

# Health of refugees and migrants

Practices in addressing the health  
needs of refugees and migrants

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

## ALGERIA

**CONTEXT:** Mixed migration flows have been a constant in the history of Algeria. The country host Saharawi refugees and regularly sub-Saharan Africans regularly move to southern Algeria after natural disasters as well as refugees fleeing crisis in Ivory Coast, Democratic Republic of Congo and recently Niger and Nigeria. Since 2011, many Syrian have sought refuge in the country. Initially considered as a transit route for migration towards northern Europe, currently many individuals stay in Algeria seeking asylum and by the end of 2016, 99,944 refugees and asylum seekers were registered in the country according to UNHCR.<sup>1</sup>

### **PRACTICES:**

**Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants.** Algeria has replaced the 1966 ordinance 66 - 211 with the law 08 - 11 in June 2008. The new law does not distinguish between different categories of migrants. The 2017 health law draft<sup>2</sup> states that all people in difficulty (refugees and migrants are considered people in difficulties) are entitled to health protection at the expense of the State.

**Addressing social determinants of health and health inequality for refugees and migrants:** Currently the Algerian State is working on setting up reception and accommodation centres for refugees and irregular migrants. The pilot centre in Tizi Ouzou provide shelter with running water and electricity with periodic visits from the Ministry of National Solidarity ensuring good conditions of hygiene and sanitation are met. In addition, Refugees and migrants also have access to routine medical check-up to identify health problems and have access to all national health programs.<sup>3</sup>

**Provision of equitable access to universal health coverage, including access to quality essential services, medicines and vaccines and health care financing for refugees and migrants:** The state provides free healthcare and guarantees access to all citizens<sup>4</sup>. It implements all means of diagnosis, treatment and hospitalization of the sick in all structures and public health establishments as well as all actions intended to protect and promote their health, providing and organizing health prevention, protection and promotion activities

**Provision of free health care for persons in difficulty (comprises refugees and migrants:** The protection of the health of persons in difficulty is reflected in section four of the draft Health Law 2017<sup>5</sup>. Public and private health structures and institutions with a public service mission must provide free health coverage for all people in difficulty, especially those living in an institutional environment and ensure compliance with health and safety standards.

**Medical and psychological care for victims of violence:** The State provides medical and psychological care and puts in place medical means to relieve the suffering of victims of violence and/or in situations of psychological distress with a view to their reintegration into society.

**Promoting people-centred, gender, refugee and migrant -sensitive health policies and health systems and program interventions:** The state takes the necessary measures to encourage the participation of concerned institutions as well as associations to protect the health of persons in difficulty and to provide them with the care, education required by their health status with a view to enabling their integration or reintegration into social life.

**Provision of short and long-term public health interventions to reduce mortality and morbidity among refugees and migrants. Promoting continuity and quality of care for refugees and migrants:** The State implements health protection programs and ensures its implementation at local, regional and national levels<sup>6</sup>, providing enough financial resources for its implementation. Health structures organize, as part of the implementation of health programs, with the assistance and assistance of any authority concerned, awareness campaigns, information and preventive actions against diseases, plagues accidents and catastrophes of whatever nature.

**Targeted immunisation campaigns:** In case of epidemic situation and/or protection of certain people at risk, the health authorities organize vaccination campaigns and take any appropriated measure for the population

<sup>1</sup> <http://popstats.unhcr.org/en/overview>

<sup>2</sup> Draft Health Law: Section 4, article 94

<sup>3</sup> Information collected from an online questionnaire submitted in 2017 by the Direction Générale de Santé de la Réforme Hospitalière

<sup>4</sup> Draft Health Law 2017 Articles 12, 13 and 14

<sup>5</sup> Draft health Law: Section 4, articles 95, 96, 97 and 98.

<sup>6</sup> Draft Health Law 2017, Article 30 and 31

or persons concerned. Authorised health services are required to provide compulsory immunisations free of charge to the concerned population.

**Improving the health and well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee and migrant women and girls:** The State ensures special conditions for health surveillance and care for institutionalized children, including those under the Ministry of National Solidarity. These children in distress must benefit from all the health and socio-educational measures favourable to their harmonious development and insertion in the family and society.

**Mother and Child health programs:** The protection of maternal and child health is ensured by medical, psychological, social, educational and administrative measures intended to: promote breastfeeding, provide all necessary care for the mother before, during and after pregnancy, ensure the physical, and mental health as well as the mental and psychomotor development of the child<sup>7</sup>.

**Protecting and promoting the health of adolescents:** Protecting and promoting the health of adolescents and young people is a priority of the State. The Minister of Health develops and implements, in collaboration with the services concerned, specific programs adapted to the health needs of adolescents and young people.

**Addressing the health of migrant workers, occupational health safety measures, including improving working conditions:** The State ensures the protection and promotion of health in the workplace in accordance with the legislation and regulations in force.<sup>8</sup> Workplace protection aims to promote and maintain the highest degree of physical, mental and social well-being of workers in all occupations. Including, prevention of damage to the health workers by the conditions of their work and protection against the risks resulting from the presence of agents prejudicial to their health. Occupational medicine is an obligation borne by the employer for the benefit to the worker in accordance with the legislation and regulations in force.

*(Source: Ministère de la Santé de la Population et de la Réforme Hospitalière)*

## CABO VERDE

### Equality and integration policies

**CONTEXT:** Migration is part of Cabo Verde's history. Over decades Cabo Verde has been a country of emigration. Recently, Cabo Verde started to become a reception county, receiving immigration flows from West Africa. This brought to the archipelago to develop appropriated and effective instruments to deal with migration management.

**PRACTICE:** The General Immigration Department undertook initiatives, including conferences on migration to sensitize the local population and migrants to the importance of migration and mutual respect. Regular training plans for both public care services and the national police are also organized, to ensure that migrants receive equal access to public services and an improved access to the enforcement of their rights.

**RESULTS:** The National Immigration Strategy (Resolution No. 2/2012) is based on the principle of non-discrimination and includes measures aimed at integration and inclusion of migrant workers in society.<sup>9</sup>

*(Source: International Labour Organization)*

<sup>7</sup> Draft Health Law 2017 Articles 72, 73, 74, 77, 78, 86 and 89

<sup>8</sup> Draft Health Law 2017, articles 102, 103, 104 and 105

<sup>9</sup> ILO Promoting fair migration. International Labour Conference. 105th session, 2016 ILC.105/III/1B

## ETHIOPIA

**CONTEXT:** In 2017, more than 850,000 refugees were hosted in Ethiopia in 25 camps across five regional states, mainly from Eritrea, Somalia and South Sudan<sup>10</sup>. Many of the border regions receiving refugees face the challenges of poor infrastructure, high levels of poverty, adverse environmental conditions, low capacity and poor development indicators. The institutional responsibility for the implementation of policies relating to refugees and returnees lies with the Administration for Refugee and Returnee Affairs (ARRA). In responding to the crisis ARRA and UNHCR have established a close cooperation with Ministers at both the Federal and State levels to facilitate refugee inclusion in the national systems. The Ethiopian Government has set targets for the country in the pledges it made during the Refugees Leaders' Summit in September 2016. The Government decision to roll-out the UNHCR-led comprehensive refugee response framework may further improve access to rights and basic service delivery to refugees. The government aims to achieve universal health coverage including refugees and migrants and develop integrated host community and refugee water supply and sanitation systems with integrated operation and management models.

**Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants:** Based on the Memorandum of Understanding signed between the Federal Ministry of Health (FMOH), ARRA, UNICEF and UNHCR, all refugees have the right to get basic health services and be treated like that of the host community.

**Health Sector Transformation plan:**<sup>11</sup> In the past two decades the Government of Ethiopia has invested in health system strengthening guided by pro-poor policies making impressive progress to improve the country health indicators. The Health Sector Transformation Plan has set ambitious goals to improve equity, coverage, quality and utilization of essential health services. The efforts will cover all nationals, refugees and migrants.

**Provision of short- and long-term public health interventions to reduce mortality and morbidity among refugees and migrants, including bridging short-term emergency and humanitarian health assistance with long-term health programmes:** There is Memorandum of Understanding (MoU) signed between FMOH, ARRA, UNICEF and UNHCR regarding delivering health services for refugees in the country. Based on the MoU all refugees have the right to get basic health services and will be treated like that of the host community.

**Vaccinating refugees:** Routine immunization service is delivered in all refugee camps regularly. During planning of SIAs all refugee camps will be considered along with the host community.

**LESSONS LEARNED AND WAY FORWARD:** The risk of polio importation from neighbouring countries have been abolished by providing SIA considering all refugee camps. Continue provision of health services in the refugee camps based on the MoU and at the same time sustain vaccinating children at all border entries.

*(Source: Federal Ministry of Health)*

## Addressing social determinants of health and health inequality for refugees and migrants

**CONTEXT:** Water and sanitation provision in refugee camps are delivered by UNHCR's non-governmental organization (NGO) partners through water schemes or water trucking to the camps. The unit cost of water is relatively high and the achievement of international minimum standards varies from one location to another. Where the standards have been met usually is with the support of humanitarian financing. The government, donors and humanitarian and development actors have put forward new models for sustainable water provision to benefit refugees and host communities alike.

