



# Promoting the health of refugees and migrants

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Experiences from around  
the world



World Health  
Organization

## **WHO Health and Migration Programme (PHM)**

The WHO Health and Migration Programme (PHM; Office of the Deputy Director-General, WHO headquarters, Geneva) brings together WHO's technical departments, regional and country offices, as well as partners, to secure the health of refugees and migrants and achieve universal health coverage. It provides global leadership in refugee and migrant health issues and provides technical assistance to the implementation of policies on promoting refugee and migrant health. The Programme's objective is to ensure that refugees and migrants get the support they need to lead healthy and productive lives. This will benefit both them and the communities that host them.

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Promoting the health of refugees and migrants: experiences from around the world

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# Foreword

**T**oday, almost 13% of the people worldwide are either refugees or migrants. Many are on the move, driven by conflict, climate change, drought, famine, poverty and other global health emergencies – and the hope of a better life for themselves and their families. Refugees and migrants often suffer from poor health and have challenges accessing services due to discrimination; poor living conditions; and financial, linguistic and cultural barriers.

At the World Health Assembly in 2019, Member States agreed on a five-year global action plan to promote the health of refugees and migrants. It laid down six priority areas of action and several objectives for WHO's work in the field of refugee and migrant health. And this has been the compass of our work.

In July 2022 WHO published the first world report on the health of refugees and migrants, providing a comprehensive overview of their health status and highlighting good practices to safeguard their health.

This compendium of country examples from around the world features the impressive commitments and advancements that have occurred at country and local levels on work to improve refugee and migrant health. Our aim is to voice the positive experiences by showcasing integrated and innovative examples from a range of countries in promoting the health of refugees and migrants. We provide practical considerations, drawn from the findings of 49 case studies from around the world, from low- to high-income countries, which have generated information supporting the development of policies, programmes and actions. It is important to acknowledge that there are many other important projects underway around the world that were not submitted and, therefore, are not included in this publication. The intention is to develop a live repository or compendium of projects, which will optimize sharing and learning.

A key point is also to reflect that the work is far from being over. WHO will continue to provide technical assistance in addressing the root causes of disease; creating the conditions for good health and well-being for all; reorienting health systems to include integrated and inclusive health services and programmes for refugees and migrants; raising public awareness about the health of refugees and migrants; promoting high-quality research and information; and building capacity to support evidence-informed policies and actions in refugee and migrant health.



Action at country level has been fundamental to advancing progress towards national, regional and global commitments, including the Sustainable Development Goals, the Global Compact for Safe, Orderly and Regular Migration and the Global Compact on Refugees. This will help to drive progress towards the WHO Triple Billion Targets and improve health and well-being for all, regardless of a person's legal status or origin.

Protecting and promoting the health of those who have been displaced from their homes and communities is not a burden, it is a responsibility for all of us.

**Dr Santino Severoni**  
**Director**  
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Ana Carolina Baptista (University of Maastricht, the Netherlands) carried out the initial non-systematic review of experiences in refugee and migrant health and supported the development of the call for contributions for case examples on promoting the health of refugees and migrants.

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# Abbreviations and acronyms



CALD Service	Culturally and Linguistically Diverse Service (New Zealand)
CoP	community of practice
COVAX	COVID-19 Vaccines Global Access
EU	European Union
GAP	Global action plan to promote the health of refugees and migrants
GBV	gender-based violence
GP	general practitioner
IDP	internally displaced person
IOM	International Organization for Migration
MHPSS	mental health and psychosocial support
NCD	noncommunicable disease
NDVP	national deployment and vaccination plan

NGO	nongovernmental organization
NHS	National Health Service
PAHO	Pan American Health Organization
PoC	persons of concern
RESAMI	Réseau Santé et Migration
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2 (causing COVID-19)
SDG	Sustainable Development Goal
SGBV	sexual and gender-based violence
SRH	sexual and reproductive health
SRHR	sexual and reproductive health rights
TB	tuberculosis
UHC	universal health coverage
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children’s Fund



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# Introduction

**T**his report was based on the responses to the call for countries to submit information about promising practices and experiences in promoting the health of refugees and migrants formulated and/or implemented since May 2019. The aim was to showcase how different countries – with different health systems and different challenges and facilitators to implementation of health care for all – have implemented practices to promote the health of refugees and migrants. The country case examples do not assess or evaluate implementation but explore collaboration among different organizations and stakeholders,

governance models to promote the health of refugees and migrants and the lessons learned during implementation of practices. The country and local experiences have been used to support provision of general policy considerations for progression of health and well-being for all, including refugees, migrants and the host populations they live with. This report contains an initial set of 49 case studies to form the basis of a live repository of projects that it is hoped will be further populated by Member States and partners to facilitate sharing and learning on refugee and migrant health.



# Background

There are over 1 billion migrants globally, about one in eight of the global population. These include 281 million international migrants (2020) and 763 million internal migrants (2005). The number of forcibly displaced people reached 101.1 million in June 2022.

Migration and displacement are key determinants of health and well-being. Refugees and migrants remain among the most vulnerable members of society, often faced with

xenophobia; discrimination; poor living and working conditions; and inadequate access to health services, despite frequently occurring physical and mental health problems.

The public health impact of population movement is undeniable. A detailed overview of the health of refugees and migrants and the associated public health challenges are provided in the 2022 WHO *World report on the health of refugees and migrants*.<sup>1</sup>

## Key points from the WHO World report on the health of migrants and refugees

- **Migrant workers face discrimination**, exploitation and limited workplace rights and social protection, as well as significant occupational health problems.
- **Male migrant workers appear to be at a higher risk of occupational injuries**, mainly because of their employment in high-risk industries, such as mining and construction.
- **Migrant workers may be excluded from legal frameworks** on the reporting of occupational accidents and diseases in many countries.
- **Refugee and displaced women have poorer health outcomes** compared with migrant and host country populations.
- **Sexual and gender-based violence (SGBV)**, including intimate partner violence, is frequently experienced by refugees and migrants, particularly women, during displacement and after arrival.
- **Female genital mutilation is practised among some refugee and migrant groups** whose countries of origin still widely carry out the practice.
- **Access to maternal and child health services** is often more difficult for refugees and migrants than for women and children of the host country and this includes low levels of attendance for antenatal care.
- **Higher rates of anaemia in women and children are found among refugees and migrants** compared with local populations in most WHO regions and there is an increased risk of both anaemia and malnutrition in some camp-based settings.
- **Refugee and migrant women may face various challenges with infant-feeding practices**, notably unfamiliarity with local health care and societal norms and exposure to poor-quality substitutes for breastmilk.
- **Noncommunicable diseases (NCDs) are an increasing health burden among refugee and migrant populations**, often linked to longer residence in the host country, particularly in middle- and high-income host countries.
- **Cancer is often diagnosed at later stages among refugees and migrants**, who often have lower uptake of, or access to, preventive measures. Similarly, diabetes and hypertension are left undiagnosed and uncontrolled for some refugees and migrants and have a higher prevalence than in the host population.
- **Changes in lifestyle as migrants integrate within host communities** may contribute to an increased risk of poorer nutritional status and higher levels of obesity.
- **The prevalence of depression and anxiety can be higher among refugees and migrants** at different stages of the migration experience, resulting from various individual, social and environmental factors.

<sup>1</sup> WHO (2022). World report on the health of refugees and migrants. Geneva: World Health Organization (<https://apps.who.int/iris/handle/10665/360404>, accessed 19 November 2022).

### Key points from the *WHO World report on the health of migrants and refugees* contd

- **Conflict- and war-affected refugees and migrants** display higher levels of post-traumatic stress disorder and other mental health issues, particularly younger migrants and adolescents.
- **Refugee, asylum-seeking and irregular migrant children** display a higher prevalence of mental health issues compared with host populations.
- **There is evidence that the incidence of psychoses is higher among migrant populations** in a number of countries, linked to the cumulative effect of social disadvantages before, during and after migration.
- **Evidence indicates that refugees and migrants do not spread diseases in host countries**, but their susceptibility to infection is increased by the environmental risk factors related to their living and working conditions.
- **Delayed HIV testing and diagnosis** are major challenges for refugee and migrant populations.
- **Tuberculosis (TB) data show a recently increased prevalence among refugee and migrant populations** in the countries hosting the largest numbers. However, overall prevalence in many host countries remains low.
- **Multidrug-resistant and latent TB affect refugees and migrants** at higher levels than host populations; evidence varies regarding the prevalence of extrapulmonary TB.
- **Multidrug-resistant and latent TB affect refugees and migrants** at higher levels than host populations; evidence varies regarding the prevalence of extrapulmonary TB.
- **Malaria is an emerging concern** in low-transmission and non-endemic areas that are also destination countries.
- **Various tropical and parasitic diseases** largely endemic to one or more WHO regions risk spreading to other regions if timely diagnosis and treatment are not provided to mobile populations.
- **Risk factors for the spread of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)** and resulting COVID-19 can be exacerbated among refugees and migrants, such as crowded living conditions or occupations in which working from home is not possible; in addition, national and local policies may exclude refugees and migrants from pandemic-related health services.
- **In countries where essential health care workers include significant numbers of migrants**, such workers were at a much greater risk of severe COVID-19 than non-essential workers.

The access of refugees and migrants to quality health services is of paramount importance to rights-based, responsive and sensitive health systems, global health security, health promotion and public efforts aimed at reducing health inequities and meeting global commitments. These commitments include those set in the 2030 Agenda for Sustainable Development and its 17 Sustainable Development Goals (SDGs), particularly SDG 3 on health, SDG 5 on gender equality, SDG 10 on reducing inequalities and SDG 16 on promoting peace and ending violence. Target 3.8 on universal health coverage (UHC) provides an opportunity to promote a more coherent and integrated approach to health beyond the treatment of specific diseases, and to provide it for all populations, including refugees and migrants, irrespective of their legal status. However, UHC is only a reality if health systems take account of all community members, including refugees and migrants.

