

Report on the roundtable discussion on

WHO-EM/EHS/003/E

Expanding universal health coverage among refugees and migrants: challenges and opportunities

Co-organized by

WHO, IOM, UNHCR and UNRWA

Cairo, Egypt
10 December 2020



REGIONAL OFFICE FOR THE

**World Health
Organization**

Eastern Mediterranean

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1. Introduction

The Sustainable Development Goals (SDGs) provide an opportunity for the international community to address migration health issues, particularly through targets 3.8 (achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all) and 10.7 (facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies).

The inclusion of refugees and migrants in health service provisions is of particular relevance to the WHO Eastern Mediterranean Region where refugees and migrants constitute a sizable population and are often vulnerable to poor health due to living conditions and limited access to quality health care and other social services. In many instances they are excluded from national health programmes and from financial protection schemes. At a time when the Region is facing the challenges of the COVID-19 pandemic, exclusion makes the implementation of prevention and control measures among refugees and migrants more difficult, increasing the risk of the pandemic spreading among these populations, in host countries and in countries of return.

Universal health coverage (UHC) means that all people and communities, irrespective of their social and legal status and background, have access to health services of sufficient quality to be effective, while also ensuring use of these services does not expose the user to financial hardship.

WHO's Thirteenth General Programme of Work (GPW 13) and the Eastern Mediterranean Region's Vision 2023 call for solidarity and action to promote "Health for All by All", with a focus on advancing

UHC in vulnerable populations, including refugees and migrants. WHO is not alone in this vision. UHC has been identified as a strategic priority by the United Nations (UN) agencies responsible for refugees and migrants: the International Organization for Migration (IOM), United Nations Refugee Agency (UNHCR) and United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA).

UHC also remains high on the political agenda of many governments in the Region, as illustrated by the September 2018 Salalah Declaration. Many countries have formulated strategies to expand coverage to their entire populations, including refugees and migrants, though implementation remains a challenge.

To celebrate UHC Day 2020 (12 December), which fell on a weekend, a roundtable discussion was held on 10 December 2020 as part of a series of events bringing health partners and stakeholders together to review and discuss the opportunities and challenges facing the expansion of UHC in the Region.

The event was co-organized by the WHO Regional Office for the Eastern Mediterranean, IOM Regional Office for the Middle East and North Africa, UNHCR Middle East and North Africa, and UNRWA. Discussions were moderated by Dr Ali Ardalan, Regional Adviser and Head of the Health Systems in Emergencies Lab (HSEL), Department of UHC/Health Systems, WHO Regional Office for the Eastern Mediterranean.

This report was produced by Dr Tonia Rifaey, Technical Officer for Refugees' and Migrants' Health, HSEL, Department of UHC/Health Systems, WHO Regional Office for the Eastern Mediterranean.

2. Expected outcome

The expected outcome of the event was to identify opportunities for collective action by health actors at regional and country levels to expand UHC among refugees and migrants. The discussions aimed to identify the lessons learned and good practices employed to date.

The roundtable discussion addressed three components of UHC among refugees and migrants:

- who is covered
- which services are covered
- what do people have to pay.

3. Opening remarks

The meeting was inaugurated by Dr Ahmed Al-Mandhari, WHO Regional Director for the Eastern Mediterranean. He underlined that UHC is the foundation of WHO's approach to addressing the health of refugees and migrants, through the SDGs and GPW 13, both of which provide opportunities for the international community to address migration health issues and require the inclusion of all groups of migrants into national health systems. This is of particular significance in the Region, where refugees and migrants constitute a sizable population, and whose vulnerability to poor health due to living conditions and limited access to quality health care and other social services has been compounded by the COVID-19 pandemic. Which is why, Dr Al-Mandhari said, that along with her sister UN agencies, IOM, UNHCR and UNWRA, WHO must seek to ensure the provision of access to good quality, essential health services with financial protection for all refugees and migrants, regardless of their social or legal status and background.