### PRACTICES:

**Itang integrated water project:**<sup>12</sup> ARRA supported the establishment of a professional water utility management in Gambella region. ARRA, UNHCR, UNICEF and the Regional Water Bureau went ahead to build system spanning two refugee camps and two towns through a pipe network covering 100 km. This large infrastructure development, the Itang integrated water project, has been functional since 2016 and is currently being extended to one additional site.

<sup>10</sup> UNHCR global trends: forced displacement in 2016

<sup>11</sup> [https://www.globalfinancingfacility.org/sites/gff\\_new/files/Ethiopia-health-system-transformation-plan.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/Ethiopia-health-system-transformation-plan.pdf)

<sup>12</sup> UNHCR Submission. More information on the Itang project at: <http://crf.unhcr.org/en/documents/download/111>

**RESULTS:** The Itang integrated water system will provide water (once is completed) to 250,000 people (75 percent or more are refugee beneficiaries).

**LESSONS LEARNED:** Ethiopia's willingness to include refugees in the national water system makes it stand apart from the more traditional humanitarian responses. In many aspects this experience is likely to shape future water programming in other refugee camp settings.

**Provision of equitable access to universal health coverage, including access to quality essential services, medicines and vaccines and health care financing for refugees and migrants:** Primary Health Care services are implemented by ARRA in all 26 refugee camps free of charge for refugees and host communities. For secondary health care, refugees are referred to government hospitals where they can access care at the same cost as nationals. Health care financing is done through ARRA, either paying directly the cost to the hospital or reimbursing expenses to refugees.

*(Source: United Nations High Commissioner for Refugees)*

## Preventing sexual exploitation and abuse

**CONTEXT:** Young women who have relocated to urban areas and slums in Ethiopia are at risk of coerced sex, sex work and exploitative labour. There are few programs seeking to address social exclusion and HIV vulnerabilities among the most marginalized girls including migrant girls. Biruh Tesfa project reached out-of-school adolescent girls in urban slums in 18 cities in Ethiopia, two thirds of the girls enrolled were migrants. From 2006 to 2014, the Biruh Tesfa ("Bright Future") project addressed vulnerabilities of young women in urban areas and slums. A main activity of Biruh Tesfa was mentoring out-of-school girls and young adults aged 7-24 on topics such as HIV and AIDS, reproductive health, and violence and coercion. The mentorship program empowered young women by identifying, training and hiring female community leaders as mentors and by creating 'safe spaces'.

**PRACTICE: Biruh Tesfa Project:** The program provided basic literacy and life skills, financial literacy and entrepreneurship and education about HIV and reproductive health. Participants obtained social support for violence as well as assistance in developing communication and psychosocial skills. Given the extreme poverty of most of the participants, health care is usually out of their reach, mentors provided the girls with vouchers for subsidized or free medical and HIV services at participating clinics. In addition to referrals to a local NGO called Organization for the Prevention Rehabilitation and Integration of Female Street Children which provided support services to rape victims and shelters for evicted domestic workers.

**RESULTS:** Starting in Addis Ababa and Bahir Dar where the project reached 3,700 girls, Biruh Tesfa was scaled up to reach 18 cities and by 2016 the number of girls participating in the project was more than 75,000. The girls in the intervention sites were more than twice as likely to report social support and to score highly on HIV knowledge questions, know where to obtain voluntary counselling and testing and to want to be tested compared to girls in the control site. Further evaluations indicated that participation in the project corresponded to better performance on reading and numeracy tests.

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

## Countering human trafficking and exploitation

**CONTEXT:** Ethiopia has large amounts of migrants leaving for position as domestic workers in the Middle East and Gulf States. Approximately 180,000 women depart each year and 60 - 70 percent of those are estimated to be undocumented. Exploitation, neglect and physical and sexual against Ethiopian domestic workers is common given the legal status of the migrant and weak labour laws. In response, the Ethiopian Government has established bilateral agreements to protect migrants and assigned four national offices to lead its migration-related work. In addition, the government is conducting awareness raising campaigns in an effort to reduce the vulnerability of migrants and reduce risky migration.

**PRACTICE:** In partnership with the Ethiopian Government, the Freedom Fund launched the “hotspot” program<sup>13</sup> to reduce the risk of human trafficking in domestic work abroad in 2015. The focus of the programme is to encourage improved preparedness for safe migration. The hotspot programme aims to create alternative livelihood options amongst women and girls likely to migrate and to generate improved understanding and practice of safer migration in the communities. Activities include self-help groups; community-based saving loans and vocational training and awareness raising through community and one-on-one meetings. In 2016, the programme had a total of 13 community-based partners in Addis Ababa and the Amhara region.

**RESULTS:** In 2016, hotspot partners supported 11,849 individuals through community groups, partners provided social or legal services to 5,192 individuals including women returnees. The assistance includes medical treatment, individual and group counselling and recreational activities. 458 women and girls graduated from vocational training and 373 people earned new income or started a microenterprise.

**LESSONS LEARNED AND WAYS FORWARD:** Coordination and collaboration with government officials at all levels improve outcomes for overseas workers. Local community members are best placed to identify and execute local solutions. Exchange with other countries is very valuable, in 2016 the Freedom Fund sponsored a trip for Ethiopian Government officials to Philippines to exchange experiences. Following the Philippines trip, a report including suggestions to adapt Ethiopia’s migration policy to promote more effective migration practises and develop services provided to migrants and their families was produced. There is a need to pursue further research on communities’ attitudes on migrations and evaluate partners and to establish a national migration platform to bring together government officials and civil society organisations.<sup>14</sup>

*(Source: Freedom Fund)*

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<sup>13</sup> <http://freedomfund.org/programs/hotspot-projects/ethiopia-hotspot/>

<sup>14</sup> <http://freedomfund.org/wp-content/uploads/Ethiopia-2016-Annual-Report.pdf>



## KENYA

### Integrating health in the National Migration Policy

**CONTEXT:** Kenya experiences both forced internal displacement (as a result of conflict, natural disasters, climate change and environmental degradation) and voluntary migration of people looking for better opportunities elsewhere in the country and beyond. Kenya is also a regional hub for migration as an origin, transit and destination country and is home to one of the largest refugee populations and some of the oldest refugee camps in Africa. Migrant and mobile populations face many barriers in accessing essential health care services, especially irregular migrants who may choose to avoid accessing public services due to distrust and fear of deportation therefore missing out on important promotive health measures such as immunization, pregnancy care and safe childbirth. Lack of migrant-inclusive health policies also discourage patients' attendance.

**PRACTICE: National consultation on migrant health.**<sup>15</sup> The Ministry of Public Health and Sanitation in partnership with WHO and IOM hosted a National consultation on migration and health in 2011. The national consultation aimed to reach a common consensus on achieving quality and equitable health services for migrants and mobile populations in Kenya and serve as a platform to materialize the WHA resolution 61.17 on the Health of Migrants. Participants which included various ministries, NGOs, academics, migrant representatives and embassies agreed in a set of recommendations on policy, programmatic issues and partnerships. Following the national consultation, the Ministry of Public Health commissioned an analysis of Migration Health in Kenya to provide an overview of the issue aiming to stimulate discussion and lead to action from the Government to ensure migrants enjoy equitable access to health services.

**RESULTS:** In 2017, the National Coordination Mechanism on Migration submitted a draft policy for validation which covers various migration issues including migration and health, providing a comprehensive normative framework that will guide migration management with the main goal to enhance socio-economic development and security in the country while considering achieving the Sustainable Development Goals.

*(Source: Government of Kenya and World Health Organization)*

### Providing Primary Health Care for urban refugees and migrants

**CONTEXT:** Eastleigh is a large trading district in Nairobi, Kenya. It is located east of the central business district and it is home to thousands of migrants largely fleeing prolonged poverty and conflict in Ethiopia and Somalia. Eastleigh is also a major transit point between refugee camps, Somalia, and third countries to which migrant travel through legal and irregular channels. Eastleigh hosts many of the urban refugees, as well as a large number of irregular migrants. A large proportion of the population lives in overcrowded, dark and poorly ventilated apartment blocks with poor hygiene, which are conducive to the spread of tuberculosis (TB), cholera and other communicable diseases. The majority of migrants in Eastleigh are residing with irregular immigration status and are deprived of basic health services. A pilot IOM study found substantial differences in access to maternal and child health services between migrant and Kenyan women in the community of Eastleigh.

**PRACTICES: Integrated Primary Health Care Programme for Migrants and Host Population in Urban Setting of Nairobi:** In 2002 IOM established The Eastleigh Community Wellness Centre (ECWC) in collaboration with the Kamukunji Sub-County Health Management Team (SCHMT). The ECWC was established to manage migration health by offering migrant-friendly services to both migrants and host communities. Initially, ECWC offered free TB treatment to assist migrants, including refugees, to fulfil health requirements for long-term resettlement overseas. ECWC has expanded and currently offers free primary health care services including: comprehensive TB and HIV health services; sexual and reproductive health (SRH) services; maternal and child health services such as antenatal, postnatal and new-born care, immunization and growth monitoring; nutrition services; health promotion through community mobilization and health outreach; and interpretation services for disease prevention and demand creation. In conjunction with the clinic, IOM started a community health promotion and outreach initiatives tailored for multi-cultural communities. Through the ECWC, tailored community outreach services were carried out in a form of community health units in compliance with MOH community health strategy for health promotion, demand creation and disease prevention. Community health

<sup>15</sup> [http://www.who.int/hac/techguidance/health\\_of\\_migrants/national\\_consultation\\_kenya\\_2011.pdf](http://www.who.int/hac/techguidance/health_of_migrants/national_consultation_kenya_2011.pdf)

units are crucial to the strengthening of health-care systems and access to health services for migrants and host communities. They form the most vital linkage of the community to healthcare facilities.