In 2018 the United Nations General Assembly adopted the Global Compact on Refugees and the Global Compact for

Migration, in which the concept of access of refugees and migrants to quality health services is also encompassed. The 2019 United Nations political declaration on UHC specifically reflects the inclusion of refugees and migrants, clearly stating that “no one should be left behind” and calls on States to address the needs and vulnerabilities of migrants.

While several advancements have been made at country and local level, there is still much room to prioritize and promote the public health aspects of migration, addressing the root causes of disease, creating the conditions for good health and well-being for all, and supporting Member States in working for UHC.

Investing in refugee and migrant health will make a vital contribution to the overall improvement of global health, allowing the health and well-being of migrants to be addressed in an inclusive and comprehensive manner as part of holistic efforts to respond to the health needs of all.

At the World Health Assembly in 2019, Member States agreed a five-year global action plan to promote the health of refugees and migrants (GAP).<sup>2</sup> Created in alignment with global frameworks, the GAP asserts the need for improving the health and well-being of refugees and migrants by

focusing on achieving UHC and the highest attainable standard of health for all populations. It laid down six priority areas of action and several objectives for WHO work in the field of refugee and migrant health.



**1** Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions.



**3** Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms.



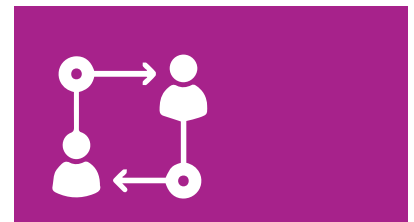
**5** Strengthen health monitoring and health information systems.



**2** Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures.



**4** Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage.



**6** Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health.

<sup>2</sup> WHO (2019). Global action plan on promoting the health of refugees and migrants, 2019–2023. In: Seventy-second World Health Assembly, Geneva, 20–28 May 2019. Geneva: World Health Organization (WHA72/2019/REC/1; <https://apps.who.int/iris/handle/10665/328690>, accessed 10 December 2022).



# Aim of this report

The purpose of this report is to map promising practices and experiences in promoting the health of refugees and migrants. These grounded experiences showcase how the GAP has been implemented at national and subnational levels to foster and ensure collaboration across governments on refugee and migrant health.

This report offers a snapshot of country and local experiences in advancing the GAP, including an overview of common challenges and facilitators to implementation, and provides general policy considerations on how WHO Member States can continue progressing in this subject.

The country case examples do not assess or evaluate implementation but explore the types of collaboration on the ground among different organizations and stakeholders, the governance models to promote the health of refugees and migrants and the lessons learned from the implementation of practices.

These examples will form the basis of a live repository of projects that Member States and partners will be invited to populate. It will facilitate sharing and learning on refugee and migrant health.

# Target audience

This report is intended for stakeholders working towards promoting the health of refugees and migrants. These stakeholders include high-level decision-makers responsible for setting policies, strategies and plans and for developing budgets for refugees and migrants at national and subnational levels. The report is also designed to support

wider health communities: specialists in health financing, gender specialists, health insurance authorities, national statistical offices, monitoring specialists, advocates, researchers, consultants and civil society organizations active in the field of refugee and migrant health.

# Methodology

WHO Member States were invited to submit voluntary contributions between July and August 2022 to a compilation of promising practices, at country level, in promoting the health of refugees and migrants. The focus of the call was on submissions about projects formulated and/or implemented with government involvement after the GAP adoption in May 2019.

Data were collected through an online questionnaire. When needed, additional information was requested to key focal points of each submission.

The first step in developing the online questionnaire was to carry out a mapping exercise of the priorities, objectives

and options for support included in the GAP. This helped to formulate closed- and open-ended questions. A document containing relevant information, such as the purpose of the call, the advantages of participating, the requirements for the submissions and the questions included in the survey was developed and is available ([https://cdn.who.int/media/docs/default-source/health-and-migration-programme/call-for-submissions-accompanying-document.pdf?sfvrsn=b14b1683\\_10](https://cdn.who.int/media/docs/default-source/health-and-migration-programme/call-for-submissions-accompanying-document.pdf?sfvrsn=b14b1683_10)).

A pre-prepared coding framework (Annex 1) was used to assess all submitted projects for alignment with each of the WHO GAP priorities. The open call resulted in submission of 72 examples of projects (policies, programmes and/

or interventions) implemented across 39 Member States (Annex 2).

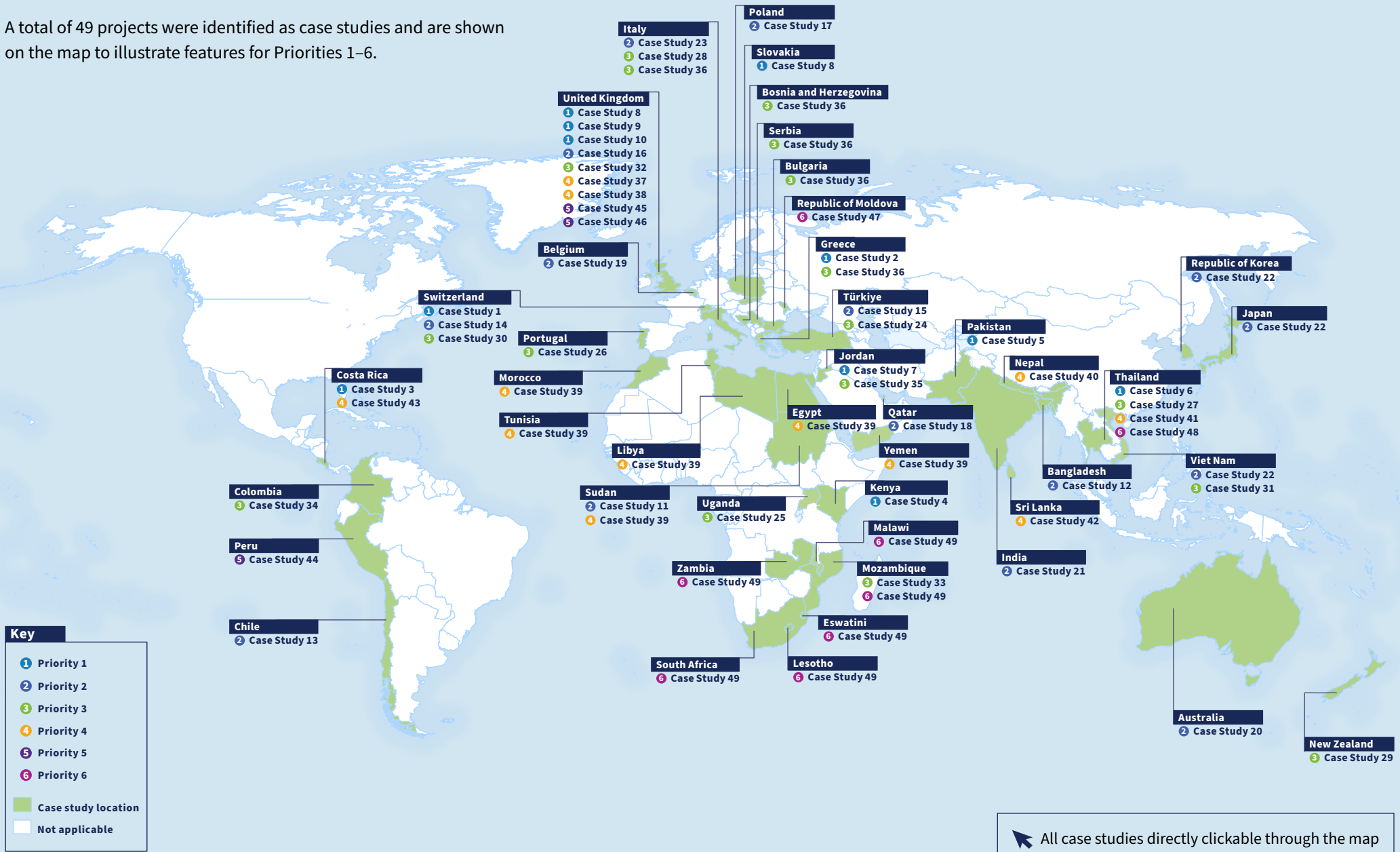
The choice of case examples for each priority area was based on the following criteria:

- representation of the six WHO regions (African, Americas, South-East Asia, European, Eastern Mediterranean and Western Pacific);
- demonstrated implementation of a specific policy/ programme/intervention to promote the health of refugees and migrants;
- showed intersectoral collaboration; and
- had evidence of sustainability or project scale-up.

Most of the projects aligned with more than one GAP priority, reflecting the cross-cutting elements of health promotion activities in terms of aims, actors and activities. In order to ensure that all six priority areas and all WHO regions were represented in the included case studies, a mix of projects was selected from each region to exemplify the implementation of priority areas, even if the alignment was a relatively minor element of the overall project. This might mean, for example, that a larger project with a major alignment with Priority 1 might be selected to exemplify Priority 5 if it contained a health information system component and there were no other Priority 5 exemplars for that region.

# Examples from around the world

A total of 49 projects were identified as case studies and are shown on the map to illustrate features for Priorities 1–6.



All case studies directly clickable through the map



# PRIORITY

**Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions**



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Priority 1 inspires the promotion of physical and emotional health of refugees and migrants, with a focus on groups in vulnerable situations, through developing emergency and humanitarian public health responses, responding to communicable disease outbreaks, providing health promotion, and developing initiatives that support disease prevention, timely diagnosis and treatment across health care services. There are 10 case studies presented for Priority 1.

Case studies 1–5 are examples of emergency and humanitarian responses specifically to the COVID-19 pandemic, demonstrating support for equitable access to COVID-19 vaccines.

