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REGIONAL OFFICE FOR THE Eastern Mediterranean

WHO interim guidance note

Health system response to COVID-19 in the context of internally displaced persons, refugees, migrants and returnees in the Eastern Mediterranean Region

7 April 2020

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1. OVERVIEW

Internally displaced persons (IDPs), refugees, migrants and returnees constitute a sizeable population in the WHO Eastern Mediterranean Region.[1] There were 12 million refugees (half are Palestinians) and 13 million IDPs in the Region as of 2018 *(1,2)*. These populations are often vulnerable to poor health due to the conditions they live in and limited access to needed quality health care. In addition, those who can access care, are often faced with financial hardship. There are also 46 million professionals and low-income labour migrants in the Region (of which 22 million are from the Region), with differential access to health services and varied health coverage schemes *(3)*.

Universal health coverage means that all people and communities have access to the needed health services of good quality and with financial protection. Universal health coverage is high on the political agenda of many governments in the Region who are formulating strategies to expand coverage to their entire populations.

All people, including refugees and migrants, and regardless of migratory status, are entitled to human rights and thus have a right to health care services under international human rights law *(4)*, the WHO Constitution *(5)* and other relevant declarations, resolutions and frameworks. Countries in the Region have adopted different models to promote the health of refugees and migrants in their territories. IDPs and returnees are nationals of the country and, as such, expanding coverage to them does not require further legislation.

In Egypt, Iraq, Jordan, Lebanon and Tunisia, in accordance with national legislation, refugees and migrants can access health care for free at the primary health care level; nonetheless, this right is not always realized in reality. In Morocco and the Syrian Arab Republic, health care is provided by the state for regular migrants *(6)*. In Bahrain, Kuwait, Qatar, Saudi Arabia and the United Arab Emirates migrants are covered by their employers. In Oman, it is the migrant that is responsible, although migrants from the Gulf Cooperation Council (GCC) member states receive health care coverage and in the case of lifesaving measures, all migrants are cared for *(6)*. For Palestine refugees, UNWRA provides coverage for primary health care services and selective tertiary care, and in Yemen health care services are provided by the international community *(6)*. In Yemen, this includes, but is not limited to, procurement of medicines and vaccines, mobile and primary health care clinics, surgical teams, fuel for hospital generators, clean water, and therapeutic feeding centres.

The coronavirus disease (COVID-19) outbreak that was first identified in China in December 2019, spread within three months to the Eastern Mediterranean Region. As of 1 April 2020, there are an estimated 54 281 reported cases (6.6% of the global burden) in all countries of the Region with the exception of Yemen, with an estimated 3115 deaths (7.7% of the global burden) *(7)*. As with other infectious diseases, COVID-19 does not discriminate between individuals and has not remained within national borders. As such, communities on the move such as refugees, IDPs, migrants and returnees remain highly vulnerable to contracting the disease.

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[1] For definitions of the terms “internally displaced person”, “refugee”, “migrant” and “returnee” see Convention and protocol relating to the status of refugees (Geneva: Office of the United Nations High Commissioner for Refugees; 1951) and Glossary on migration (Geneva: International Organization for Migration; 2019).

It is very important that refugees, IDPs, migrants and returnees are included in all measures taken to control and manage COVID-19. If not, this will jeopardize the efforts taken by countries to curtail the spread of the outbreak, and their progress towards universal health coverage and the Sustainable Development Goal (SDGs). Within this context, employing a comprehensive approach to universal health coverage in the context of COVID-19 that involves all stakeholders and leaves no one behind, is paramount for advancing WHO's vision of health for all by all in the Region *(8)*.

2. CHALLENGES IN COMBATTING COVID-19 AMONGST IDPS, REFUGEES, MIGRANTS AND RETURNEES IN THE EASTERN MEDITERRANEAN REGION

Countries of the Region face considerable public health challenges, including: an increase in communicable diseases and lack of continuity of care for chronic diseases, including noncommunicable diseases; fragmented governance arrangements and weak institutional setups; inadequate financial and human resources for health, with limited financial protection; lack of access to essential medicines and technologies; and suboptimal information systems for setting priorities and guiding decision-making. The ability of existing health systems to provide health care is degraded by the loss of physical, human and institutional infrastructure, and compounded by insecurity and instability, due to protracted emergencies and forcible displacement, all undermining progress towards universal health coverage.

