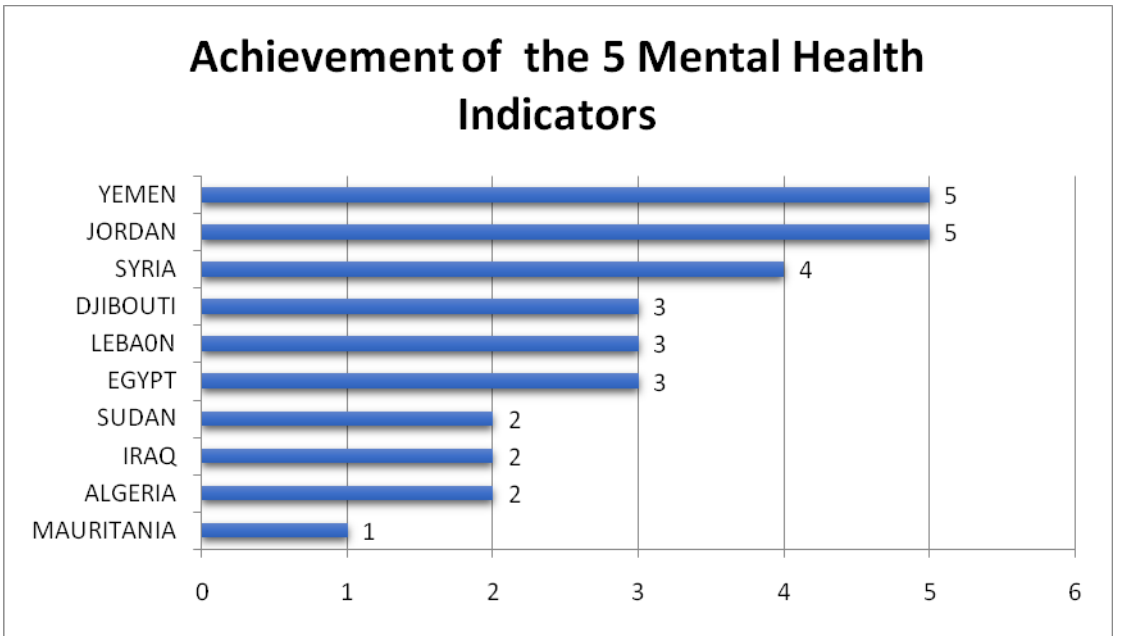
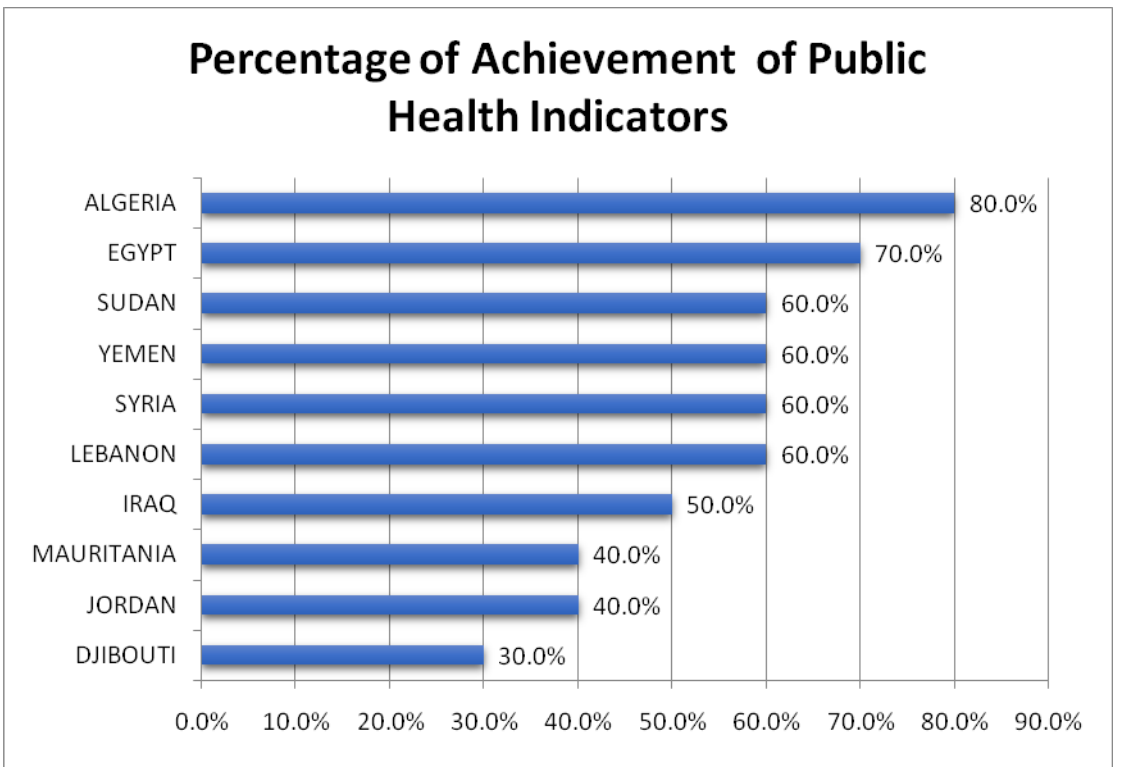


Table 11: Achievement of public health indicators




UNHCR
UN High Commissioner for Refugees
المفوضية السامية للأمم المتحدة لشؤون اللاجئين


جامعة الدول العربية