Case study 1 provides details of a wide-ranging vaccination campaign with a particular focus on promoting the vaccine rollout among undocumented migrants in the Canton of Vaud, Switzerland. Case studies 2 and 3 present similar approaches adopted in Greece and Costa Rica, respectively, in supporting access to COVID-19 vaccinations for migrants in a regular and irregular situation and for refugees and asylum seekers. Case study 4 outlines how modifications to existing pre-migration health activities were operationalized at a health assessment centre in Kenya to include predeparture COVID-19 testing and vaccination services. Case study 5 describes a mobile COVID-19 vaccination initiative, showcasing how so-called “integrated health service camps” were operationalized in supporting equitable access to vaccines for refugees and marginalized populations in Pakistan.

Case study 6 is presented as an example of targeted health promotion interventions that support disease prevention and management for refugees and migrants other than through vaccination programmes. Migrant health volunteers were used as an approach to providing refugee- and migrant-sensitive health promotion initiatives and responding to health needs of hard-to-reach migrants in Thailand.

Case study 7 refers to the use of a well-established working group for preparedness and readiness for vulnerable refugee populations that has been used to prevent different public health emergencies.

The remaining three case studies are from the United Kingdom and are presented as examples of responsive initiatives that support timely diagnosis and health treatment for refugees and migrants with a particular focus on groups in vulnerable situations. Case study 8 illustrates a targeted approach to health screening and referral pathways for asylum-seeking families in initial accommodation sites. Case study 9 describes the development of a health assessment toolkit in primary care settings in response to a growing number of refugees from Afghanistan, which offers guidance on carrying out holistic initial health assessments for new migrants. Case study 10 is an example of a targeted holistic health assessment, including health screening, for unaccompanied asylum-seeking children within the first two weeks of arriving in the United Kingdom.



## Case study

## 1

Country:  
**Switzerland**

**Title:** COVID-19 vaccination programme for undocumented migrants in a regional centre of general medicine and public health, Canton of Vaud

In Switzerland, COVID-19 vaccinations were available in vaccination centres, hospitals and general practitioner (GP) surgeries for the general population. Access to these services requires evidence and, therefore, undocumented and uninsured migrants were unable to access the services and COVID-19 vaccination.

With more than 800 000 inhabitants, the Canton of Vaud is the third most populous canton in Switzerland and represents 10% of the total population of the country. In May 2021 a health centre initiated a vaccination programme for uninsured undocumented migrants. A multidisciplinary working group composed of administrative, medical, nursing and pharmacy managers, with expertise in vaccination and migrant populations, was formed to implement the programme.

Through collaborations between the health authorities, the regional centres and community partners, a free walk-in COVID-19 vaccination service was implemented. Many documents were adapted and translated because of the low French proficiency of a significant part of this population, and interpreters were available. A widespread communication campaign was initiated and approximately

50 community partners were informed about the vaccination programme. These community partners played a critical role in promoting the COVID-19 vaccination programme and sharing communication campaign messages (translated into 10 different languages) through existing online social groups and community-associated media.

From the first six months of this initiative, 2242 undocumented migrants from 97 different nationalities were considered fully vaccinated.

The coordination between health authorities, the regional medical centres and community partners, as well as the long-term upstream work required to build and maintain trust with these populations, was key to the success of this programme. The logistical barriers, the short delay in obtaining COVID-19 vaccinations and the heavy workload of health staff during the public health emergency were some of the challenges encountered. It was also difficult to establish the effectiveness of this vaccination programme in terms of proportions of undocumented migrants reached because of the lack of recorded data regarding undocumented migrants in the Canton of Vaud.

“ From the first six months of this initiative, 2242 undocumented migrants from 97 different nationalities were considered fully vaccinated. ”

## Case study

## 2

Country:  
**Greece**

**Title:** COVID-19 vaccinations for refugees and migrants, including undocumented migrants

The context for this project was a lack of inclusion of vulnerable refugee and migrant populations in the Greek national COVID-19 vaccination programme. An initiative was

commenced to increase vaccination of refugees and migrants, irrespective of their legal status, as part of the nationwide vaccination programme against COVID-19, which started in

January 2021 and is still ongoing. This intervention is taking place at national level, in reception centres, in open and closed refugee camps, in refugee accommodation centres and also in the community. It specifically targets people who do not have a social security number or necessary documents to access health care services. Social security numbers are issued to those with refugee status and those awaiting the outcome of the asylum application process.

Special provisions were, therefore, made for people without social security numbers, including people without legal documents. Through a series of ministerial decisions, a procedure was put in place so that these individuals could be issued with a temporary social security number solely for the purposes of COVID-19 vaccination. In order to facilitate this, particularly in the case of migrants without documents, all relevant administrative procedures could also take place at community centres or migrant integration centres in municipalities, either by the applicant in person or in cooperation with participating nongovernmental organizations (NGOs). Individuals with the temporary social security number were then able to access COVID-19 vaccination through NGOs (Médecins Sans Frontières, Médecins du Monde – Greece, PRAKSIS, Hellenic Red Cross and the Syrian American Medical Society) at municipal clinics or mobile clinic units. A smaller working group was also established for coordination purposes.

The implementation of this initiative was facilitated by the extensive collaboration between government bodies, regional and municipal authorities, international organizations, the National Public Health Organization implementing the programme PHILOS – Emergency Health Response to Refugee Crisis, Health Units SA and NGOs. An informal health working group established under the auspices of the United Nations High Commissioner for Refugees (UNHCR) in Greece in 2016, and to which many of the stakeholders belong, contributed to the policy coordination and promotion.

The project was additionally facilitated by the political will to protect the health of vulnerable refugee and migrant groups as well as that of the general population. The well-established channels of communication and collaboration between ministries, state actors, international organizations and NGOs working with refugees and migrants also contributed to its success. The project faced several challenges, including initial administrative and legal issues regarding the issuance of temporary social security numbers and the vaccination of people without legal documents; migrants' lack of trust in government agencies and official state institutions; and COVID-19 vaccine hesitancy more generally.

“ Through a series of ministerial decisions, a procedure was put in place so that these individuals could be issued with a temporary social security number solely for the purposes of COVID-19 vaccination. ”

## Case study

# 3

Country:  
**Costa Rica**

**Title:** vaccination against COVID-19 for refugees, asylum seekers and migrant populations in regular and irregular situations in the health establishments of the Costa Rican Social Security Fund

The Costa Rican Social Security Fund<sup>3</sup> began a COVID-19 vaccination campaign in 2021 to specifically include refugees, asylum seekers and migrant populations in regular and irregular situations. The leadership of the

Vice Ministry of Health worked in collaboration with other governmental structures: the International Organization for Migration (IOM), the Pan American Health Organization (PAHO)–WHO, UNHCR and the General Directorate

<sup>3</sup> Costa Rica vacuna a población migrante regular, irregular y refugiada residente en el país que cumpla requisitos establecidos en manual de vacunación vigente. San Jose: Ministry of Health; 2021 (<https://www.ministeriodesalud.go.cr/index.php/prensa/43-noticias-2021/1117-costa-rica-vacuna-a-poblacion-migrante-regular-irregular-y-refugiada-residente-en-el-pais-que-cumpla-requisitos-establecidos-en-manual-de-vacunacion-vigente>, accessed 10 December 2022).

of Migration were all instrumental to the success of this initiative.

This case study illustrates how COVID-19 vaccination procedures were modified in health establishments such as these to include migrants in regular and irregular situations. In particular, the requirements section for vaccination was updated to specify that a foreign person with an

identification document but in an irregular situation can be vaccinated.

The lack of available vaccines at the time was a particular challenge. The inter-institutional and interagency work and the leadership of the Ministry of Health and the Costa Rican Social Security Fund facilitated the implementation of this intervention.

“ In particular, the requirements section for vaccination was updated to specify that a foreign person with an identification document but in an irregular situation can be vaccinated. ”

## Case study

# 4

Country:  
**Kenya**

**Title:** COVID-19 vaccine administration for refugees and migrants in Nairobi

The IOM Migration Health Assessment Centre in Nairobi, Kenya, provides comprehensive vaccination programmes in the context of migration on behalf of various receiving countries and has collaborated with the Kenyan Ministry of Health in other health areas. The Centre has a sufficiently robust infrastructure to support vaccination storage and delivery, and members of staff undergo regular training in vaccination activities in line with international best practice standards.

Consequently, the IOM Migration Health Assessment Centre was designated an official COVID-19 vaccination facility. In collaboration with the IOM, the Ministry of Health supported

the provision of additional training on COVID-19 vaccination activities for IOM health and data staff. The Ministry of Health additionally donated initial vaccines for administration by IOM staff.

This arrangement has supported the administration of COVID-19 vaccinations to refugees and migrants as part of existing pre-migration health processes and in various health settings, including public, private and NGO providers. The IOM Migration Health Assessment Centre also provides pre-departure COVID-19 testing for refugees and migrants.

“ The Centre has a sufficiently robust infrastructure to support vaccination storage and delivery, and members of staff undergo regular training in vaccination activities in line with international best practice standards. ”



## Case study

## 5

Country:  
**Pakistan**

**Title:** enhancing COVID-19 coverage through mobile vaccination services for Afghan refugees, nomads and marginalized populations

The COVID-19 pandemic has impacted significantly on the health of Afghan refugees in Pakistan by further reducing access to health care and medicines, including vaccinations. Cognizant of the situation, WHO in Pakistan established COVID-19 mobile vaccination services to ensure equitable access to vaccines across Pakistan, particularly for Afghan refugees and marginalized populations.

Seven mobile outreach teams were allocated to Afghan camps and areas of Karachi, and two mobile outreach teams were allocated to Hyderabad. As of 6 July 2022, a total of 155 328 vaccine doses were administered by outreach teams to refugees settled in Karachi and Hyderabad. These included 78 887 and 76 441 first and second doses, respectively. Four mobile COVID-19 vaccination centres were additionally deployed to refugee camps in Islamabad. WHO supported human resourcing and logistics and provided four vehicles for mobile vaccination. As a result, 68 412 COVID-19 vaccine doses have been administered to refugees in Islamabad, including 38 298 first doses and 30 114 second doses.