**RESULTS:** Currently the clinic serves a catchment population of over 300,000, with a monthly attendance of close to 2500 patients, half of whom are migrants. In the period 2014-2016 the clinic had served 102,880 clients. 8,440 clients received HIV counselling and test, with 633 who tested positive and were referred for treatment. 4,946 clients were screened for TB and 260 new TB cases were enrolled for treatment. 17,050 children attended the child welfare clinic, of which 8,062 were migrant children. 1,570 pregnant women were referred and 2,508 women (15-49 years) were provided with family planning. In addition, community health workers are weekly engaging members of the community in health education, community surveillance and treatment follow-up with door-to-door activities and group campaigns.

**LESSONS LEARNED AND WAYS FORWARD:** Health service delivery in migration-affected areas promotes equitable access for all including migrants and mobile populations, as well as host communities. The ECWC model of migration-responsive health service delivery demonstrates how to address this challenge in urban areas by applying an integrated and inclusive approach to ensure equal access to care for both migrants and host population. The model includes health systems strengthening, community participation and health promotion, institutional partnership and close engagement with government and local authorities.

*(Source: International Organization for Migration)*

## Providing financial protection for urban refugees

**Urban refugee programme:** 8771 refugee families have been registered to the National Hospital Insurance Fund (NHIF) which is providing unrestricted secondary and tertiary healthcare to subscribers after paying US\$ 5 per family per month. Subscribers also enjoy out-patient care but only in a specific facility that they selected during the registration (they can change the facility in the course of the year). More refugees have registered for NHIF on their own and UNHCR is doing robust sensitization to ensure that refugees are registered for NHIF using any of the recognized document – Asylum Seeker, Alien Cards etc. In refugees hosting areas, UNHCR is working with the County Authority to ensure harmonized and integrated healthcare with County Government in the lead. This is working well in areas of shared infrastructure for both communities, integrated surveillance and commodity supplies –e.g. ARV, TB drugs, Malaria drugs, vaccines, and use of training curriculum.

*(Source: United Nations High Commission for Refugees)*

## LIBERIA

**CONTEXT:** In 2017, Liberia was hosting 99,000 international migrants <sup>16</sup>including 18,990 refugees by the end of 2016. <sup>17</sup> Majority of refugees are coming from Ivory Coast and as conditions for return have been met, a process of voluntary repatriation is ongoing. However, based existing cultural, family and economic activities there will be a need to locally integrate some of the refugees that will choose to stay in the country. Liberia is also invested in pushing migration issues to the policy agenda and hosted the first meeting of the high-level panel on international migration in Africa in January 2018. The government and its partners want to gradually integrate refugee programs into local development strategies ensuring that all activities are beneficial to both refugees and hosting communities.

**Promoting the right to the enjoyment of the highest attainable standard of physical and mental health, equality and non-discrimination of refugees and migrants.** The responsibility for the management of refugees in Liberia falls under the Liberia Refugee Repatriation and Resettlement Commission (LRRRC) guided by the Liberia constitution, the Liberia Refugee Act, the National Local Integration Strategy plan and the Kampala Convention. Provision of international protection and humanitarian assistance to the population of concern is done through collaboration, coordination and cooperation with humanitarian and development partners.

**Lessons learnt and way forward:** Refugees have rights and that there remain challenges in providing services to refugees and migrants faced by stakeholders and humanitarian actors. Continue technical and financial support to the government to uphold/maintain its protection regime and humanitarian assistance for the population of concern.

**Addressing social determinants of health and health inequality for refugees and migrants.** The Government of Liberia through LRRRC and its partners are providing basic social services to the population of concern based in camps while those in host communities share available services.

**Lessons learnt and way forward.** There exists an enabling environment where refugees, migrants and local population co-exist and share available services. The Government of Liberia should endorse the National Local Integration Plan, Refugee Act, Kampala Convention through LRRRC with the increased advocacy of WHO in order to ensure promotion of health and access of health services in collaboration with partners (UNHCR, IOM, ICRC, UNICEF, etc.)

**Provision of equitable access to universal health coverage, including access to quality essential services, medicines and vaccines and health care financing for refugees and migrants.** The provision of protection and humanitarian assistance to the population of concern is done through collaboration, coordination and cooperation with humanitarian and development partners. The Ministry of Health has in place a national health plan and policy that addresses the health needs and concern of refugees and migrants. County health facilities are accessible to refugees and migrants.

**Lessons learnt and way forward:** There exists an enabling environment where refugees, migrants and locals peacefully co-exist and share available basic services together. WHO and relevant humanitarian and developmental partners should strengthen national capacity in order to adequately address dire health needs of our population of concern.

**Provision of short and long-term public health interventions to reduce mortality and morbidity among refugees and migrants. Promoting continuity and quality of care for refugees and migrants.** The Government of Liberia through LRRRC and the Ministry of Health has in place a national health plan and policy that addresses the health needs and concern of refugees and migrants. The national health plan is the major legal framework, law, regulation that protects the health needs of population of concern in Liberia. Health services are provided to refugees and migrants in dedicated structures in camps and/or integrated in national health structures. Both, refugee and host population have access to basic services. Surveillance and emergency response is guaranteed by partners and the LRRRC. House-to-house visits are conducted to profile refugees and migrants with major health concerns and find remedies.

**Lessons learnt and way forward:** Refugees and migrants have access to health service providers. WHO and relevant humanitarian and developmental partners should continue to strengthen national capacity of LRRRC in order to adequately address dire health needs of the population of concern.

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<sup>16</sup> UN DESA 2017

<sup>17</sup> UNHCR data

**Prevention and control of communicable and non-communicable diseases including mental health for refugees and migrants.** There is a disease surveillance control system in place coordinated by the National Public Health Institute of Liberia with input from other agencies like LRRRC on refugees and migrant issues across the country. The LRRRC conducts regular health awareness and sensitization forums. Major health related issues for refugees and migrants are published on bulletin boards and shared with partners, refugees and migrants.

**Lessons learnt and way forward:** Coordination, collaboration and cooperation with LRRRC and all partners works in the best interest of the people of concern. WHO and relevant humanitarian and developmental partners should continue to strengthen national capacity of LRRRC in order to adequately address dire health needs of the population of concern.

**Improving the well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee women and girls.** The LRRRC monitor the safety of refugee and migrant women, girls and children in the counties where they are concentrated and report any abuse to relevant protection actors for action. Refugees and migrants participate in leadership meetings and dialogues to highlight their concerns.

**Lessons learnt and way forward:** A coordination mechanism is in place through regular inter-agency collaboration where refugees and migrant issues are addressed. WHO and relevant humanitarian and developmental partners need to continue strengthening the capacity of LRRRC in order to adequately address dire health needs of the population of concern.

**Addressing the health of migrant workers, occupational health safety measures, including improving working conditions and addressing workforce shortages.** The Government of Liberia through LRRRC and the Ministry of Labour has in place National Labour guidelines, Plan and Policy which addresses the Occupational health safety measures including improving working conditions of refugees and migrants. The LRRRC facilitates and coordinates the processing of essential work documents for migrants. In addition, LRRRC monitors the implementation of the National Labour Guidelines, plan and policies.

**Lessons learnt and way forward:** There is adequate coordination among LRRRC and partners to address refugees and migrant related issues. WHO and relevant humanitarian and developmental partners need to continue strengthen the capacity of LRRRC in order to adequately address dire health needs of the population of concern.

*(Source: Liberia Refugee Repatriation and Resettlement Commission)*

## MALI

### Improving access to basic services including mental health to forced return migrants

**CONTEXT:** Mali has a long history of emigration and has also become an important transit point for migratory flows within the region and beyond. The daily average of observed individuals in December 2017 was 215 persons per day at 10 active flow monitoring points. Every year, hundreds of migrants of different nationalities are sent to Bamako from Europe or other West African Countries. They may also arrive to border posts of Kidal and Nioro after expulsion from Algeria and Mauritania. Most deportees are traumatised by their ordeal and Malian authorities have limited capacity to provide them with the necessary assistance. Representatives from the Civil Protection Department, the Ministry for Overseas Malians, African Integration as well as the police, rely for this purpose on the Association Malienne des Expulsées (AME) founded by former deportees able to provide peer-to-peer support.

**PRACTICE:** Migrants are often suffering from injuries caused by transport or being ill or exhausted because of long periods in the desert, AME provides first aid and financial support to ensure continuation of treatment to forced returnees. In 2009, AME partnered with Médecins du Monde to provide mental health support to forced returnees and set up a referral system to the Malian health system. The capacities of AME staff to respond to the medical needs was improved through training on psychological first aid and peer support. In parallel, AME supports integration into families and home communities and run awareness building campaigns in Malian society to reduce the stigma associated with failed migration and overcome the ensuing trauma.