The Region remains in the early stages of combatting COVID-19. The virus was first detected in the Region in the Islamic Republic of Iran in February 2020, and the country has the highest number of both cases and related deaths in the Region (according to the latest reported figures). In addition, the country is home to an estimated 2.3 million Afghanis *(3)* who had sought refuge.

Many IDPs, refugees, migrants and returnees live in circumstances that make them particularly vulnerable to respiratory infections, including for COVID-19. This includes overcrowded, and often unhygienic, living and working conditions, physical and mental distress, and deprivation due to lack of income, food and clean water. The vulnerable populations living in camps or camp-like settings are of particular concern due to the limited water, sanitation and hygiene services and overcrowded conditions, in particular in northern Syrian Arab Republic**.** Immigration detention is also characterized by overcrowded and unhygienic conditions, with limited space for quarantine and self-isolation. These circumstances are compounded by gender discrimination and a lack of protection for children and unaccompanied minors.

The importance of access to essential services for everyone needs to be stressed; the current pandemic shows how any population group without access to services not only creates a huge risk for those individuals concerned, but for the entire population in general. Therefore, closing gaps in coverage is fundamental to addressing the current challenge. Removing financial and other barriers to accessing services is central to this. Providing an integrated and all-inclusive approach for all populations within a given geographical area, irrespective of their nationality or legal status, including residence, is a key public health approach for the collective good of the entire population. In addition, risk communication activities should address the need to disseminate correct information about the pandemic and dispel any false information, myths and rumours, especially those that try to put the blame on vulnerable populations such as IDPs, refugees, migrants and returnees.

Reaching IDPs, refugees, migrants and returnees

Reaching IDPs, refugees, migrants and returnees during an outbreak such as the current COVID-19 outbreak remains a challenge. Irregular migrants are the most at-risk population and suffer the greatest stigma and discrimination. They are continuously in fear of being reported or arrested, and as such are fearful of using even free health care services. However, Bahrain, Kuwait, Morocco, Saudi Arabia and United Arab Emirates have all passed laws allowing irregular migrants to regularize their status without incurring fines *(6)*. IDPs and returnees face similar issues such as squalid and overcrowded conditions in camps or camp-like settings, with basic services not functioning at full capacity or having collapsed. International Organization for Migration (IOM) and the office of the United Nations High Commissioner for Refugees (UNHCR), as well as a number of local and international nongovernmental organizations, work on the frontline to support these vulnerable populations, putting their staff at risk for COVID-19.

Financial assistance and coverage

Refugees face several challenges that progressively deteriorate the longer they remain unsettled, such as in Jordan and Lebanon. Iraqis who fled the war in 2003 to Jordan no longer receive any type of assistance from UNHCR and the Jordanian government, both of whom were overburdened by the Syrian refugee crisis. As the Syrian crisis continues into its ninth year, funding for Syrian refugees has begun to dry up. This has put a great deal of pressure on the ability of the government and United Nations (UN) agencies to finance health care, which has resulted in Syrians in the country being unable to afford medication and health care services. Furthermore, quality health care services are often inaccessible and for the most unaffordable, as in the case of Somalia where care for noncommunicable diseases must be sought in the private sector or across the border. Countries supporting large numbers of IDPs, refugees and irregular migrants are in need of additional financial support and social protection to cover prevention, control and treatment services for these communities.

Access to quality primary health care

Primary health care, the entry point to the health system, is often not accessible to IDPs, refugees, migrants and returnees. As such, many vulnerable communities are deprived of essential preventive and promotive care, as well as treatment, outreach and referral services. Primary health care remains the foundation of an effective health system and the key to achieving universal health coverage. However, it cannot be attained if IDPs, refugees, migrants and returnees are left out. In many countries of the Region, the access of IDPs, refugees, migrants and returnees to health services is not well defined and this makes it increasingly difficult for these populations to receive the care they need at an affordable cost.