WHO also organized 63 integrated COVID-19 vaccination and medical camps catering for reproductive, maternal, newborn, child and adolescent health services and for an essential programme on immunization for Afghan refugees in 21 high-risk Union Councils of Islamabad. To maximize engagement and vaccine uptake, 35 volunteers (Afghan

students/Pashtuns) were identified to support registration and vaccination of Afghan refugees in these high-risk areas. With the support of social mobilizers, consultants and medical officers, WHO organized more than 280 health education sessions to raise awareness around preventive and protective COVID-19 measures and the importance of COVID-19 vaccination.

In Sihala, WHO supported and refurbished the Rural Health Centre and improved laboratory services by providing advanced equipment. This aligns with a wider aim to strengthen primary health care and work towards UHC by 2030. Through this model health facility, a significant number from the marginalized and refugee population of the adjacent area/villages have been able to access basic health services close to their homes. To enhance the understanding of COVID-19 risks and promote preventive measures, banners were displayed at the entry points. Information, education and communication materials were additionally provided for local Baithak and mosques in the five major Afghan refugee villages.

These consistent efforts have led to increased COVID-19 vaccination uptake and access among refugees and marginalized and nomadic populations (from 5% to 48% within a relatively short time frame). There is a need for continued funding and efforts to achieve a 100% COVID-19 vaccination rate.

“ These consistent efforts have led to increased COVID-19 vaccination uptake and access among refugees and marginalized and nomadic populations (from 5% to 48% within a relatively short time frame). ”

## Case study

## 6

Country:  
**Thailand**

**Title:** supporting case finding, community engagement and border health responses to COVID-19 among migrant communities

Migrant communities in Thailand experience an intersection of vulnerabilities, with limited access to social services, including health services and education for children.

The subsequent movement restrictions and disruption to income-generating activities as part of emergency measures implemented to contain SARS-CoV-2 transmission compounded the burden experienced by migrant workers employed in formal and informal settings.

In 2021 with funding from the United States Centers for Disease Control and Prevention, IOM and the World Vision Foundation of Thailand, a 10-month project was implemented in two border provinces of Thailand: Tak (Mae Sot district) and Ranong. These are major destination and transit zones for labour migration (regular and irregular) from Myanmar into Thailand. The project was designed to empower migrant populations to protect themselves and their communities from COVID-19.

The project arose through collaboration across government agencies, hospitals, NGOs and private sector partners. These included provincial and district public health offices, subdistrict municipalities, six hospitals in Tak and nine in Ranong, Help Without Frontiers, Right Beyond Borders, Human Rights and Development Foundation, the Mae Tao Clinic, the Marist Asia Foundation and Save the Children. In Ranong, private sector stakeholders included the Provincial Fisheries Association and the Provincial Fisheries Office. In both provinces, partner collaboration was led by the provincial public health office and provincial hospitals.

The project had three objectives:

- supporting active case finding;
- supporting risk communication and community engagement; and

- providing protective equipment (face mask, alcohol gel and face shield) and support for migrants and their families to access quarantine facilities and treatment.

To support these objectives, training was provided to 56 migrant health volunteers in Tak and Ranong. The training focused on COVID-19 information, government regulation updates, communication skills, child protection in emergencies and labour rights. As a result, the project reached beneficiaries in villages and migrant communities across 10 subdistricts in Tak and four subdistricts in Ranong. Migrant health volunteers supported local disease surveillance teams to conduct 239 active case-finding sessions in migrant communities. The project reached 5986 beneficiaries in Tak and 5751 in Ranong for outreach health education sessions on COVID-19 prevention, isolation and treatment in migrant communities and quarantine facilities.

The close collaboration between government authorities and employers was key to the success of the project. Through proactive project coordination, led by the provincial public health offices, an effective collaborative model for migrant workers to access accurate health information was established. Migrant health volunteers as community insiders additionally facilitated the project in supporting the most vulnerable and hard-to-reach migrants.

The project was challenged by difficulties with contact tracing when conducting active case finding as many migrants did not want to engage with government authorities and were worried about the consequences of testing positive.

“ The close collaboration between government authorities and employers was key to the success of the project. ”

## Case study

## 7

Country:  
**Jordan**

**Title:** enhancing cholera readiness through the Jordan Humanitarian Health Sector Working Group

The Inter-Sector Working Group in Jordan was formed in August 2013 as a forum of the sectors' heads to encourage synergies between sectors, avoid duplication and work on common processes. However, since 2014 the main framework and the primary strategic document for the refugee response has been the Jordan Response Plan to the Syrian Crisis.

The Health Sector Working Group has been pivotal since 2015 in ensuring the inclusion and coordination of all the key humanitarian partners in the health sector. Specifically, its effort has been driven by the main objective of supporting and enhancing national capacity in responding to the humanitarian crisis. This has been led by UNHCR and WHO, which coordinated this platform in order to streamline response through information sharing and through pooling of health expertise, resources and health information.

The Health Sector Working Group was particularly instrumental during the COVID-19 pandemic in providing the most up-to-date technical support to partners operating in refugee camps and in urban settings across the strategic preparedness and response plan. In parallel, the Working Group functioned well to synergize efforts to advocate for inclusion of refugees in the national response to the pandemic.

In the framework of the cholera outbreak that emerged in the Syrian Arab Republic in September 2022, WHO started from the September monthly meeting of the Health Sector Working Group to update and inform partners on the latest information from the Syrian Arab Republic, and with technical guidance. The latter was conducted in accordance with the published contents of the Global Task Force on Cholera Control and across key preparedness and response pillars such as surveillance, risk communication and community engagement, clinical management and water, sanitation and hygiene. This is in line with the other main objective of the Health Sector Working Group, namely "to coordinate assessment, design, planning, resource mobilization, implementation, monitoring and

evaluation of health strategies and activities, with the avoidance of duplication and overlaps and ensuring geographical coverage".

With the deterioration of the situation in the Syrian Arab Republic and the spillover of the epidemic into Lebanon, WHO proposed to shift to a "readiness" modality and reinforced coordination in the Health Sector Working Group in October 2022. This was implemented by establishing a weekly 4W exercise (who is where, when, doing what) to gather and analyse information on operational presence of partners involved in cholera activities. Such an exercise ensures awareness of activities; for example, WHO was actively supporting the Ministry of Health in surveillance outside the camps, while the UNHCR was enhancing detection in the camps with collaborators such as Save the Children, and the IOM was involved in points of entry activities. It should be noted that this initiative was successfully implemented even though there was no committee in place to regularly discuss needs, address challenges, align and monitor activities in accordance with the National Cholera Response Plan. Such a committee is a priority and should be composed of relevant government institutions, agencies and local authorities and national and international partners.

In light of the cholera situation, the Health Sector Working Group is proactively aligning all partners within the refugee health arena, such as Caritas, International Medical Corps, International Rescue Committee, IOM, Médecins Sans Frontières, Save the Children, the United Nations Children's Fund (UNICEF), UNHCR and others, to optimize support to the Jordanian Government and enhance readiness support for vulnerable populations in Jordan. As several of the partners in the Working Group operate in the area of migrant health, such an approach can have a direct positive effect on other vulnerable populations in addition to registered refugees.

The WHO Jordan Country Office also reached out to the United Nations Relief and Works Agency for Palestine Refugees in the Near East to ensure coordination and regular

exchange of information around activities to prevent and mitigate the threat of cholera. In this case, such an approach

would optimize the readiness approach in Palestinian refugee camps.

“ The Health Sector Working Group was particularly instrumental during the COVID-19 pandemic in providing the most up-to-date technical support to partners operating in refugee camps and in urban settings across the strategic preparedness and response plan. ”

## Case study

# 8

Country:  
**United Kingdom**

**Title:** initial accommodation contingency site health and operational partnerships for asylum seekers

Asylum-seeking families require support in navigating health care access when there are language barriers, differing health care expectations and limited understanding of different health care systems. It is in this context that this project was initiated, with the aim of providing immediate support to enhance access to health care for asylum-seeking families in initial accommodation contingency hotel sites in England (United Kingdom).

Following meetings with United Kingdom Visas and Immigration, accommodation providers and representatives from the local authorities and other agencies, a smaller subgroup was established to focus on a health pathway for asylum seeker arrivals at the hotel site. This subgroup consisted of representatives from National Health Service (NHS) England, integrated care boards, a local GP group, Lancashire County Council, Serco United Kingdom (a private company providing public services) and the accommodation provider.

The project had several elements targeting enhanced access to health and related support.

- Responsibilities for the completion of patient registration forms were assigned. A process for sharing registrations across practices in the area was operationalized.

- Focused approaches to health screening were delivered to approximately 160 asylum seekers. These were scheduled to be timely, within a few days, and to enable GPs to support a steady flow of new arrivals.
- Accommodation staff onsite were available to provide support and guidance and they were provided with a protocol for accessing urgent care out of hours.
- A midwifery referral procedure was established to ensure that new patients received timely referrals when required. The 0–19 team were onsite on a weekly basis and provided prearranged appointments or drop-in services to support families.
- Schooling applications for all children at the site were also completed. A process was implemented to support accommodation onsite for staff completing schooling applications for new arrivals.
- COVID-19 vaccination support and resources were provided onsite. This included a COVID-19 vaccination translation service for adding prior vaccination details to the NHS records.

While health funding is available, access to mental health support continues to be a challenge, and wider funding is not readily available for this purpose. There is a need for a longer-term funding commitment for sustainability, including access to interpreting services.