**RESULTS AND LESSONS LEARNED:** The project achieved positive results in providing immediate assistance to forced returnees. The setting up of a referral system faced difficulties due to a shortage of suitably qualified staff within the national health system. Strengthening of the health system, including the training and retention of mental health professionals is necessary to integrate mental health care.<sup>18</sup>

*(Source: Joint Migration and Development Initiative)*

### Preparedness and response in humanitarian crisis

**CONTEXT:** Since January 2012, Mali has been confronted with a political and security crisis that has led to the occupation of two-thirds of the country by armed terrorist groups as well as social unrest. Marked by the intervention of international forces to support the return to constitutional normalcy, a political transition started on 2013 with presidential elections, followed by legislative elections in 2014 and the signing of the Peace and Reconciliation Agreement in 2015. Despite the peace agreement, the humanitarian situation in the country remains worrying with an internally displaced population estimated at 47,706 persons in January 2018. Inter-communal tensions and conflicts together with terrorist attacks continue to displace people internally as well as outside the country (17,698 persons have been displaced between October 2017 and January 2018).<sup>19</sup>

**PRACTICE:** The health cluster lead by WHO was established in March 2012 to reduce mortality and morbidity and to quickly restore provision of care. The health cluster was reinforced to ensure key functions are supported such as public health and data and information management. The WHO work in Mali includes: the reinforcement of the surveillance system in collaboration with NGOs for data collection, especially in conflict-affected areas; mapping and coordination of the NGOs interventions; development of interagency plans, WHO country and contingency plans and the early recovery plan of the Ministry of Health; pre-positioning of material and drugs; establishment of an emergency coordination unit; recruitment and deployment of support physicians; deployment of humanitarian missions and organization of vaccination campaigns against JNV, polio and measles.

**RESULTS:** Regular production of strategic information for programmatic decision-making (inventory of national stocks, analysis of trends of priority diseases, early warning and outbreak detection, Health Resource Availability Mapping System surveys etc.); reopening of some health centres; mobilization of CERF funds and deployment of 16 humanitarian missions in which WHO physicians conducted 79,476 consultations, assisted 2,702 deliveries and conducted 2,652 surgical interventions (including 548 caesarean sections), attended 99 war-wounded and supported hospitalization of 9,613 patients.

*(Source: WHO Submission)*

<sup>18</sup>[http://www.globalmigrationgroup.org/system/files/uploads/UNCT\\_Corner/theme7/jmdi\\_august\\_2011\\_handbook\\_migration\\_for\\_development.pdf](http://www.globalmigrationgroup.org/system/files/uploads/UNCT_Corner/theme7/jmdi_august_2011_handbook_migration_for_development.pdf)

<sup>19</sup>[https://mali.iom.int/sites/default/files/CMP%20reports/DTM\\_Janvier\\_2018.pdf](https://mali.iom.int/sites/default/files/CMP%20reports/DTM_Janvier_2018.pdf)

## MAURITANIA

### Improving the well-being of women, children and adolescents living in refugee and migrant settings; promoting gender equality and empowering refugee women and girls

**CONTEXT:** Mauritania maintains an open-door policy towards refugees and asylum seekers. At the end of 2016, Mauritania hosted 74,735 refugees, people in refugee-like situation and asylum seekers.<sup>20</sup> This includes more than 50,000 Malians in Mbera, a camp established in 2012 in the arid south-eastern region close to the Malian border. Due to the unstable situation in northern Mali, large scale returns of Malian refugees are not expected in 2018.<sup>21</sup>

**PRACTICE:**

**Community protection network:** UNHCR is reinforcing the established community protection network and training its members on core child protection principles. Comprised of young refugee women and men, the community protection network complements child protection monitoring by identifying and referring children with protection needs to UNHCR and partners, while also undertaking prevention and community-sensitization activities. UNHCR's community mobilization efforts also address specific issues such as education, health, early marriage, and targeted outreach to men and boys to address harmful practices.

*(Source: United Nations High Commission for Refugees)*

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<sup>20</sup> UNHCR figures

<sup>21</sup> <https://reliefweb.int/report/mauritania/mauritania-unhcr-operational-update-12-february-2018>

## MAURITIUS

### Promoting the health of migrants among the member states of the Indian Ocean Commission (IOC)

**CONTEXT:** About 29,000 international migrants live in Mauritius and 13,000 in Seychelles<sup>22</sup>. Indian Oceania was built in successive waves of migration from Africa, the East, India, China and Europe. In the era of globalization, south-north, south-south, or north-south migration, and even more intra-regional migration, are intensifying. The reasons are economic and political, social and cultural, or ecological and climatic. The management of migratory movements poses many challenges, such as those of integration, assimilation and care; in short, the welcome.

#### PRACTICES:

**Migration and health strategy:** The Indian Ocean Commission<sup>23</sup> and IOM have developed a Migration and Health Strategy (2016-2018), which focuses on the intersection of migration and health issues in the sub-region. The Strategy also takes into account the commitments of Member States of the WHO contained in WHA Resolution 61.17 and the first World Consultation on Health Promotion, the health of migrants and mobile populations held in Madrid in 2010. The strategy is based on existing strategic documents and takes into account the specificities of states and internal, regional and international migration flows. It comprises four main areas of intervention based on four objectives aimed at removing barriers to migrants' access to health services and making the necessary adjustments to address current and future challenges.

**Universal Health coverage and free movement of people living with HIV:** In Mauritius and Seychelles, medical coverage extends to all, including migrants. Health services are free for all in public hospitals. This free treatment applies to first aid as well as to the treatment of chronic conditions, such as diabetes or hypertension and for certain infectious diseases that have occurred in Mauritius, such as tuberculosis. In 2014, the Union of the Comoros enacted a law promoting the absence of restrictions to the entrance, stay and residence based on HIV status, stipulating the prohibition of mandatory testing as condition for employment and guaranteeing access to treatment for migrants living with HIV.

**Protection of migrant workers:** The Migrant Workers Unit of the Ministry of Health in Mauritius verifies contracts and inspects migrant workplaces and dormitories made available by the employers. In Seychelles, the Immigration and Employment departments have recently merged to form a single ministry. The new Ministry has established an enforcement unit to investigate cases of abuse or ill-treatment of migrant workers. In addition, a 24/7 hotline is in place to report cases of trafficking or exploitation.

**RESULTS:** In 2015, 860 foreign nationals went to public hospitals. 148 were referred for treatment by their employer while 712 were tourists. However, it should be noted that certain categories of professionals must subscribe to health insurance and the migrants concerned most often use private structures.

**WAYS FORWARD:** At the end of 2017, IOC began the third phase of an Indian Ocean Health Watch project managed by the IOC Health Surveillance Unit (UVS). This five-year phase of the project (2018 - 2022) aims to contribute to a coordinated control of health risks in the Indian Ocean by eventually having a regional team in the General Secretariat of the IOC in charge of the animation and the coordination of the health monitoring network on the basis of the "One Health" concept. During the IOC Technical Committee in October 2016, a reflection was initiated on the feasibility of introducing migration and mobility data into routine surveillance systems. Such data could facilitate the medical follow-up of migrants and circulating patients in the sub-region, epidemiological surveillance in places where transient and sedentary populations live together (for example port or mining towns), the search for contacts within the framework of the fight against epidemics such as tuberculosis or plague and allow a better distribution and adaptation of services. It would be a long-term effort to modify the National Statistical Information Systems (SNIS) and to train the staff concerned, but it is feasible because it is relatively simple data to collect.

*(Source: International Organization for Migration)*

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<sup>22</sup> UN DESA

<sup>23</sup> Indian Ocean Commission member States: Union of Comoros, France - Reunion Island, Madagascar, Mauritius and Seychelles

## NIGERIA

### Improved access to mental health services through outreach to Primary Health Care facilities and support to referral system

**CONTEXT:** In emergency settings, the rate of common mental disorders can double - often from 10 percent to 20 percent<sup>24</sup>. Over the last nine years the Boko-Haram insurgency in north-eastern Nigeria has caused a humanitarian emergency, with estimated 7.7 million people in need of support including health services. The insurgency has created a situation that has led to significant displacement of people thereby resulting in significant psychological suffering of affected population. In addition to the impact of the displacement and the weakened health delivery system on the health; gross atrocities such as abduction, suicide bombings and killings are also expected to have a negative effect on mental health.

**PRACTICE:** WHO in collaboration with the Federal Neuropsychiatry Hospital, trained health workers from Primary Health Care Centres (PHCs) in six Local Government Areas (LGAs) of Borno state on the WHO Mental Health Gap Action Programme (mhGAP) and launched mental health services at 36 PHCs. Mental health specialists from the Federal Neuropsychiatry Hospital conduct outreach sessions on mental health and mentor the trained PHC workers. WHO in addition to the logistic support to the outreach is also providing psychotropic drugs and support to patients requiring referral and admission.

**RESULTS:** A total of 64 PHC health workers were trained for five days on mhGAP. Nine mental health specialists from the Neuropsychiatry hospital conducted 241 outreach sessions on mental health at selected PHCs. During these outreach sessions a total of 3320 patients with mental health problems were treated over four months period. Out of these, 253 were referred for better care and 27 were treated as an inpatient.

**LESSONS LEARNED:** This project complements the humanitarian health response of the sector in general and WHO's efforts in particular by addressing one of the unmet needs (mental health) of the affected population. More specifically, this intervention complements the efforts of partners engaged in second and third layer of mental health and psychosocial support (MHPSS) response by ensuring availability of the fourth layer (specialized care) bringing specialized care close to the community in a more sustainable way.