Furthermore, immunization rates remain low in a number of countries with refugee and IDP populations, due to the prolonged complex emergency situations they face. Communities that are marginalized tend to be left out of routine immunization and vaccination campaigns and are therefore vulnerable to outbreaks.

Access to water, sanitation and hygiene services

Access to water, sanitation and hygiene services is a challenge in the Region. This makes hygiene standards harder to maintain among vulnerable communities, including displaced populations. In Yemen, for instance, where inadequate sanitation and access to drinking water has led to cholera outbreaks, "even basic precautions such as regular hand washing are often beyond reach" *(9)*. These conditions make it very difficult to contain the spread of COVID-19, given that water, sanitation and hygiene measures are central to the prevention and control of the outbreak.

Access to food and nutrition

The disruptions associated with the COVID-19 outbreak have a heavy impact on the poor and other marginalized groups, including displaced populations, who have less capacity and resources to adapt to the crisis. Individuals and families in camps and camp-like settings who need to isolate for 14 days may not be able to collect rations and food distributions, and may need to consider alternative delivery arrangements.

Access to gender-based violence services

Humanitarian crises, including pandemics, can impact gender and family dynamics and exacerbate gender-based violence in its many forms, including intimate partner violence and child marriage. Forced coexistence with a perpetrator, community closure (lockdown), perceived and real food insecurity, economic stress and fears of COVID19 are some of the issues which result in more tension at home and therefore increased risk of gender-based violence against women and girls. Refugee, IDP, migrant and returnee women are already at increased risk of gender-based violence due to the nature of their displacement, which is expected to increase further due to COVID-19. This situation is compounded by difficulties in accessing gender-based violence services as many of these services have been disrupted due to restrictions in movement. Furthermore, gender-based violence is not always seen as a priority by the health system during acute emergencies. In addition, women in situations of lockdown or curfew can be isolated by perpetrators and prevented from having social interaction, including interaction with family and friends, which can make it impossible to access services, including hotlines, as the risk of being caught doing so is high. Innovative measures are therefore needed, and health care professionals need to be equipped to detect and link or refer cases to the required specialized services.

Mental health and psychosocial support

Displaced populations tend to have higher rates of mental health problems due to trauma experienced as a result of conflict, not only because of exposure to wartime trauma but also due to post-migration socioeconomic factors *(10)*. As the COVID-19 crisis continues, psychosocial support services that were already weak in the Region for these vulnerable groups may begin to disappear. Therefore, measures to ensure the recommended mental health services and psychical support at the primary health care level must be put in place.

In addition, tobacco is often used due to the perception that it alleviates stress. But research in populations living in non-conflict settings has shown that greater tobacco use and nicotine dependence are associated with both post-traumatic stress disorder (PTSD) and common mental disorders such as depression and anxiety *(11)*. Furthermore, people who use tobacco products are at higher risk of developing severe COVID-19 symptoms *(12)*.

3. PURPOSE OF THE GUIDANCE

The purpose of this document is to provide guidance to countries of the Region and partners for the prevention and management of COVID-19 outbreaks in IDP, refugee, migrant and returnee communities. This guidance is intended to address the needs of refugees and migrants living in all types of settings, aligned with Inter-Agency Standing Committee (IASC) interim guidance on scaling-up COVID-19 outbreak readiness and response operations in humanitarian situations, including camps and camp-like settings, the Alliance for Child Protection in Humanitarian Action technical note on protection of children during the coronavirus pandemic, and IASC interim guidance on COVID-19 for persons deprived of their liberty *(13,14,15)*.

The guidance acknowledges that laws, regulations and policies governing access to health services and financial protection for health by refugees and migrants varies across countries in the Region and are determined by national laws, policies and priorities.