“ There is a need for a longer-term funding commitment for sustainability, including access to interpreting services. ”

## Case study

## 9

Country:  
**United Kingdom**

**Title:** development of a refugee health assessment toolkit for specific populations to support primary care

In autumn 2021 approximately 4000 refugees arrived from Afghanistan into London. GPs identified a need for readily accessible and comprehensive guidance to support them in conducting health assessments for the new arrivals with a complex range of needs.<sup>4</sup> The rapid pace of the influx meant that additional infrastructure was required to enrol and support this cohort, many of whom were in temporary accommodation. Primary care provision was also recovering from COVID-19-related pressures, and routine expertise in migrant health was not widespread. This led to concerns about the access to, and quality of, initial health assessments for newly arrived refugees.<sup>5</sup>

A London health community of practice (CoP) had been established in September 2021 to respond to the arrival of Afghan refugees. The CoP provided a structure in which the NHS, the Association of Directors of Public Health, local and regional public health teams, the Office for Health Improvement and Disparities, the United Kingdom Health Security Agency London Region and Greater London Authority could facilitate multiagency conversations, identify issues and pragmatic solutions, escalate operational challenges, share practices and advocate for the health of refugees. The CoP connected into other national governmental structures (including the Home Office), coordinating support for Afghan arrivals. NGOs, such as Doctors of the World, were also closely involved.

The CoP outlined a need to develop a bespoke initial assessment toolkit for Afghan migrants to support capacity-building in primary care and a standardized London-wide approach. The CoP facilitated the development of the toolkit and the compilation of a pan-London perspective on local challenges and initiatives. The CoP enabled both problem identification – insufficient infrastructure, capacity and guidance to meet the needs of refugees at this pace and scale – and suggested a solution

(the toolkit) and brought together the partners necessary to realize this work.

The toolkit consolidated guidance and expertise across several sources:

- CoP expertise and advice;
- the Migrant Health Guide, developed by the Office for Health Improvement and Disparities; and
- clinicians with humanitarian experience, front-line practitioners, NGOs and those leading the health and public health response.

Stakeholders across the patient pathway from GP registration to specialist and routine care were interviewed, with a focus on mental health screening/presentation, health protection, immunization and safeguarding. Their advice was complemented by suggestions from real-world experience to facilitate triaging of needs, for example on wound management, dental triage and malnutrition, while applying public health approaches to long-term condition prevention and management.

The final toolkit ensured greater consistency in assessments, considered primary needs alongside broader well-being and was responsive to both anticipated and known health priorities.

The initial health assessment toolkit for Afghan migrants demonstrated a partnership working towards holistic initial health assessments for new migrants in the context of primary care. The toolkit and associated supporting information were made available nationally for the wider system and have formed a template that can be rapidly adapted to suit emerging needs, for example for further waves of migrants. This work is applicable to asylum seeker health, and these partnership structures and outputs have

<sup>4</sup> Office for Health Improvements and Disparities (2022). Afghan refugees and newly displaced populations: individual health assessment. London: Office for Health Improvements and Disparities (<https://www.gov.uk/government/publications/individual-health-assessments-for-afghan-refugees/afghan-refugees-and-newly-displaced-populations-individual-health-assessment>, accessed 10 December 2022).

<sup>5</sup> Boshari T, Hassan S, Hussain K, Billett J, Garry S, Weil L (2022). Development of a refugee health assessment toolkit for specific populations to support primary care. *Eur J Public Health*. 32(suppl 3):ckac131.243. doi:10.1093/eurpub/ckac131.243.

implications internationally for other countries experiencing similar trends in migration and providing health care to an increasing number of refugees. In London, the CoP has evolved into a new regional workstream to produce a core London offer of best practice in support for primary care capacity and access.

The central role of public health within the CoP allowed for the successful championing of broader well-being needs and patients' voices – an asset when supporting new arrivals to rebuild their lives. Capturing the voices of migrants to drive and inform the content of the toolkit was anticipated. Unfortunately, this was delayed, highlighting a need for appropriate structures through which to engage

with vulnerable communities around their health and care needs in a timely manner. Based on this learning, a targeted, co-produced piece of work is now underway to collect and incorporate their lived experience.

Organizational bureaucracy led to delays in publishing the toolkit. To overcome this, it was circulated in draft among health partners to ensure that the critical window of opportunity for assessments was not missed. This enabled the toolkit to be refined based on feedback prior to publication. Feedback from frontline staff using the draft toolkit suggest that it was well received; however, usage was not formally monitored because of its online format. Additional capacity is needed to evaluate its overall impact.

“ The central role of public health within the CoP allowed for the successful championing of broader well-being needs and patients' voices – an asset when supporting new arrivals to rebuild their lives. ”

## Case study

# 10

Country:  
**United Kingdom**

**Title:** new to country service for unaccompanied asylum-seeking children in Birmingham

In January 2019 there was an increase in unaccompanied asylum seekers arriving in the United Kingdom and presenting in Birmingham. There was a lack of coordination regarding their health and a delay in paediatrician consultation opportunities. The Birmingham Children's Trust and the Children in Care team aspired to create a new service that would support the health needs of unaccompanied asylum-seeking children. These children were arriving in the United Kingdom, often having travelled for several years and often having experienced both physical and mental trauma. Unaccompanied young asylum seekers were invited to attend clinics as a means of ensuring that all their health needs were addressed in a timely manner and that prompt treatment was initiated when required.

Offering young people a health assessment with a nurse and supported by a social worker, support worker or foster carer within 1–2 weeks of arriving in the United Kingdom was a critical component of this service. Young people were

asked about their past medical history and immunization history and interpreting services were always available. A full screening test was also provided, which included, for example, height, weight, blood pressure, pulse recording, TB screening, urine testing and blood testing.

The screening results were shared with the young people and onward referrals to appropriate services were made as required. Young people accessing these services were offered further appointments (2–4 appointments each month) to support access to appropriate health services, emotional health and continuing with immunizations. On discharge from the clinic, a discharge letter was provided to the young person and a copy of this discharge letter was sent to the appropriate GP and social worker.

This initial service was set up by a group including the Head, Team Manager and Social Worker of the Service Provider Services Unaccompanied Asylum-Seeking

Children, the Clinical Lead Community Integrated Care, a specialist nurse for community integrated care, a community paediatrician, the TB service and clinical commissioning groups.

The limited allocation of nurses, lack of clinical space and the growing numbers of unaccompanied asylum-

seeking children requiring the service were all identified as challenges that require consideration. Although joint clinics with paediatricians is recommended as a means of reducing the volume of health care appointments, one-to-one appointments with a nurse for advice on sexual health, contraception, sexually transmitted infections, consent and the law in the United Kingdom are necessary.

“ The Birmingham Children’s Trust and the Children in Care team aspired to create a new service that would support the health needs of unaccompanied asylum-seeking children. ”

# 2

## PRIORITY

**Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures**





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Priority 2 highlights the importance of strengthening the quality, acceptability and availability of health services and ensuring that they are responsive to the needs of refugees and migrants, with particular attention required for services for chronic illness and mental health. It also highlights the importance of working to prevent occupational and work-related diseases and improving the coverage, accessibility and quality of occupational health and primary health care services. There are 12 case studies presented for Priority 2.

Strengthening the quality, acceptability and availability of health services for refugees and migrants is a particular focus in seven case studies. Case study 11 outlines how mobile health clinics provided access to outpatient health care in Sudan. Case study 12 describes efforts to fight NCDs in Cox Bazar. Case study 13 describes how health care facilities are strategically located across nine border regions in Chile, providing immediate access to health assessments and guidance on health services during the first period of arriving in the country. Case study 14 describes how health consultations for refugee groups who may have specific physical and psychological health needs are provided in Switzerland. It demonstrates how physical and mental health assessments are prioritized and appropriate referral pathways are initiated.

Case study 15 outlines an approach to strengthening the quality and availability of mental health supports for refugees and migrants in Türkiye. Case study 16 describes the development of a model of oral health and dentistry care for refugees and asylum seekers in the United Kingdom. Case study 17 outlines an initiative that promotes continuity of psychiatric treatment and provides a pathway for refugees from Ukraine to access psychotropic medication in Poland. Finally, Case study 18 describes how an established health assessment programme can be adapted and scaled up in responding to the health access needs of specific refugee and migrant communities in Qatar.

The last two case studies showcase how health care services have been adapted in response to the diverse cultural and linguistic needs of refugees and migrants. Case study 19 describes how free remote intercultural mediation services are readily available in Belgium using video conferencing technology; these are scheduled by care providers through a specifically developed application. Case study 20 details a culturally and linguistically responsive, free-of-charge and group-based multidisciplinary model of ante- and postnatal care that was codesigned and implemented in Australia. Under this care model, referrals can be made to other agencies, such as social work and housing services.



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The final three case studies provide examples of projects that support the accessibility of occupational health and primary health care services for migrant workers. Case study 21 illustrates how partnering with community health centres supports health literacy and access to health care services among migrant workers in India. Case study 22 describes the development of targeted resources that

provide pre-departure guidance to Vietnamese migrant workers regarding occupational health and navigation of health care services in the destination country. Case study 23 is an example of a mobile multidisciplinary clinic that enables basic sanitary assistance, primary health care, health screening and mental health support to be delivered to undocumented workers in Italy.



## Case study

## 11

Country:  
**Sudan**

**Title:** mobile clinics for Sudanese refugee crises in Al Gadarif State

Three mobile clinics were deployed to eastern Sudan (Al Gadarif State) to provide outpatient health services for the refugees at Um-Rakoba and Tunaybdah Camps. One of the mobile clinics was fully equipped to provide TB, HIV and malaria services, in addition to other primary health services; it was funded by the Global Fund and implemented by Epi-Lab and Sudan's National TB Programme. The mobile clinics rotated between the two camps (Um-Rakoba and Tunaybdah) every month. The clinics provided diagnostic services including radiography and blood testing for TB, HIV and malaria and worked as a referral point for these diseases.