Mrs Carmela Godeau, IOM Regional Director for the Middle East and North Africa, emphasized that many reasons, including poor living and working conditions, language and cultural barriers, legal status and stigma, and a lack of full inclusion in national health systems and policies, hamper refugees' and migrants' access to health care. IOM, in collaboration with ministries of health and WHO, has been working across the Region to address these challenges. IOM continues to provide a range of health services to migrants and host communities, and advocates, through evidence-based communications, for a truly inclusive UHC. A solid partnership with all key stakeholders, and a whole-of-society and whole-of-government approach, is actively required. IOM has signed a memorandum of understanding with Gavi, the Vaccine Alliance, in order to strengthen collaboration on routine immunizations and responses to outbreaks and related health services for migrants.

Stressing that migrants contribute positively to societies, IOM's Regional Director underlined that good health is necessary to allow them to do so to their full potential. COVID-19 has shown that individual health is inextricably linked to the health of the community. Making sure that everyone has access to adequate health services, including fair and equitable access to COVID-19 vaccinations, is not just the right thing to do, it is the responsible thing to do. Societies cannot be healthy without their migrant communities being healthy, and now more than ever we must leave no migrant behind.

4. Summary of discussions

4.1 Introduction

Dr Awad Mataria, Director of UHC/Health Systems, WHO Regional Office for the Eastern Mediterranean, provided an introduction to the webinar, noting that this year's UHC Day theme is "Protect Everyone".

UHC requires that all individuals and communities, including refugees and migrants, receive the health services they need, from health promotion to prevention, treatment, rehabilitation, and palliative care, without suffering financial hardship.

The Region is facing an unprecedented set of emergencies, many the result of violent conflicts. Although the Region is home to just 9% of the global population, it receives 53% of humanitarian aid, and has 15 graded emergencies and six extremely fragile countries. Sixty million people in the Region are currently in need of humanitarian assistance, 30 million are forcibly displaced (half the global total), and there are 46 million professional and low-income labour migrants. Many of these vulnerable groups are marginalized, with limited access to quality health care, and face financial hardship even when health services are available.

Addressing the health needs of migrants, approximately half of whom are from the Region, requires an interregional, coordinated response. Differential access to health services, poor living conditions, financial hardship, and the risk of deportation, lend urgency to the expansion of UHC as the key strategy to promoting the health of refugees and migrants, and to advocacy for their inclusion and social cohesion, while simultaneously preparing for and responding to emergencies and working with countries to integrate refugee and migrant health into national policies, strategies and plans and ensuring that “no one is left behind”.

Dr Santino Severoni, Director of the Migration Health Programme, Office of the Deputy Director-General at WHO headquarters in Geneva, continued the webinar by highlighting the powerful instruments that exist to enhance and move forward the UHC agenda. The SDGs bring migrants into the discussion throughout the 2030 agenda, and target 3.8 is specifically focused on UHC. Thirty-four indicators allow continuous monitoring of progress on the SDG agenda. Two intergovernmental

agreements, the Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees, also help to ensure the inclusion of migrants and refugees in the agenda.

In addition, the COVID-19 pandemic has provided opportunities to develop homogeneous responses, though countries' approaches toward refugees and migrants have often been ad hoc, with some incorporating them into their response while others have failed to address the issues, despite many migrants being essential and frontline workers, a fact that highlights the immense contribution migrants make to the fabric of societies.

The pandemic has highlighted the importance of building on strong alliances and instruments such as UHC, and that there is no UHC without the inclusion of migrants. WHO is working hand in hand with IOM and UNHCR to support migrants, and has made great strides in the Region in pushing forward the refugee and migrant health agenda. The Region is the most affected by these vulnerable groups, and much remains to be done. Refugees and migrants cannot be left behind: access to health services is a fundamental human right for everyone, including migrants with irregular status.

4.2 Panel discussion

The first session of the webinar was conducted through a panel discussion, which centred around five groups of questions:

1. Have the needs of refugees and migrants in the Region been adequately addressed to ensure that no refugee or migrant is left behind? What recommendations could address any coverage gaps?
2. Given the pandemic has stretched the capacities of national health systems and the international community in the Region, how is UNRWA ensuring universal access to health services among target beneficiaries?