4. KEY CONSIDERATIONS

This guidance refers to World Health Assembly resolutions WHA61.17 *(16)* on the health of migrants and WHA70.15 on promoting the health of refugees and migrants *(17)*, the WHO global action plan to promote the health of refugees and migrants *(18)*, the Global Compact on Refugees *(19)*, the Global Compact for Safe, Orderly and Regular Migration *(20)*, the International Health Regulations 2005 *(21)*, WHO's global and regional COVID-19 strategic preparedness and response plans *(22,23)*.

The guidance emphasizes the necessity of adopting whole-of-government and whole-of-society approaches to control and contain the spread of COVID-19, while leveraging strategies for universal health coverage to ensure that "no one is left behind", including IDPS, refugees, migrants and returnees. It also highlights that health systems need to remain people-centred as well as migrant-sensitive, in order to ensure that IDPs, refugees, migrants and returnees have access to the timely, quality and affordable health services that are required for the prevention and control COVID-19.

5. RECOMMENDATIONS

Ministries of health

1. Ensure the access of IDPs, refugees, migrants and returnees to quality, equitable and affordable COVID-19 health care services.
2. Ensure that national and local COVID-19 preparedness and response strategies and plans are inclusive of IDPs, refugees, migrants and returnees.
3. Monitor and evaluate implementation of COVID-19 preparedness and response plans, including contingency plans to maintain and enhance access to essential health services for IDPs, refugees, migrants and returnees.
4. Ensure that gender-based violence services are innovative in their outreach to women and girls at risk of gender-based violence and include hotlines and other forms of remote counselling and psychosocial support. Health care professionals should be trained and equipped to detect and link or refer gender-based violence cases using a gender-based

violence survivor-centred approach, and service directories should be updated continuously.

5. Assess and address the needs of persons living with a disability within IDP, refugee, migrant and returnee communities who require special assistance.
6. Ensure that mental health and psychosocial support, including interventions for substance use and self-harm, continues to be provided to all IDPs, refugees, migrants and returnees. In addition, ensure that a supply of psychotropic drugs is available.
7. Ensure national strategies and plans for disease infection, prevention and control, as well as for continued access to essential non-COVID health services, include IDPs, refugees, migrants and returnees, and address specific ways to reach marginalized or hard to reach groups amongst them.
8. Provide COVID-19 prevention and control measures to IDPs, refugees, migrants and returnees, with full respect for the dignity, human rights and fundamental freedoms of persons, and where the need arises for isolation and quarantine, they should be afforded the right to have interpreters when required.
9. Ensure that the fear of registration as IDPs, refugees, migrants and returnees will not prevent these populations seeking health care and become an obstacle in receiving medical attention, and therefore a threat to their community and the host community.
10. Enhance cross-border collaboration for COVID-19 information-sharing on the refugees and migrants that cross borders.
11. Provide prevention messages and practical information on where and how to access health services at country points of entry and collect contact details to allow for proper risk assessment and contact tracing.
12. Enhance COVID-19 surveillance and health information systems to include IDPs, refugees, migrants and returnees, and ensure that data is disaggregated by age, sex, pregnancy status and migratory status.
13. Ensure that treatment of COVID-19 patients is administered free of charge and that this is clearly communicated to the patient, family members and community, including IDPs, refugees, migrants and returnees.
14. Ensure that IDP, refugee, migrant and returnee families and communities are kept informed about COVID-19 prevention, including lockdown, measures and that places for isolation are available if they do not have their own dwellings to be able to do so in.
15. Develop and implement outreach plans to prevent, detect, isolate and treat COVID-19 among marginalized and hard to reach IDPs, refugees, migrants and returnees, using community members with health care training, where possible.
16. Work with IDP, refugee, migrant and returnee communities to ensure that all COVID-19 risk communication materials and community engagement activities are provided in the language/dialect of the community. Public awareness messages should cover basic protective measures including: physical distancing; hand hygiene; respiratory hygiene; seeking medical care early in case of fever, cough and difficulty of breathing; and protection measures for persons who live in or have recently visited (in the past 14 days) areas with COVID-19 community spread.
17. Identify and apply appropriate communication technologies that IDPs, refugees, migrants and returnees can utilize. This can include flyers, call centres and in-person channels, as well as SMS text or social media messages, as appropriate.