Between March and June 2021, these mobile clinics facilitated 9690 consultations and 244 radiography scans across both camps. A little over half of these consultations were for women. These mobile clinics supported the diagnosis of 3665 cases of malaria, 49 cases of HIV and 45 cases of TB. During this same period there were 385 health care consultations outside of the three diseases (TB, HIV and malaria) across both camps.

Logistical challenges such as issues with power supply, air conditioning, fuel availability and extreme weather conditions impacted the operation of the mobile clinics. Cross-organizational collaboration was a key factor that facilitated the success of this project.

“ These mobile clinics supported the diagnosis of 3665 cases of malaria, 49 cases of HIV and 45 cases of TB. ”

## Case study

## 12

Country:  
**Bangladesh**

**Title:** fighting NCDs in Cox's Bazar

Seven out of every 10 people will die from an NCD. In Bangladesh, NCDs account for 67% of all deaths and one in five Bangladeshis between the ages of 30 and 70 years is at risk of dying due to an NCD. The prevalence and high mortality rates of NCDs make them a high priority for intervention at national and local levels.

NCDs disproportionately affect the poor and marginalized. Those impacted are more likely to experience worsening cycles of disease, poverty and non-productivity. Refugees and migrants may be particularly affected by NCDs due to poor living conditions and limited access to healthy lifestyle

choices. The treatment and prevention of NCDs is, therefore, a worldwide priority for health care access.

In August 2017, over half a million forcibly displaced Myanmar nationals crossed the border into Bangladesh. Facing persecution and violence in their home State, whole families made the journey on foot, risking starvation, dehydration and the dangers of the wilderness. They took with them only as much as they could carry.

Cox's Bazar today plays host to over 900 000 forcibly displaced Myanmar nationals spread across Kutupalong's

33 displacement camps. In addition, the State also supports a large host community facing its own health equity challenges. All of these people need access to quality care and protection from the damaging effects of NCDs.

WHO Bangladesh supported the Government of Bangladesh in adapting the *WHO package of essential noncommunicable (PEN) disease interventions for primary health care* (the Package) to the Bangladeshi context. This included the development of guidelines, protocols, tools, procurement systems and training to build facility capacity for NCD treatment and prevention.<sup>6</sup>

The primary actors for the delivery of NCD services across the State are WHO Bangladesh, the Ministry of Health and Family Welfare, the Government of Bangladesh and the Cox's Bazar Civil Surgeon's Office. As there are many partner organizations that are critical to delivery at the community level within both the Kutupalong camps and the host community, WHO established the NCD Core Group, a coordination mechanism involving the Ministry of Health and Family Welfare, United Nations agencies, international and national NGOs, and philanthropic institutions. Work is also carried out with the Upazila Health Complexes to build local capacity.

The fight against NCDs in Cox's Bazar also involved provision of training for health care providers in 65 facilities where care is currently delivered to forcibly displaced Myanmar nationals and host communities. To date, over 1000 primary and community health care workers have received training on the Package, building capacity for treatment and prevention, as well as the identification of NCD risk factors. Patient counselling is a critical part of the training and workers are equipped to help at-risk or affected community members to make good choices for their health.

In addition to these core training sessions, more than 100 facilities are supported with essential diagnostics equipment and medicines for NCD management. A further 60 primary health care facilities have received hands-on supportive supervision.

A simplified screening register has been set up and will be used for any patients over 40 years of age who visit a health facility. An improved NCD patient register will further improve record management, follow-up and referrals. Finally, improved risk communications activities, including an NCD flipchart, group counselling sessions and courtyard meetings have raised the profile of NCD risk among communities and health care staff.

At the start of usage of the Package in 2019, just over 116 000 patients were registered as having diabetes or hypertension by the Ministry of Health and Family Welfare using the electronic district health information system (DHIS2) data management system. In 2022 almost 251 000 were identified. Out of 1.4 million adults across both the forcibly displaced Myanmar nationals and host communities, 27.3% have now access to NCD services.

The camps in Cox's Bazar are perhaps the quintessential example of a low-resource health care setting. The health system was constructed as an emergency response in a short time frame, with priority given to imminent epidemiological and environmental threats. As a result, NCD treatment and care has historically been a lower priority. Also, despite its severe lack of resources, the system has had to weather numerous shocks, including natural disasters such as cyclones, floods and landslides, and compounded with the COVID-19 pandemic. All of these challenges have been exacerbated by the close living conditions and dangerous physical environment of the camps.

Such conditions highlight the need for disease interventions designed to cater to low-resource settings. The Package has been crucial in facilitating treatment in situations where health care workers would not otherwise have access to the tools and training they need to save lives. It ensures comprehensive and consistent service delivery, facilitated by the unwavering support of our essential partner agencies.

“Refugees and migrants may be particularly affected by NCDs due to poor living conditions and limited access to healthy lifestyle choice.”

<sup>6</sup> Bangladesh initiates trainings on package of essential noncommunicable disease interventions [website]. Dhaka: WHO Bangladesh; 2019 (<https://www.who.int/bangladesh/news/detail/01-07-2019-bangladesh-initiates-trainings-on-package-of-essential-noncommunicable-disease-interventions>, accessed 14 December 2022).

## Case study

## 13

Country:  
**Chile**

**Title:** Safe Corridors for Inclusion strategy to promote access to health care for migrants from point of entry to point of destination

In the context of the COVID-19 pandemic and closure of borders, there was a slight increase of unauthorized crossings into Chile at the northern tri-border (105 344 migrants in 2020–2022 according to the Chilean Investigative Police, but this number could be higher). Most of the migrants came from Venezuela and could be exposed to risks and vulnerabilities in terms of mental health, violence, COVID-19 and human smuggling/trafficking.

This increase led to a humanitarian crisis in which many migrant individuals and their families found themselves in extremely vulnerable situations, such as homelessness or living in shelters or camps in overcrowded and unsanitary conditions. In addition, some communities in the border regions have carried out public discriminatory and xenophobic demonstrations against migrants, and even against some of the institutions that work with these populations.

The combined impact of the pandemic and the humanitarian crisis brought new challenges to Chile's health system because of its lack of operational capacity to care for migrants in transit after the pandemic. The lack of awareness of existing regulations and policies on health and migration among officials also created unnecessary administrative barriers in accessing health services, as well as encouraging discriminative and xenophobic attitudes. Consequently, public and health sectors mobilized to generate comprehensive and integrated territorial responses to this large influx of migrants.<sup>7</sup>

A new strategy, Safe Corridors for Inclusion, was created and implemented as a collaborative initiative between government agencies (Ministry of Health, Social Security, regional secretariats, Ministries of Home Affairs, Education, Women's Affairs and Social Development), PAHO–WHO, other United Nations agencies (IOM, UNHCR, UNICEF and the United Nations Population Fund) and civil society stakeholders. This

strategy aimed to contribute to the welfare and inclusion of refugees and migrants through health assistance at the points of entry, transit and destination, strengthening the migration and health response. The strategy had three components: the implementation of health facilities at the border, the creation of a team of professionals in the field (“Duplas”) at entry, transit and destination, and the generation of a reception plan at the place of destination. All this was coordinated in the territory by local representatives with the aim of providing a comprehensive response.

With oversight from PAHO and the Ministry of Health, the Duplas team of 11 was hired in February 2021 and comprised health pairs (nurse and nursing technician) and psychosocial pairs (social worker and psychologist). The team was assigned to the first three northern regions to implement actions to improve information on health rights and to reduce health care access barriers for the migrant and refugee population from their arrival at the border, in transit and at their destination. These field teams contact migrants when they arrive in the country. They carry out a preliminary assessment of the health situation and provide guidance to the health services of Chile to facilitate and improve access. Additionally, the Duplas provide information to other areas, assisting in the interconnection of health with the social support ecosystem in each territory, thus enhancing relevant and comprehensive solutions to complex cases. After the success of this initiative, the project has been extended to six regions and 52 professionals in 2022.

This response has been facilitated by the existence of a consolidated health network and the institutional support given to the Duplas project. The main challenge of this initiative is that it needs to be flexible to maximize territorial relevance. For it to be sustainable, it will need to be mainstreamed and embedded into the Chilean public health system.

“After the success of this initiative, the project has been extended to six regions and 52 professionals in 2022.”

<sup>7</sup> Ministry of Health (2019). Salud del Inmigrante [Migrant health]. Santiago: Ministry of Health (<https://www.minsal.cl/salud-del-inmigrante/>, accessed 10 December 2022).

## Case study

## 14

Country:  
**Switzerland**

**Title:** care management for Ukrainian refugees in the Cantons of Vaud and Geneva

In response to the current Ukrainian crisis, Switzerland created a specific temporary protection order that allowed Ukrainian refugees to have equitable access to health care, among other things.

### Geneva

In Geneva, University Hospitals Geneva created the second “migrants’ health programme”, an example of a primary care facility for Ukrainian refugees.

With specific new human resources – medical doctors, nurses, administrative staff and interpreters – this facility aims to identify rapidly the health needs of Ukrainian refugees. An initial nursing assessment includes medical history and screening for post-traumatic stress disorder and other mental health disorders.

A post-traumatic stress disorder programme was implemented to facilitate early recognition and intervention and used a screening tool inspired by the Primary Care PTSD Screen for DSM-5. This was paramount to allow more effective treatment and to improve prognosis.

Following a positive screening result, patients are assigned to a doctor or psychologist within the programme who provides integrative medical help and mental health and psychosocial support (MHPSS). When necessary, patients are referred for advanced psychiatric treatment to the hospital’s consultancy for victims of torture and war, or to the ambulatory psychiatric unit. Nonpharmacological approaches are part of the integrative medical management of post-traumatic stress disorder offered through the programme. It is an added tool to the standard practices and a useful therapeutic option for patients who fear the stigmatization of psychiatry and use of psychotropic drugs. As many refugees are single women with children, mothers who are identified with post-traumatic stress are also linked with paediatricians so that special attention can be paid to the mental health of their children. Adults and children psychologists work closely together.