3. How is UNHCR Middle East and North Africa translating UHC into action? What lessons have been learned? How can we build on these lessons and existing opportunities in the Region to maximize coverage for refugees and migrants?
4. How can the humanitarian–development–peace nexus approach be leveraged to expand UHC among refugees and migrants?
5. What are the research priorities in the Region, in terms of informing policy-making on UHC expansion by different actors, including governments and the international community?

Answering **the first question**, Dr Chiaki Ito, Regional Migration Health Specialist, IOM Regional Office for the Middle East and North Africa, said one key action is to ensure service delivery covers the most vulnerable, both among migrants and host communities, and provides access to essential migrant-friendly health care regardless of legal status. IOM has a large presence on the ground which includes a health response capacity and provides health care services to over 1 million beneficiaries annually in the Region, either through IOM health facilities directly managed in collaboration with ministries of health or through implementing partners. IOM also uses mobile clinics in hard-to-reach communities where there are no health services or where migrants are afraid to access other health facilities.

Dr Ito stressed the importance of being mindful not to create a parallel health system, but rather to contribute to strengthening the overall health system by conducting capacity-building for national governments, rehabilitating health facilities, and providing equipment and supplies that benefit not only migrants but also host populations. IOM advocates for mainstreaming migrants in UHC national policies and continues to be engaged in dialogue and discussions with partners to ensure that migration and migrants are integrated in national health policies and plans, including national COVID-19 response plans. IOM has organized a health advocacy

initiative in the Middle East and North Africa, using a variety of platforms to share countries' experiences of inclusion of migrants in UHC, so that successful experiences can be replicated in other countries. As COVID-19 vaccination becomes available, such advocacy becomes more important than ever. Access to health is a fundamental human right for everyone, including migrants with irregular status. Migrants must not be left outside coverage: no one is safe until everyone is safe.

One lesson learned in advancing UHC is the importance of clear communication at different levels. It is important to highlight the positive contributions migrants make to societies and economies, and that for migrants to maximize their potential and fully contribute, they have to be healthy. This positive aspect of migration is often overlooked but is an important fact to communicate to counter misperceptions about migrants.

Years of experience has shown that partnership at all levels plays a key role in advancing UHC, which requires a whole-of-society and whole-of-government approach, working closely not only with the ministry of health but also with ministries of foreign affairs and interior and with border authorities, especially when it comes to border health and point-of-entry interventions in the context of the COVID-19 pandemic. Partnerships must also include engagement and trust building with communities hosting migrants where tensions could grow if they are not properly managed.

IOM also offers technical support to governments in advancing UHC through capacity-building, standard operating procedures, protocols, and frameworks, and by providing practical support to operationalize migrant-inclusive UHC.

The second question was answered by Dr Akihiro Seita, Director of Health and WHO Special Representative, UNRWA, who noted that

COVID-19 has caused enormous shock to national health systems, and by default to UNRWA's health services. UNRWA provides primary health care to 5.7 million Palestine refugees. A network of 141 clinics offers 9 million consultations each year, including for 280 000 patients with diabetes and/or hypertension and 90 000 pregnant women, and administers 200 000 vaccinations.

The COVID-19 pandemic has placed these health services at risk. In order to maintain Palestine refugees' universal access to primary health care, UNWRA has done the following:

- It has worked with host governments. Strategically, COVID-19 has demanded a national response and UNWRA needs to be part of such a response. Practically, UNWRA has needed to rely on national diagnosis and treatment facilities for COVID-19.
- It has continued lifesaving primary health care services, maintaining its focus on patients, including those with diabetes and hypertension and high-risk pregnancies. UNWRA has devised a system to provide two months' worth of medications, delivering them to patients' houses, and has introduced hotline consultations. It has also introduced a phased system to maintain primary health care services based on the COVID-19 epidemiological situation, starting from phase 1 (full movement restriction) to phase 4 (no movement restriction).
- UNWRA has ensured staff and patients are protected from COVID-19 at clinics. It has provided personal protective equipment to all staff, and infection prevention and control training. UNWRA has introduced a triage system at the entrance to clinics and rolled out telemedicine (telephone consultations), first in Gaza and then Jordan. In Gaza, UNWRA receives 5000 phone calls a day, and is modifying its electronic medical records accordingly. UNWRA also has two smartphone applications for patients, one for maternal and child health and the other for noncommunicable diseases (diabetes and hypertension), to help patients manage their health situation better.

None of UNWRA's 141 clinics halted services in the past year. The number of medical consultations during the pandemic have been around 70–80% of those in previous years. UNWRA has also maintained refugees' access to hospital services, particularly in Lebanon where refugees do not have access to government health services, and has continued financial assistance for refugees so they can use hospital services when needed. COVID-19 continues to seriously impact the social and economic life of Palestine refugees, which naturally affects their health status. For this reason, UNWRA has increased its focus on economic and social support for refugees.

The third question was addressed by Dr Shaden Khallaf, Senior Policy Advisor, UNHCR Middle East and North Africa, who underlined that one reality the pandemic has foregrounded is that we must all work together. In some countries in the Middle East and North Africa region, refugees access health care services the same way as nationals, in some they do so as foreigners, and in others they cannot access them at all. UNHCR has been working with host governments towards the inclusion of refugees in national health systems, as enshrined in the Global Compact on Refugees. COVID-19 has highlighted that many countries are struggling to meet the needs of their own populations, and while providing services to refugees through a single national system rather than a parallel one has distinct advantages, this requires that health systems in refugee-hosting countries receive adequate financial and technical support to equitably advance inclusion.

UNHCR prioritizes working with governments to improve health services and include refugees in national health systems and plans. This requires political will, financing, planning, monitoring, and accountability, to strengthen the capacity of systems to cope and to ensure continued progress towards inclusion. UNHCR is engaged with ministries of health, other government entities, and WHO, on inclusion efforts in regional,

national, and local preparedness and response plans, and supports local authorities in preparing responses for their entire communities. Civil society actors, particularly local and national actors, have been filling crucial gaps in ground-level responses and are keen to see inclusion become more firmly embedded in official policy. This will help relieve strain on their limited resources and enable them to support holistic, long-term solutions. Development actors, closely working with line ministries, also play an important role in supporting inclusion in national and local responses. The World Bank has been a key partner in improving national responses to forced displacement in low- and middle-income countries.

UNHCR advocates that all countries include refugees in their COVID-19 vaccination campaigns. In some countries, language constitutes a barrier to this, while in others, unemployment means refugees cannot cover the costs, and there are countries where the health system has been weakened. It is important that services are strengthened to promote self-reliance and to ensure that a whole-of-government and whole-of-society approach, including academia and nongovernmental organizations, is adopted.

The fourth question was answered by Dr Rick Brennan, Regional Emergency Director, WHO Regional Office for the Eastern Mediterranean, who stressed that the humanitarian–development–peace nexus grew out of the realization that in a protracted crisis, neither an exclusively development nor exclusively humanitarian approach works as well as a hybrid approach in which collective goals for joint assessment and plans are identified and the humanitarian and development sectors work together. Internally displaced persons (IDPs), refugees and migrants can then be integrated into the relevant processes and, keeping concrete goals in sight, the principles can be adapted to each country.