*(Source: World Health Organization)*

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<sup>24</sup> [http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf?ua=1)



## SOUTH AFRICA

### Africa Health Placement: Support for refugee doctors in South Africa

**CONTEXT:** South Africa has a long history of providing asylum. In 2015, the country accepted 120,000 refugees some of them doctors. Africa Health Placements<sup>25</sup> (AHP) is a NGO that was established in 2005 with the mission to help plan for, find and retain the health workforce needed to provide access in rural and underserved communities. A major component of AHP's work has been recruiting foreign-qualified doctors to take up vacant posts in rural government hospitals in South Africa, usually for one-year period.

**PRACTICES:** AHP supports refugee doctors in their applications for professional registration and employment through active partnership with the national department of health and the Health Professions Council of South Africa (HPCSA). AHP provides support to refugee doctors by helping them to complete their application forms to the Foreign Workforce Management Directorate at the national Department of Health for permission to seek employment, as well as to the HPCSA for professional registration. AHP checks that the forms are compliant with the regulations and helps to submit them on behalf of the refugee doctor including follow up on progress. Once these applications have been approved, AHP helps the refugee doctors to find a job by matching them with available posts in the public sector. Refugee doctors are only allowed to work in the public-sector facilities and must work at least one year in an underserved community.

**RESULTS:** So far AHP has supported the placement of 430 refugee doctors from the Democratic Republic of the Congo. AHP has found that the foreign-qualified doctors who have come as refugees stay longer in rural posts than those from high-income countries; for example, the doctors recruited from the Democratic Republic of the Congo have an average length of placement of 2.8 years compared to 1.3 years for their counterparts from the United Kingdom, and many refugee doctors stay for life.

**LESSONS LEARNED AND WAYS FORWARD:** AHP believes that supporting refugee doctors to work in the health system in South Africa brings considerable benefits to both the country and to the refugees. Staying longer enables these doctors to adapt more to the local practice and culture and to be available to take on important clinical leadership roles in the facilities where they work. For the refugees, the ability to take up posts in the health system brings the obvious benefits of being able to work, support their families and continue in their careers. The process for obtaining professional registration and a job offer is also a difficult one that can be slow and expensive to complete. There may therefore be opportunities to streamline the process further, for example by providing more regular opportunities for candidates to undertake the HPCSA examinations or by offering bridging programmes (such as in language skills or medical practice) to help refugees to reach the required standards more quickly. It is essential that due processes are followed to prevent active recruitment from critical shortage countries and to ensure the professional competency of all doctors. If these are in place, the experience of South Africa demonstrates that enabling and supporting refugees with medical qualifications to practice as doctors can provide mutual benefits for both refugees and the host country.

*(Source: Africa Health Placement)*

### Protecting domestic workers rights in South Africa

**CONTEXT:** Workers unions have been instrumental in the development of legislation guaranteeing a minimum wage and fair working conditions for domestic workers. In spite of the incorporation of targeted protections in the labour law itself, much effort is still required in ensuring that domestic workers receive other entitlements, including maternity leave, access to health care and protective mechanisms against sexual harassment at work.

**PRACTICE:** The South African Domestic Service and Allied Workers Union (SADSAWU), founded by Myrtle Witbooi, an advocate for domestic workers' rights and Hester Stephens, a full-time domestic worker, has been at the forefront of advocacy efforts regarding the institution of national legislation for domestic workers. The main purpose of this union, with currently over 25,000 members, is to continue defending domestic workers' human and labour rights with special attention to the health component. Ongoing SADSAWU advocacy efforts include: preventing exploitation by recruitment agencies, performing living wage campaigns, defending the Health Act Campaign and preventing sexual harassment at work. Partnering with the Government, SADSAWU offers development training for domestic workers and employers. Other successes include participation in designing unemployment insurance and a dispute resolution system.

<sup>25</sup> <http://www.who.int/workforcealliance/brain-drain-brain-gain/17-304-south-africa-case-studies2017-09-26-justified.pdf>

## Providing insurance to domestic workers

**CONTEXT:** A defining characteristic of domestic workers in South Africa is that most are internal migrant workers. Many live in isolated situations and work under strenuous conditions. The common violation of labour rights and absence of social protection intensifies the risks faced by this working population to HIV. DomestiCare is a private, affordable healthcare insurance option for South African domestic workers run by two of the largest healthcare companies in the country: Occupational Cares South Africa (OCSA) and CareCross Health.

**PRACTICE:** At minimal cost to the employer, the insurance gives domestic workers employed in private households the right to occupational and private primary healthcare, previously unavailable for this group of employees. It provides for consultations with general practitioners, medicines, X-rays and blood testing. At additional cost, DomestiCare Plus also offers basic optometry and dentistry benefits, after required waiting periods.

**RESULTS:** Proponents of this initiative remark that it not only enhances realization of basic health rights, it also contributes to healthier workers, reducing sick leave and turnover, improving productivity, and enhancing worker loyalty and satisfaction.

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

## Empowerment of refugees and migrants

**CONTEXT:** Johannesburg inner city is highly heterogeneous hosting a large number of domestic and international migrants as well as refugees and asylum seekers from across the continent. An estimated 14 percent of the population in Johannesburg is foreign-born, mainly from Mozambique, Nigeria and Zimbabwe. Informal housing in cities is the most frequent accommodation for poor and marginalised populations. Migrants and refugees in Johannesburg usually live in same-sex hostels as they are the cheaper form of accommodation in town, many companies also use these as cheap housing for migrant workers.

**PRACTICE: Mpilonhle-Mpilonde (Quality life-long life).** Initially the intervention was designed to prevent HIV infection in migrants and refugees, and to improve access to HIV-related health services through quality of life clubs which are community health clubs that were a central vehicle for driving change in the communities. In a series of structured learning sessions facilitated by a trained expert facilitator, community participants identify challenging and problematic aspects of their environment and collectively formulate responses to bring about change. Similar clubs have been implemented in rural settings in Sierra Leone and Zimbabwe as a long-term strategy to enhance people's control over social determinants of health<sup>26</sup>.

**RESULTS:** Hostel residents were predominantly internal migrants from another province and most felt withdrawn from the rest of the city. Men prioritised the needs for jobs while women were concerned about water, sanitation, housing and poverty alleviation regarding their community as unsafe. Some clubs focused on individual capacity-building, others implemented broader community-focused activities such as cleaning campaigns or support for raising issues with the authorities and others made income-generating activities their focus. The intervention objectives were modified to include HIV prevention within a broader health and development focus

**LESSONS LEARNED:** Addressing HIV prevention in urban informal settings requires to acknowledge and work on priorities set by marginalised communities which may comprise more pressing issues related with daily survival. The study found that quality of life clubs were a sustainable and effective method of enhancing migrant's control over the determinants of health, via empowering individuals with the necessary social capital for accessing available resources, networks and knowledge. Quality of life clubs may assist migrants and refugee communities with integrating with the host community, access local services and improve self-control of their life.

*(Source: Wits Reproductive Health and HIV Institute)*

<sup>26</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5438852/>

## Tracking xenophobic threats and attacks

**CONTEXT:** International migrants in South Africa have been vulnerable to exclusion and violence since its transition to democracy and in recent years the country has witnessed extreme acts of violence against perceived “others”. While public discourse continues to focus on the supposed negative impacts of migration there is limited information on the frequency, location and causes of attacks. This hampers government, international organisations and civil society responses to xenophobic violence. To fill this knowledge gap, the African Centre for Migration & Society (ACMS) at the University of the Witwatersrand in Johannesburg and the technology website iAfrikan have launched a crowdsourcing platform called *Xenowatch* in 2016<sup>27</sup>.

**PRACTICE: Xenowatch** is an open source system for information collection aiming at tracking all forms of xenophobic threats and attacks as well as government responses to xenophobic attacks. Reports to Xenowatch<sup>28</sup> are lodged in a confidential database and a project administrator verifies the report in 48 hours. Anonymous incident descriptions will be replayed to the South African Police Service, UNHCR and other partners. The ACMS and iAfrikan are working with the South Africa Local Government Association to have data from the database included in the scorecards they use for evaluating local political performance, the data is analysed, reports are used to inform conflict prevention and resolution initiatives, identify communities at risk and encourage greater accountability among police and other government officials.

*(Source: Office of the High Commissioner for Human Rights)*

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<sup>27</sup> <https://www.iafrikan.com/xenowatch/>

<sup>28</sup> Using free SMSs, email or the website

## SOUTH SUDAN

### Enhancing the psychosocial wellbeing of internally displaced persons and conflict affected populations

**CONTEXT:** The project, which began in 2015, seeks to address the psychosocial needs of Internally Displaced Persons (IDPs) living in Protection of Civilian (PoC) sites (Bor, Bentiu and Malakal) in South Sudan, and to contribute to the enhancement of their psychosocial well-being. In addition, the project targets IDPs living outside the PoCs, by developing the capacity of humanitarian actors sent as first responders in the provision of Psychological First Aid (PFA) and by mainstreaming mental health and psychosocial support (MHPSS) approach. Although most IDPs are living outside of the PoCs, it is urgent to address the psychosocial needs within the PoCs as declining living conditions, the breakdown of social structures and the rising levels of violence among and between communities have significantly exacerbated tensions inside the PoCs. The project adopts a community based and integrated approach, with specific attention to youth and adults.