There were emerging enablers for implementation of the programme, including the support provided by the administration; the motivated and trained staff (when the programme was established); pre-existent partnerships; design and implementation of clear protocols; and recruitment of health professionals who knew the language and the culture.

### Vaud

In Switzerland, Ukrainian refugees are granted an S permit to provide essential legal protection and health insurance coverage. In addition, the Canton of Vaud reimburses the costs of community interpreting for health services. Information about Ukrainian people’s rights and access to health care is available in French, Russian and Ukrainian on the cantonal website.

The Migrant Care Unit organizes a nursing triage consultation for all Ukrainian refugees arriving in Vaud who are accommodated in a community centre. This consultation assesses physical and mental health needs and offers serological tests and vaccinations. People requiring follow-up are prioritized according to the urgency of their needs. They are then put in contact with a RESAMI (Réseau Santé et Migration, a medicosanitary network) doctor, with whom their medical information is shared to guarantee the continuity of care.

The scale of the migratory wave has led to a rapid upscaling in human resources to ensure the quality of care and follow-up; effectively, the entire health system had to be mobilized. Therefore, Unisanté, the University Centre for General Medicine and Public Health in Lausanne, decided to organize free training courses for all health professionals in the Canton of Vaud. These training sessions address the main identified health issues and needs, including care coordination, infectious diseases, paediatrics, psychiatry, gynaecology and risk of human trafficking. These courses are offered by videoconference and face to face. In addition, they are recorded and freely available on the RESAMI website.

Weekly meetings of the main actors enabled rapid implementation and adaptation of cantonal policies:

- the Office of the Cantonal Physician, responsible for medical matters concerning public health and representing the cantonal medical authority;
- the Department of Vulnerabilities and Social Medicine (Département Vulnérabilités et médecine sociale), Unisanté, which is responsible for the cantonal coordination of care for migrants;
- the Cantonal Coordination of Mental Health for Vulnerable Migrants, which is responsible for the coordination of mental health for Ukrainian refugees;
- the Paediatric Department of the Lausanne University Hospital (CHUV) and the cantonal paediatricians' group,

which are responsible for the coordination of care for Ukrainian children;

- RESAMI, a network of more than 200 primary care physicians throughout the Canton; the Migrant Care Unit, which is the pillar and front line of the network, includes nurses with transcultural clinical skills, administrative support staff and medical supervision; and
- EVAM (Établissement Vaudois d'accueil des Migrants), which is the cantonal structure responsible for the reception and accommodation of refugees and asylum seekers.

The complexity of social and health situations such as seen in the care needed for Ukrainian people illustrates the dynamic, rapidly changing and unpredictable environment that requires coordination between the various social and health actors.

“ The scale of the migratory wave has led to a rapid upscaling in human resources to ensure the quality of care and follow-up. ”

## Case study

# 15

Country:  
**Türkiye**

**Title:** prioritizing mental health of Syrian refugees in Türkiye

Türkiye hosts over 4 million refugees and migrants, primarily Syrians, but also Afghanis, Iranians and Iraqis. A range of culturally and linguistically sensitive services, including across social, health and education sectors, is available free of charge to all refugees and migrants registered in the country. Services are coordinated under the auspices of the Regional Refugee and Resilience Framework through the WHO Türkiye Office. Essential health services are also supported by a multitude of donors, particularly for primary health care. The Ministry of Health maintains a network of 183 refugee/migrant health centres across the 29 provinces with the largest concentration of refugees and migrants. This network is resourced with Syrian health professionals, trained by the Ministry of Health and WHO and funded by the European Union (EU) under the Facility for Refugees in Türkiye.

A key element of responding to refugee and migrant health needs is delivering appropriate MHPSS. Unpublished data

from 2017 indicated that almost 38% of refugees/migrants arriving in Türkiye from the Syrian Arab Republic had signs and symptoms of major depression and other mental health disorders. However, most of these went undiagnosed at primary health care level. It was in this context that the Ministry of Health Mental Health Department and the WHO Refugee Health and Mental Health Programme initiated a joint effort in mid 2017. The aim was to improve the services provided to refugees and migrants and responses to their mental health needs by strengthening the capacity of primary health care providers to diagnose and treat mental health problems and to deliver psychosocial support. A key element was to develop training for health care professionals that would be available in a range of languages, free of charge and in an online, self-directed format.

Training programmes were developed in Arabic and Turkish for all health providers involved in providing services to refugees and migrants. The training for doctors was based

on the WHO Mental Health Gap Programme. Several training programmes were developed for nurses, including on early childhood development, gender-based violence (GBV), psychosocial issues, problem management and self-care. To ensure continuity of care and training during the COVID-19 pandemic, the mental health training topics were included in the distance learning platform developed by the Refugee Health Programme with funding from the EU. This ensured that thousands of health professionals would have free access to training courses in their own language and at their leisure.

During 2018–2021 over 1500 Syrian and Turkish doctors completed the training, which equipped them with skills to identify, diagnose, treat and refer patients needing MHPSS in non-specialist health settings. In addition, over

800 nurses received training in GBV; over 2000 nurses received early childhood development training, and over 1600 psychologists and social workers were trained in psychosocial interventions.

A 2021 impact assessment demonstrated that the training was well-received by health providers and had led to improved rates of diagnoses, compliance with treatment guidelines and high satisfaction rates among service users. This project demonstrates the positive impact of developing, implementing and evaluating training programmes that address unmet health needs to improve efficiency and effectiveness of health interventions in humanitarian settings.

“ A key element of responding to refugee and migrant health needs is delivering appropriate psychosocial support. ”

## Case study

# 16

Country:  
**United Kingdom**

**Title:** focus on supporting oral health for asylum-seeking people and refugees in England

Asylum-seeking people and refugees commonly have poor oral health, and complex needs may be identified on arrival in host countries. In England (United Kingdom), primary care dentistry is provided by the NHS via a co-payment structure in which those on low income or in receipt of welfare and benefit packages, including asylum seekers and refugees, may access dental care that is free of charge or requiring a small co-payment.

Following reports that a recent group of refugees arriving from the Syrian Arab Republic were experiencing difficulties accessing NHS dental care, a task group was convened comprising a range of intersectoral agencies including:

- NHS England, who currently commission NHS dental services and are ultimately responsible for ensuring equitable access to services;
- national, regional and local public health actors who define guidance and best practice.
- primary care dentists and teams providing dental care;

- local dental committees supporting local dentists on a range of issues;
- local dental networks supported by NHS England to improve outcomes through clinical focus, expertise and collaboration initiatives;
- local government, which provides preventive initiatives, interventions and services and supports asylum seeker and refugee resettlement; and
- third sector organizations that provide local and regional support, coordination and advocacy.

This task group collaborated through partnership meetings led by Public Health England (now replaced by the Office for Health Improvement and Disparities) to identify issues, needs and enablers to secure oral health care for asylum seekers and refugees.

A mixed-methods cross-sectional service evaluation was developed to identify barriers and enablers for asylum seekers and refugees in accessing NHS dental care. This was



undertaken in 2019 in Leicester, a culturally and ethnically diverse, medium-sized city in England.

The evaluation identified multiple structural and knowledge-based barriers for asylum seekers and refugees in accessing free or reduced-cost NHS primary care dentistry. Although asylum seekers and refugees were eligible to access NHS dentistry, there seemed to be a misinterpretation of national policy and guidance. Confusion and uncertainty about what dental care asylum seekers and refugees were entitled to, and the process to confirm entitlement, were recurrent barriers reported. Dental professionals that participated in the study requested clear, unambiguous information and identified a need for specific training to support the understanding of the rights and oral health needs of this

migrant population, and as a result national guidance was updated.

The study highlighted that dental professionals require additional funding for this initiative to support interpreting services and to facilitate the longer consultations that are required. A planned phase of embedding training with dental professionals and community engagement was also needed and had started but ceased due to the COVID-19 pandemic. Recently, the United Kingdom Government has announced significant changes to the national dental contract that seek to dismantle access barriers and to address the challenges associated in delivering care to patients with higher needs. This could support the financial needs identified by dental professionals.

“ The evaluation identified multiple structural and knowledge-based barriers for asylum seekers and refugees in accessing free or reduced-cost NHS primary care dentistry. ”

## Case study

# 17

Country:  
**Poland**

**Title:** a pathway to access psychotropic medication for refugees from Ukraine

The mental health and psychosocial well-being of the people who fled from Ukraine and arrived in Poland since the beginning of the crisis have been severely impacted. These Ukrainians have been exposed to life-threatening events, displacement, interrupted family and loss of social connections, and they are also affected by loss of homes and livelihoods; lack of access to health, education and social services; and fear and anxiety about the future of those who remain in conflict areas.

Additionally, prior to the conflict, many refugees were already receiving psychotropic treatment for different mental health conditions. Routine treatments can be interrupted for those fleeing to a new country and facing difficulties in navigating a foreign health system and in accessing services because of language barriers or long waiting lists.

To facilitate access to psychotropic medication, the WHO Country Office in Poland, the Ministry of Health of Poland and the Ministry of Health of Ukraine jointly agreed on a pathway to access psychotropic medication for refugees from Ukraine.<sup>8</sup> Since 24 February 2022 all Ukrainian citizens arriving in Poland due to the crisis in Ukraine are entitled to free care and reimbursement for medication in Poland through a special law, under the same conditions as Polish citizens. All people will be able to continue their psychiatric treatment in Poland. Prescriptions issued by a psychiatrist or other doctors are required to obtain medication from a pharmacy, and prescriptions issued in Ukraine are also valid in Poland.