18. Ensure the wide dissemination of correct information on COVID-19 to the population, address myths and false information, and combat any stigmatization of IDPs, refugees, migrants and returnees.
19. Guarantee all vulnerable groups have access to water, sanitation and hygiene services; if this cannot be provided, then alcohol-based hand sanitizer containing at least 70% alcohol should be distributed among these communities with clear instructions on how and when it should be used.
20. Ensure that IDP, refugee, migrant and returnee COVID-19 patients who require referral receive patient confidentiality and are reassured that they are safe from persecution and deportation.
21. Ensure the coordination and accountability of health sector partners in COVID19 prevention and control activities in IDP, refugee, migrant and returnee settings.
22. Provide training on special context considerations for health workers, community health workers and others responsible for meeting the health needs of IDPs, refugees, migrants and returnees.
23. Guarantee that care-rationing choices should not be made on the basis of nationality or displacement status.
24. Enhance advocacy and collaboration with other sectors, including religious authorities and the private sector, to address non-health issues that directly or indirectly impact on COVID19 spread among IDPs, refugees, migrants and returnees.
25. Ensure that health sector policies, plans and strategies are informed by lessons learnt from COVID19 experience in IDP, refugee, migrant and returnee contexts.

WHO and partners

26. Continue to work and act collectively to promote the health of IDPs, refugees, migrants and returnees through joint programming, resource mobilization, advocacy and coordination of donor support to ensure effective COVID-19 preparedness and responses in countries of origin, transit, destination and return, and host communities.
27. Support governments in the preparation of appeals and responding to calls for proposals, especially in those countries supporting large numbers of IDPs, refugees, migrants and returnees that are in need of additional financial support.
28. Support countries to repurpose their health system to include IDPs, refugees, migrants and returnees, including in their COVID-19 preparedness and responses plans.
29. Ensure that financing is in place so that IDPs, refugees, migrants and returnees are not left out of the health care system.
30. Ensure financial support is given by the international community for the health of IDPs, refugees, migrants and returnees, specifically in countries experiencing conflict and sanctions. International humanitarian funds may be used to cover those that are uninsured or uncovered, including irregular migrants.
31. Provide technical and advisory support to governments to enhance their capacity to manage mobility and borders during the COVID-19 outbreak through appropriate policies, procedures and equipment for points of entry, surveillance, community engagement, inter-agency coordination and contingency planning.

32. Ensure that testing kits, essential medicines and other consumables for the COVID-19 outbreak response are sufficient to cover IDPs, refugees, migrants and returnees, and where shortages arise ensure that a supply chain is opened.
33. Provide technical guidance to ensure that rapid response teams are trained and equipped to investigate suspected COVID-19 cases in IDP, refugee, migrant and returnee communities.
34. Ensure that the maintenance and enhancement of access to essential non-COVID-19 health services for IDPs, refugees, migrants and returnees, are included as part of COVID-19 preparedness and response plans.
35. Promote whole-of government and whole-of-society approaches, integrated joint action and coherent public policy responses to COVID-19, involving all relevant sectors, including the health, social welfare, finance, education, interior and development sectors.
36. Conduct a health system response after action review once the COVID-19 pandemic has ceased, to assess gaps and lessons learnt.
37. Advocate and provide guidance to ensure that investments related to COVID-19 also contribute to longer term health system strengthening for improved emergency preparedness and response to the health needs of IDPs, refugees, migrants and returnees.
38. Advocate for the strengthening of health systems and better collection of data, so that data can be disaggregated by age, sex, pregnancy status and migratory status, to better serve the health needs of individuals and ensure that no one is left behind.
39. Advocate for the continuation of services for gender-based violence and sexual and reproductive health, including services for antenatal care, access to family planning and the clinical management of rape.
40. Support tobacco cessation programmes among IDPs, refugees, migrants and returnees, as tobacco use is a factor in developing severe COVID-19 symptoms.
41. Support the provision of lifesaving treatment to children suffering from malnutrition, especially in Iraq, Pakistan, Sudan, Syrian Arab Republic and Yemen, and increased access to food and income.

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