**PRACTICE:** MHPSS has been an integral part of IOM's response in South Sudan. In Emergency Response, basic MHPSS services have helped to address high levels of distress, strengthen positive coping mechanisms and contribute to effective referral and protective mechanisms. Mitigation measures have included: provision of training in basic life skills, establishment of a network of support groups, provision of psychological interventions as needed, and contribution to community rebuilding activities. Measures to promote prevention and preparedness have included: the establishment of Resource Centres and safe spaces and MHPSS capacity building in the IDP sites, frontline services, and social institutions.

The specific activities offered by the project have included the following: Counselling and home visits; support groups for mothers and widows, teenage mothers, men, youth and children, people living with HIV/AIDs and their caregivers, elderly and people with disabilities or special needs (PWD/PSN) (the final 2, organized in collaboration with UNHCR and WDG); recreational, learning, and cultural activities and capacity building activities trained participants in psychological first aid (PFA), MHPSS 101, counselling skills, reporting, forming of support groups and activities, introduction to social work, caring for gender-based violence (GBV) survivors.

**RESULTS:** Ninety participants who are IDPs participated in an in-depth training on provision of basic psychosocial support, which included modules on basic concepts in psychosocial support, psychological first aid, basic lay counselling skills, use of creative methodologies such as art and drama, basic conflict mediation, GBV and protection issues. Following the completion of the training, PSS mobile teams were created, involving 73 team members from among the training participants. These teams focused on different themes, such as educators (targeting school-aged children and youth), women, sports, a cultural group, a mediation group, an interfaith group and a group of lay counsellors. The teams provided psychosocial (PSS) services, strengthening community and family supports, to over 10,000 individuals. In addition, the PSS mobile teams organized several awareness campaigns on MHPSS and conduct regular home visits.

**LESSONS LEARNED AND WAYS FORWARD:** Many of those trained in Psychological First Aid expressed the need for refresher trainings, and/or felt they would have benefited from additional training days. Some participants recommended that a Training of Trainers on PFA should be organized in order to enhance ability to reach more humanitarian actors. Some participants also advised to provide follow up visits to evaluate any challenges in implementation of PFA. Workshops on mainstreaming of MHPSS, based on the booklet developed by the IASC on MHPSS guidelines in emergency settings for CCCM actors were implemented. The workshops first introduced the basic concepts of MHPSS and the IASC guidelines on MHPSS in emergency settings. Participants were also engaged in group work on how they could use the guidelines within their activities. Many participants saw a need to include MHPSS considerations from the design stage of projects. For instance, they suggested that humanitarian workers start earmarking budgets and activities on MHPSS when designing and submitting proposals. In addition, they believed that donors should include MHPSS mainstreaming in their template. Moreover, it was felt that there was a need for additional PFA trainings for existing field workers in different sectors as well as MhGap training for health care professionals. Some participants recommended providing training in developing/writing proposals in mainstreaming MHPSS, as well as more sector-focused training. In the next stages, the project will deliver capacity building training for host communities, life skills activities for youth, strengthen the Peer Support Group networks, update the MHPSS Needs Assessment and scale up delivery within host communities to create a more balanced response to the conflict affected population.

*(Source: International Organization for Migration)*

## Providing humanitarian assistance- South Sudan Health Rapid Response Team

**CONTEXT:** Cholera is endemic in South Sudan and its neighbouring countries. Outbreaks are common and continue to be reported within South Sudan and across the neighbouring countries. From 2013 to 2014, there have been three cholera outbreaks involving 24 counties in 10 states of South Sudan. The cumulative cases have reached 28,677 with a case fatality rate of 2.27 percent (650 deaths). In addition, with frequent multiple displacement secondary to armed conflict, access to emergency primary health care has been challenging to the migrant population.

**PRACTICE:** In partnership with the Ministry of Health, the IOM Rapid Response Team (RRT) main mandate is to respond to the emergency health needs of acutely displaced people and the detection, treatment and containment of diseases outbreaks among conflict-affected IDP and host population. In response to the cholera outbreak in South Sudan IOM RRT conducted a reactive oral cholera vaccination (OCV) campaign and case management through cholera treatment units (CTU) and cholera treatment centres (CTC) in the affected counties. In addition, based on the multi-cluster Initial needs assessment (MIRA) outcomes organized by OCHA and the health cluster, IOM RRT has provided emergency lifesaving services to acutely displaced people.

**RESULTS:** IOM in collaboration and coordination with WHO, UNICEF, MOH and other partners vaccinated 318,036 people with two doses of OCV. IOM also set up cholera treatment centre (CTC) and cholera treatment units (CTU) for cholera case management in Ayod county, Jonglei state and Yirol East county, Lakes state.

IOM health rapid response teams were deployed 15 times to various counties of South Sudan to provide emergency lifesaving primary health care service to the acutely displaced people. A total of 136,369 persons were reached through health consultation; 19,100 children screened for malnutrition; 2,166 children under five received measles vaccination; 220 deliveries were attended by skilled birth attendants; 3,393 mothers attended ante natal care; and 394,237 people reached with key health and hygiene promotion messages.

**LESSONS LEARNED AND WAYS FORWARD:** Minimum Preparedness Actions including risk monitoring, establishment of coordination and management arrangements, preparing for joint needs assessments, and establishing operational capacity and arrangements to deliver critical emergency health assistance was found to be vital. Through the minimum preparedness action, roles and responsibilities of different agencies have been identified and agreed on; hence avoiding duplication of efforts and promoting rapid deployment of team. Availability of own chartered flight has helped in flexibility with high level of operational activity.

*(Source: International Organization for Migration)*

## UGANDA

### Progressive approach to refugee management: Integrating refugees into national systems

**CONTEXT:** Uganda has the largest refugee population in Africa and is the third largest refugee hosting nation in the world. In 2017, hosted 1.7 million international migrants<sup>29</sup> of which 1.3 million were refugees and asylum seekers primarily from Democratic Republic of Congo and South Sudan<sup>30</sup>. This number is expected to increase as conflict and political instability continue in the region and existing refugees are unlikely to return home in the near future.

**PRACTICE:** In 1999, The Office of the Prime Minister and UNHCR formalized the integration of service delivery systems for refugee and local populations in order to promote peaceful coexistence and fairness between refugee and host populations. The 2006 Refugee Act as well as the 2010 Refugee Regulations have further strengthened migrants and refugees' rights within the country. Uganda's refugee law is one of the most progressive in the world. The Government maintains an inclusive approach, granting refugees freedom of movement, a plot of land, the right to seek employment and engage in business and access to public services such as education and health on par with nationals.<sup>31</sup> Despite the challenges generated by the recent influx from South Sudan, refugee families still receive plots of land. Uganda has integrated refugees into national development plans through the Settlement Transformative Agenda (STA), which supports the objectives of refugee self-reliance through development interventions to ease pressure on the host county and communities.<sup>32</sup> Building on these existing approaches, the Office of the Prime Minister and UNHCR officially launched the Comprehensive Refugee Response Framework (CRRF) addressing four mutually-reinforcing themes: admission and rights; emergency response and ongoing needs; resilience and self-reliance of refugees; and expansion of solutions through resettlement and alternative pathways such as scholarships and work placements abroad. Through the implementation of the CRRF, Uganda seeks to accelerate the implementation of the Government's Refugee and Host Population Empowerment (ReHoPE) strategy, which provides a national framework for integrated<sup>33</sup> and holistic support to refugees and host populations.

**RESULTS AND LESSONS LEARNED:** Integrated comprehensive health care package is provided in the facilities for host and refugee populations. In 87 health facilities supported by UNHCR across the country, 72 percent of the total number of PHC consultations are made to the refugee population. The refugee response is chronically underfunded, Uganda remains a low-income country with scarce resources and the refugee response and even though the approach has proven to establish peaceful coexistence between host population and refugees, it requires support from the international community and further investments to fully realize this exemplary model.

*(Source: United Nations High Commission for Refugees)*

### Evidence-informed approach for HIV response in high prevalent hard-to-reach mobile populations

Uganda recognizes that health issues among key populations cannot be addressed by one Ministry or sector, thus supports a holistic approach that includes inter-ministerial, inter-sectoral and multi-stakeholder driven response to advance the health of migrant populations. In 2013, IOM conducted a study on HIV knowledge, attitudes and practices among fishermen population, providing information that would enable policymakers and practitioners to design evidence-based HIV programmes and policies for the fishing communities in Uganda. The findings indicated that 90 percent of the respondents were migrants with only 43 percent reporting to reside within their residence for less than 5 years. Respondents further indicated mobility contributed to fishermen's HIV vulnerability as a result of being away from their families.<sup>34</sup> The findings from the study further informed the development of the tailored National HIV and AIDS Behavioural Change Communication Strategy for Fishing communities in Uganda 2016/2020.

*(Source: International Organization for Migration)*

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<sup>29</sup> UN DESA

<sup>30</sup> UNHCR October 2017

<sup>31</sup> World Bank Group. 2016. An Assessment of Uganda's Progressive Approach to Refugee Management. World Bank, Washington, DC. © World Bank. <https://openknowledge.worldbank.org/handle/10986/24736> License: CC BY 3.0 IGO.

<sup>32</sup> UNHCR comprehensive Refugee Response Framework Uganda, The way forward (2017) <http://www.unhcr.org/comprehensive-refugee-response-framework-in-uganda.html>

<sup>33</sup> UN agencies, the World Bank, the Government of Uganda, donors, development partners and the private sector

<sup>34</sup> HIV Knowledge, Attitudes and Practices and Population Size Estimates of Fisher folk in Six Districts in Uganda 2013

## TANZANIA

### Ensuring continuity of care for refugees

**CONTEXT:** In 2015, Tanzania experienced a rapid influx of population from Burundi following unrest and violence.<sup>35</sup> By the end of 2016, 249,000 Burundian refugees sought refuge in the Country.<sup>36</sup> The rapidity and volume of the influx led to an abrupt increase of needs for diagnosis material and medicines for the newly arrived population straining the available services.