The fifth question was addressed by Dr Fouad Fouad, Associate Professor of Public Health Practice at the American University of Beirut, who interrogated the terms used. He asked to what extent is UHC universal, and people-centred or system-centred, and does “all” in health for all refer to citizens/people with legal status or all people, including those who are stateless, people on the move, and irregular migrants working in domestic service? There must be a definition of “universal”, and an understanding of how this is defined in different settings and contexts, and what factors, structural and otherwise, are integral to each setting. Specific issues arise around health care workers working without any legal basis, and how countries are able to deal with migrants who are not simply recipients but also contributors to health services. Moreover, what is the political and economic context, and role of the state, in expanding the remit of UHC among excluded/differently-included population groups, and what are the roles of key actors (political parties/leadership, local/international nongovernmental organizations and development agencies, and other sociopolitical interest groups), and how will all this be reflected in the development of a framework for UHC? In conclusion, Dr Fouad said academia had a role to play in developing the tools needed to assess these issues.

4.3 Voices of refugees and migrants

During the second session, refugees and migrants were invited to share their experiences.

A health care worker from Gaza gave her account of health care conditions in the Gaza Strip, in the occupied Palestinian territory. The health care worker, who identified herself as a Palestine refugee, said refugees in Gaza were completely reliant on health care services provided by UNWRA. During the COVID-19 pandemic, UNWRA’s health care workforce has provided home visits for noncommunicable disease

patients and continued to provide care across Gaza. She stressed that while health care providers continue to work hard, they are suffering, and emphasized that no one should be left behind, including refugees in Gaza.

An Eritrean asylum seeker in Libya spoke about his experience of UHC as a migrant. He stated that he uses IOM and UNHCR facilities as well as national hospitals. Migrants get support from the two agencies and can go to both public and private hospitals to get care.

The last speaker was Dr Ibrahim Aqel, Director of the Institute for Family Health (IFH) at the Noor Al Hussein Foundation in Jordan. He said IFH had been putting UHC into action even before the Syrian crisis and has been working with UNHCR and other agencies to create paths to health care access for refugees. He said the focus should be on creating integrated models at the primary health care level to minimize costs for other service providers.

He noted that IFH had created an integrated health model within the health service delivery sector that ensures community outreach care and primary health care services for maternal and child health, gender-based violence services, and rehabilitation services. The organization has become a one-stop-shop that focuses on prevention services that are practical and acceptable to the Ministry of Health and ensures a private/public partnership for the provision of services.

5. Conclusion

Dr Awad Mataria, defined UHC as including everyone. What is needed, he said, is that a set of entitlements based on health for all is established. The entitlements must apply equally and include IDPs, refugees and migrants, and financing must be supported by partners. WHO is

working towards finding innovative ways to ensure this becomes a reality, he said.

Dr Rana Hajjeh, Director of Programme Management at the WHO Regional Office for the Eastern Mediterranean, said that access to health care services for migrants was a priority for the Region, and that the impact of the COVID-19 pandemic on migrants remained a cause for concern. She noted that in many countries of the Region, refugees and migrants are treated equally by national systems, and that in Gulf Cooperation Council states, where infections were initially driven by migrants, considerable efforts have been made to support them. Dr Hajjeh observed that access to data remained problematic, was not readily available and needed to be shared. Gavi was planning to allocate 5% of all vaccines that come through the COVAX facility to refugees and migrants, she said, concluding that the health of refugees and migrants was high on the agenda of WHO, but that more work needed to be done in translating recommendations into actions.

6. Recommendations

1. Promote migrant-inclusive health policies and migrant-friendly services as a critical aspect of UHC.
2. Adopt a holistic approach to UHC that views migration as a social determinant of health, and acknowledges that how and where people migrate directly impacts the health of migrants.
3. Strengthen regional partnerships and cooperation on borders and along mobility corridors.
4. Establish a new “normal” for health care settings and streamline primary health care provisions.
5. Include all refugees and migrants in COVID-19 vaccine campaigns, accepting that no one is safe until everyone is safe, and guaranteeing that no migrant is excluded from COVID-19 vaccination.

6. Strengthen data collection and management regarding migrant health and integrate mobility data and health data for the effective inclusion of migrants into national health policies and programming.
7. Foster closer working practices with academia to enable the review of the responses to the pandemic provided by national health systems, UN agencies and partners, and to document and identify the lessons learned.
8. Strengthen prevention strategies by adopting a longer perspective and taking financial considerations into account.



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