**PRACTICE:**

**Tanzania HIV program during the Burundian influx:** A multi-faceted approach was adopted thorough the collaboration of the Ministry of Health, UNHCR, UNICEF and the project partners under the leadership of MOH that allowed starting and sustaining the HIV diagnosis, treatment and care services since the beginning of the emergency influx. Prevention Mother and Child Transmission (PMTCT), voluntary counselling and testing (VCT), anti-retro viral treatment (ART), treatment of opportunistic infections and food supplementation to HIV patients started at the very early stage of the emergency. Providing adequate number of HIV test kits to continue the PMTCT and VCT services has been identified as a challenge due to abrupt increase of the need in the region, UNICEF and UNHCR provided supplementary quantities of test kits to continue the services. The MOH maintained the ART supply from the beginning of the crisis to cover the entire needs and the WFP provided food supplementation for HIV positive patients. This joint effort has ensured continuation of care for refugees in Tanzania,

**RESULTS:** 1585 HIV positive refugee patients (both Burundian and Congolese) continued to have access to ART during the year 2017 while the emergency influx of Burundian refugees was going on.

*(Source: United Nations High Commission for Refugees)*

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<sup>35</sup> <http://www.refworld.org/publisher,OCHA,,BDI,558911404,0.html>

<sup>36</sup> <http://www.unhcr.org/59244aa77.pdf>



## REGIONAL INITIATIVES

### Key successful strategies from CDC-funded West Africa work in addressing health security and preparedness

**CONTEXT:** Local, regional and global human mobility is a complex and dynamic phenomenon, which can amplify the spread of communicable diseases and the impact of public health events. Global epidemics such as SARS, H1N1 and H5N1 influenza, and MERS Co-V have highlighted this fact. In 2005, WHO African region outlined the core capacities to be put in place to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade. The Ebola Crisis of 2014-2016 in West Africa served as the most recent reminder of the immense work still to be done in realizing these capacities and presented two crises in one: (i) *a crisis of a virulent, epidemic disease* with 27,237 ill persons and 11,158 deaths<sup>37</sup> including 869 health care worker infections and 507 deaths<sup>38</sup> and (ii) *a crisis of systems* that were unable to address the challenge of EVD to health services, public health, and the consequential crippling effect on all other governmental systems: education, food security, finance, and more, requiring effective solutions to concurrently address both. To respond to these gaps, in 2015, IOM and U.S Centres for Disease Control and Prevention (CDC), entered into a cooperative agreement to implement a project to build the capacities of six West African states, which supported the collaborative project, to better prevent, detect and respond to disease outbreaks and other health threats.

**PRACTICE:** The scope of this project has since expanded to include Ghana, Guinea Bissau, Guinea, Liberia, Mauritania, Mozambique, Senegal and Sierra Leone, addressing four of the 11 action packages of the Global Health Security Agenda<sup>39</sup> (GHSa): Surveillance, emergency operations centres (EOCs), public health and law enforcement, and medical countermeasures. IOM will continue operating in five countries (Ghana, Guinea, Senegal, Sierra Leone and Mozambique) through 2019. The project is grounded in IOM's Health, Border, and Mobility Management (HBMM) framework, which provides a platform to develop country-specific and multi-country interventions by focusing on international border crossings; on travel routes and congregation points where travellers interact with each other and with the surrounding communities and their health systems.

**RESULTS:** This collaborative project has focused on three priority areas for the implementation of this project: 1) Point of Entry capacity development per the International Health Regulations (IHR); 2) Border health risk mitigation through strengthened surveillance and 3) Bilateral and regional IHR coordination. Through its work on these priority areas, this best practice has facilitated the sharing of cross border information on health through participation in regional meetings such as that between Benin, Ghana, Nigeria and Togo, as well as cross-border coordination groups between Guinea and Sierra Leone; strengthened surveillance through the implementation and enhancement of community-based surveillance activities in Ghana, Guinea, Sierra Leone, which included the use of community health workers in responding to the most recent Measles outbreak in Guinea (2017); reinforced emergency response capacity through operationalization of Public Health Emergency Operations Centres in Guinea, and technical contributions to developing and revising Public Health Emergency Response Plans (PHERPs) in Ghana, Senegal and Sierra Leone; and developed the capacity of Points of Entry including through capacity assessments, logistical and procurement support, trainings on health screening and case management, and development of Standard Operating Procedures (SOPs).

**LESSONS LEARNED AND WAYS FORWARD:** This project and best practice highlights the benefits of strategically allocating resources towards building strong partnerships to improve the ability of country programs to detect and respond to events of public health concern. The EVD epidemic highlighted the importance of such partnerships, to move beyond the epidemic and to build capacities lacking before the epidemic, including EOCs, stronger laboratories and surveillance systems, and improved public awareness of the threats posed by infectious diseases. Learning from achievements made in each implementing country, relevant stakeholders should capitalize on the positive outcomes achieved to date and invest more efforts to strengthen the health systems of target countries to sustain activities and outcomes beyond the lifetime of the project.

(Source: International Organization for Migration)

<sup>37</sup> WHO Situation Report 10 June 2015

<sup>38</sup> Data as of 17 February 2015

<sup>39</sup> <https://www.ghsagenda.org/packages>



## Providing health and HIV care across borders in Southern Africa

**CONTEXT:** Development in Southern Africa significantly relies on road and rail routes connecting raw material resource extraction sites, industries, seaports, and population centres. The many 'mobile' migrant workers involved, notably transport workers, cross border commercial workers and others who are away from home and home countries frequently and for extended periods of time are at higher risk of exposure to HIV due to lack of knowledge on prevention and consequently risky sexual behaviour.

**PRACTICES: ILO transport corridor initiative:** This initiative targets cross-border mobile migrant workers and their families in Malawi, Mozambique, South Africa and Zimbabwe. In collaboration with cross-border institutions, companies and small or informal traders and communities regularly interacting with migrant workers in transportation and commerce, the ILO transport corridor initiative aims at improving key access to health services and HIV prevention mechanisms in transport corridors in Southern Africa. The transport corridor initiative has trained peer educators, notably executives of 128 "cross-border institutions" (customs agencies and other regulatory bodies) and of 76 transport companies in the implementation of HIV and AIDS programmes and for the regular distribution of condoms.

At the Ressano-Garcia border between Mozambique and South Africa, the project reached out to informal communities operating along the railways. An agreement was signed between ASSOTSI, an informal sector association, and customs authorities to ensure that informal workers are not excluded from access to HIV services at border areas. In Zimbabwe, the ILO facilitated the mobilization of leaders.

**RESULTS:** Over 42,000 transport workers, including long-distance truck drivers, are estimated to have benefited from the transport corridor initiative. The approach has taken into account local conditions and opportunities, in Zimbabwe for example, leaders from small business and informal sector associations have established a Saving and Credit Cooperative at one of the country's key border posts.<sup>40</sup>

**LESSONS LEARNED:** The liaison with small and informal traders and communities is critical to understand and address a number of key factors underlying vulnerability such as gender inequalities. Understanding and responding to local realities is central to sustainable change

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

## Engaging with diaspora for migration health: Ghana and Sierra Leone examples

**CONTEXT:** In Ghana and Sierra Leone, there is a great need to strengthen institutional capacities in key sectors such as in the health domain. In the reinforcement of capacities, the diaspora, has the potential to remarkably contribute in changing their home countries' critical situations. Therefore, it is crucial to keep them effectively engaged. This best practice is based on previous diaspora engagement projects that have been implemented by IOM, notably the Temporary Return of Qualified Nationals (TRQN) project, which was operational from 2006 until 2016. In the three phases of TRQN more than 1000 open positions were filled by qualified diaspora in a total of 14 countries. These assignments were demand-driven and contributed to the development of prioritized sectors such as health, information and communication technology and food security in the target countries.

**PRACTICE: Supporting the development of prioritized sectors** in targeted countries by strengthening the capacity of selected institutions by engaging qualified diaspora communities in the Netherlands. Specifically, to strengthen the Ghanaian and Sierra Leonean healthcare systems through the deployment of experienced diaspora health care professionals.

In addition to these physical assignments, the diaspora experts were further 'connected' to the target institutions through 50 estimated 'virtual' assignments. Through professional network groups, such as LinkedIn and meetings in the Netherlands, the connections were made sustainably and were extended to other diaspora experts and relevant institutions in the Netherlands and in the target countries. Overall, the diaspora experts were instrumental in creating and maintaining connections between institutions in the Netherlands and institutions in Ghana and Sierra Leone.

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<sup>40</sup> ILO Leaving no-one behind: Reaching key populations through workplace action on HIV and AIDS, case study 22, page 55-56  
International Labour Office, Geneva, 2014 ISBN: 978-92-2-128916-6 (print); 978-92-2-128917-3 (web pdf)

The prioritisation of key sectors per country was guided by: Priorities identified by the governments in the target countries; commitment and ownership of the relevant ministry and key institutions in the sector; availability of qualified diaspora in this sector in the Netherlands and complementarity to other brain gain projects working with diaspora engagement.

**RESULTS:** *In Ghana:* Development of Theory of Change (ToC) for key institutions; continue successful exchange and intervention in Ghana (for ICT and Health) under TRQN III; majority of assignments were undertaken by Ghanaians with Dutch nationality including: 46 hospital staff trained in healthcare management; 259 assignments in the health, education, food security, and ICT sectors; More than 70 Ghanaian Institutions benefitted directly and 30,000 health workers and students in Ghana benefitted from the IOM Diaspora projects.

*In Sierra Leone:* Increasing availability of quality health care in Koinadugu district: Human resources for health gaps and health care delivery needs were mapped. Increasing number of health care workers in Koinadugu district: 15 Diaspora Health care professionals were accredited and deployed in Sierra Leone. Strengthening capacity of local health care force: 7 health facilities supported ; Medical equipment for basic examination (e.g. blood pressure machine) were provided to hospital/ health Centre; 80 percent of diaspora health care workers recruited with high performance at the end of contract evaluation; 33 in-job training session conducted through diaspora health workers ; 120 local health workers benefitted from in-service training package; 15 percent of surgery cases carried out supported by the diaspora health care workers recruited in the district; 30 percent of births managed in facilities supported by diaspora health care workers recruited for the project; 30 interim and final performance evaluation reports of diaspora health care professionals. The Office of Diaspora Affairs (ODA) Web portal was restored for diaspora job description and project adverts. Collaboration with IOM UK was established to enhance the contact with several Sierra Leone diaspora organizations in the UK.

**LESSONS LEARNED AND WAY FORWARD:** It is important to note that the diaspora experts were generally well received by host institutions and encourages a call for more action and partnerships. With more funding, these projects can be enlarged and replicated in many more communities with a bigger diaspora involvement.<sup>41</sup>

(Source: International Organization for Migration)

## Mapping of health services along major transport corridors in East Africa

**CONTEXT:** Migrants and other populations associated with major transport hubs often face increasing vulnerability to infectious diseases and ill health due to conditions surrounding the migration process. While barriers are similar to those of other underserved populations, migrants face the additional burden of having to search for health care options while on the move. In 2013, under the umbrella of the East African Community (EAC) a regional task force on integrated health and HIV and AIDS programming along transport corridors in East Africa was established. Mapping of health services along major transportation corridors was conducted to inform the strategy<sup>42</sup>.

**PRACTICE:** Data was gathered from the five EAC Partner States Burundi, Rwanda, Uganda, Tanzania and Kenya. Information was collected through records review and a quantitative survey of health workers and facilities providing health services for key populations at selected hotspots along different transport corridors. The survey targeted all functional public, private and Civil Society Organizations-supported health facilities. Overall a total of 341 health facilities were surveyed.

**RESULTS/FINDINGS:** Majority of the surveyed health facilities were government owned in Burundi, Rwanda and Tanzania. In Uganda and Kenya, the majority of the facilities were privately owned and provided only primary health care. Several health facilities partnered with Civil Society Organizations (from 46 percent in Uganda to 79 percent in Rwanda). Key population groups<sup>43</sup> represented 16 percent of the total adult facility caseload per month. Health services needs of key and vulnerable populations included: infectious diseases, STI screening and treatment (including HIV counselling and testing) and accidents. Almost all facilities utilized a Health Management Information System and most collected information on key and vulnerable populations. Nurses and nursing aides comprised more than two thirds of professional while doctors were mainly found in

<sup>41</sup> IOM, *Diasporas and Development: Bridging Societies and States*. 2013.: [https://www.iom.int/files/live/sites/iom/files/What-We-Do/idm/workshops/IDM-2013-Diaspora-Ministerial-Conference/DMC\\_Final\\_Conference\\_Report.pdf](https://www.iom.int/files/live/sites/iom/files/What-We-Do/idm/workshops/IDM-2013-Diaspora-Ministerial-Conference/DMC_Final_Conference_Report.pdf)

<sup>42</sup> <http://repository.eac.int/bitstream/handle/11671/599/Mapping%20of%20Health%20Services%20Along%20Major%20Transport%20Corridors%20in%20East%20Africa.pdf?sequence=4&isAllowed=y>

<sup>43</sup> Key population groups for the study were: Trucker drivers, other transport drivers, female sex workers, uniformed personnel, PWID, LGBT, trafficked persons, other migrant workers

hospitals. Provision of HIV and TB treatment was low, only 40 percent of facilities reported providing HIV treatment services and only 31 percent of the facilities offering TB treatment.

**Lessons learned:** The study shown that segregating data and including information on migration status in the Health Management Information System and analysing them is important to identify migrants' health needs and gaps in health service delivery for migrant population. The study as well revealed that one of the major reported barriers to accessing health services was the lack of client-friendly, migrant-sensitive services.

*(Source: East African Community)*

## Strengthening labour inspection

### CONTEXT:

Labour inspection and implementing labour inspectorates are a key means of monitoring, upholding and enforcing labour standards, notably regarding occupational safety and health, at workplaces. Labour inspection can be an especially effective means of extending occupational safety and health protection and establishing decent working conditions for migrant workers. Spurred by the ILO-AIDS programme work and the ILO HIV and AIDS Recommendation, 2010 (No. 200), addressing HIV and AIDS has increasingly become an important component of labour inspection and in training of labour inspectors. To support implementation of HIV and AIDS Recommendation, 2010 (No. 200) and to specifically enhance the knowledge, roles and engagement of labour inspectorates regarding HIV and AIDS workplace awareness and prevention, ILO and the ILO International Training Centre (ITC) in Turin developed HIV and AIDS components for the training programs and modular training manuals. The support also targeted labour inspectors in countries in Africa, the Caribbean, Eurasia and Latin America for HIV-focused training and national strategies to advocate for and implement HIV and AIDS legislation and workplace responses.

### PRACTICES:

In **Mozambique**, occupational safety and health inspectors have been targeted for training. Training to mainstream HIV into the work of labour inspectors have also been held in **Ghana**. In **Ethiopia**, the Ministry of labour has developed a checklist to guide inspections targeting HIV and AIDS. In **Senegal**, the Labour Inspectorate also developed a methodological guide to harmonise intervention methods and practices of inspectors at the workplace. In **Namibia**, the Directorate of Labour Services completed specific inspections focusing on HIV-related discrimination in the workplace and labour inspectors aim to reach all workers with HIV prevention information and activities such as condom distribution among truck drivers. In **Kenya**, the Ministry of Labour Strategic Plan calls for a reduced workload and provision of sick leave for affected workers as well as labour inspectors are called upon to train workers and employers regarding their rights and obligations in relation to HIV and AIDS.

*(Source: International Labour Organization)*

## Partnership on health and mobility in East and Southern Africa (PHAMESA)

### CONTEXT:

East and Southern Africa experience high levels of population mobility and the largest HIV and TB epidemics in the world which makes migrant health a critical issue in the Region. However, existing interventions often fail to consider the impact of the conditions surrounding the migration process, which exposes migrants and host populations to various risks that make them vulnerable to ill health. The global policy context has evolved in recent years into a more public health-based approach, which is centred on the health of migrants as response to global health challenges, the PHAMESA program responds to the WHA Resolution 61.17 on health of migrants. From previous two programs focused on HIV and TB in Southern Africa, PHAMESA has evolved in scope scale and structure. The overall objective of the program is to contribute to improved standard of physical, mental and social wellbeing of migrants and migration-affected population.

### PRACTICE:

Since 2003, IOM has implemented regional programs addressing health vulnerabilities of migrants and migrant-affected communities in East and Southern Africa. The initiative fosters partnerships among governments, UN agencies, private sector and civil society; monitors migrant health through assessments on needs, vulnerabilities and gaps on services for migrant population; supports provision of health services in health structures; provides capacity building of implementing partners including state employees such as

police, health and social services staff about migration and health with an important focus on gender and delivers training to Community Health Workers on Social Behaviour Change Communication.<sup>44</sup>

**RESULTS:** 758 sites in various countries in East and Southern Africa are providing sensitive health services for migrants and communities affected by migration; 85 networks of strategic partnership have been identified, strengthened and improved to support programming gaps; 178,413 direct beneficiaries through the IOM health promotion and delivery model. 22 beneficiary or client satisfaction surveys were conducted

**LESSONS LEARNED:** PHAMESA play a catalytic role in mobilising resources among stakeholders in country and regional levels. However, the programme is managed by objectives and interventions and does not articulate overall programme results, making difficult to monitor and manage results. PHAMESA has evolved as a regional program but one of its challenges is that being anchored in a centralized management structure linked with one country office which limits the level of collective ownership and accountability. The greatest added value of PHAMESA involves Increasing visibility, increase partnership around resources and expertise and facilitating policy formulation and implementation at national and regional levels.<sup>45</sup>

*(Source: International Organization for Migration)*

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<sup>44</sup> <https://ropretoria.iom.int/sites/default/files/document/PHAMESA%20blurb.pdf>

<sup>45</sup> [https://www.sida.se/contentassets/2e8d09e7a9ab4fb6969ff63a7b61db7c/iom-partnership-on-health-and-mobility-in-east-and-southern-africa-phamesa\\_3851.pdf](https://www.sida.se/contentassets/2e8d09e7a9ab4fb6969ff63a7b61db7c/iom-partnership-on-health-and-mobility-in-east-and-southern-africa-phamesa_3851.pdf)