This information was summarized in a poster with advice on how Ukrainian citizens with mental health conditions should

<sup>8</sup> WHO Regional Office for Europe (2022). Were you receiving psychiatric treatment in Ukraine? Copenhagen: WHO Regional Office for Europe (<https://www.who.int/europe/publications/m/item/were-you-receiving-psychiatric-treatment-in-ukraine>, accessed 10 December 2022).

prepare before fleeing Ukraine. These posters are available in English, Polish and Ukrainian and were disseminated online and in printed versions in reception points in

Poland (such as the Blue Dots run by UNICEF and UNHCR) and Ukraine.

“ Prior to the conflict, many refugees were already receiving psychotropic treatment for different mental health conditions. ”

## Case study

# 18

Country:  
**Qatar**

**Title:** the health assessment programme response to the Afghanistan crisis

Since the middle of 2021 significant refugee outflows from Afghanistan have necessitated complex coordination to respond to their health and humanitarian needs. This has included support for the health aspects of durable solutions (resettlement and relocation) in Afghanistan, Pakistan, Qatar and other countries in Europe, central Asia and the Middle East.

To support the resettlement or relocation of Afghan nationals in third countries, it was necessary to rapidly scale up and identify innovative ways to respond in complex operating environments.

Actors joined together to respond, including the IOM and the governments of receiving countries (such as Home Affairs Australia; Immigration, Refugees and Citizenship Canada; the United Kingdom Home Office; and the United States Bureau of Population, Refugees and Migration). Technical

support was provided by the relevant IOM regional offices for implementation of the initiative. The IOM provided migration health assessments, supported pre-embarkation checks for departing refugees and provided medical escorts where required.

In Qatar, IOM supported the establishment of a significant operation as part of the United States Refugee Admissions Programme, deploying health assessment programme staff from various regions to develop capacity to undertake pre-migration health activities and recruit medical staff. It is estimated that approximately 2000 humanitarian beneficiaries a month will be assisted under the arrangement over the course of 2022. IOM's extensive experience with the provision of pre-migration health activities, including in the context of resettlement, enabled rapid scale up and deployment of capacities for response.

“ To support the resettlement or relocation of Afghan nationals in third countries, it was necessary to rapidly scale up and identify innovative ways to respond in complex operating environments. ”

## Case study

## 19

Country:  
**Belgium**

**Title:** video-remote intercultural mediation in health care

Intercultural mediators interpret and facilitate the collaboration between care providers and service users, as well as acting as patient advocates.

In Belgium, a video-remote intercultural mediation programme was initiated as a means of providing free and easily accessible intercultural mediation services in hospitals, primary care centres and medical services of reception centres for asylum seekers in a cost-effective and efficient way.

These services have access to over 100 intercultural mediators across 20 different languages. The mediators are employed by hospitals or primary care centres and funded by the Federal Public Service Health, Safety of the Food Chain and the Environment and by the Public Health Insurance Institution. The programme is organized, managed and evaluated by both organizations.

A specifically designed application (the intercult.be app) was developed for ease when scheduling intercultural mediators in real time and accessing intercultural mediators when required. The programme has recently been extended to provide video-remote intercultural medication services to psychologists and their clients in primary care centres and in health centres that have been created for refugees from Ukraine.

The number of video-remote intercultural mediation interventions (as opposed to onsite services) increased by 40% in 2021 (total number of video-remote interventions: 12 456). Preliminary analyses of data collected in the first half of 2022 suggest that the number of interventions will increase by at least 40%. The limited number of available intercultural mediators and the lack of availability of intercultural mediation services outside of office hours are the key challenges reported.

“ These services have access to over 100 intercultural mediators across 20 different languages. ”

## Case study

## 20

Country:  
**Australia**

**Title:** group pregnancy care for women with a refugee background and their families

Women from refugee backgrounds giving birth in Australia and other high-income countries can experience a range of poor perinatal outcomes and persistent health inequities. High-quality antenatal care is essential for optimal maternal and perinatal outcomes.

WHO has identified group-based models of pregnancy care as having the potential to meet the complex needs of populations vulnerable to poor outcomes. The Australian Antenatal Care Guidelines additionally outline the potential benefits of such group models for women from refugee backgrounds. It is within this context that a group pregnancy

care model was implemented in Australia.<sup>9</sup> This is an innovative new programme that aims to create a culturally safe place for women to connect, to promote health literacy and self-efficacy, increase access to preventive and health-promoting health care, and provide information and support for women during and after pregnancy.

Group pregnancy care is delivered by a multidisciplinary team of five. Fortnightly group information sessions are co-facilitated by a midwife, a maternal and child health nurse and a bicultural worker. Clinical antenatal care is provided by a second midwife and an onsite hospital-employed interpreter and is conducted in a private room at the same time as the group sessions. The sessions are free to attend; provide pregnancy care and information that is directed to the women, culturally appropriate and in women's language; and facilitate referrals to other services as required, for example social work and housing services. Women can enrol to attend the fortnightly group information sessions at any stage of pregnancy. There is flexibility to embed the programme in local service delivery systems in ways that work for local communities and services.

Initially a demonstration project in 2014, the programme was subsequently scaled up to include new sites in 2019 and was

then evaluated in 2021.<sup>10</sup> It receives funding support from the Victorian Government Department of Premier and Cabinet. This innovative approach to antenatal and postnatal care is implemented by an interagency collaboration between public maternity hospitals, refugee settlement services and universal maternal and child health services. A local Partnership Implementation Group was involved in programme co-design and evaluation and oversees its implementation. The Partnership comprises management and staff from all partner agencies and other relevant stakeholders. The project is facilitated by engaging and involving community and multiagency staff in codesign processes. This is essential for buy-in, refinement and adoption of the programme.

Findings from a formative evaluation of two programmes indicate that they have increased women's access to antenatal care.

As a result of the restrictions put in place by the Victorian Government to stop the spread of SARS-CoV-2, the two established group pregnancy care programmes transitioned to virtual platforms, further demonstrating the adaptability of the programme.

“ Women can enrol to attend the fortnightly group information sessions at any stage of pregnancy. ”

## Case study

# 21

Country:  
**India**

**Title:** strengthening post-COVID-19 support for migrant workers affected by the COVID-19 pandemic

Internal migrant workers constitute about 28.3% of India's workforce. These are mostly concentrated in the informal sector, which is characterized by low-paying, insecure jobs

and hazardous and exploitative conditions of work. The COVID-19 pandemic increased the visibility of migrants in India and the precarious conditions of their lives and work.<sup>11</sup>

<sup>9</sup> Riggs E, Muyeen S, Brown S, Dawson W, Petschel P, Tardiff W et al. (2017). Cultural safety and belonging for refugee background women attending group pregnancy care: an Australian qualitative study. *Birth*. 44(2):145–52. doi:10.1111/birt.12272.

<sup>10</sup> Riggs E, Yelland J, Mensah FK, Gold L, Szwarc J, Kaplan I et al. (2021). Group pregnancy care for refugee background women: a codesigned, multimethod evaluation protocol applying a community engagement framework and an interrupted time series design. *BMJ Open*. 11:e048271. doi:10.1136/bmjopen-2020-048271.

<sup>11</sup> WHO (2021). Strengthening resilience among migrants impacted by COVID-19 [website]. Geneva: World Health Organization (<https://www.who.int/india/news/feature-stories/detail/strengthening-resilience-among-migrants-impacted-by-covid-19>, accessed 10 December 2022).

In March 2021 the Disha Foundation, in collaboration with WHO India, implemented an intervention to support migrant workers during COVID-19. The intervention was implemented in the national capital regions: the three cities of Delhi, Gurugram and Noida; Nasik, Shirdi and Nagpur cities in Maharashtra State; and Panaji in Goa State.

The project aimed to improve health literacy among migrants and empower them to access Government health services. WHO supported the Disha Foundation in developing its COVID-19-related programme on migrant health. This included:

- ensuring that internal migrant workers continued to have access to essential health services by partnering with community health centres;
- improving the access of 12 000 migrant workers to COVID-19 vaccines by supporting them in registration and by bringing vaccination sites closer to where they work;
- providing migrant workers with timely COVID-19-related information and messages tailored to their contexts by advancing peer support and leveraging digital technology; and

- addressing the social determinants of migrant health in collaboration with relevant Government departments such as housing, legal support, food security, financial inclusion.

Throughout all these activities, the support and engagement of relevant Government departments was extremely important to mitigate the adverse impact of COVID-19 on the health and well-being of migrant workers. Together, these departments not only supported migrants but also ensured that issues were addressed in a timely manner and services were available; this helped over 48 000 migrants.

Working together under this initiative, NITI Aayog, the policy think-tank of the Government of India, the Disha Foundation and WHO India identified challenges and lessons learned to support internal migrant workers' overall health. Capacity-building tools were developed, including a standardized training module to strengthen the capacity of community-based organizations and civil society organizations to integrate migrant health into their work on the ground.

“ Together, these departments not only supported migrants but also ensured that issues were addressed in a timely manner and services were available; this helped over 48 000 migrants. ”

## Case study

# 22

Countries:

**Japan and the Republic of Korea**

**Title:** migrant-friendly handbooks for promoting the health of Vietnamese migrant workers overseas

A 2021 study highlighted difficulties experienced by Vietnamese migrant workers in Japan, the Republic of Korea and Taiwan, China, in accessing accurate and timely information about health and health services in destination countries.<sup>12</sup> The findings highlighted a need for a migrant-friendly handbook and video on health care systems and health promotion for Vietnamese migrant workers overseas.

In response a Migrant Health Working Group composed of members from the Ministry of Health, Ministry of Labour, Invalids and Social Affairs, Ministry of Foreign Affairs, IOM, WHO and other agencies, in partnership with relevant Korean and Japanese stakeholders, developed two migrant-friendly health handbooks for Vietnamese migrant workers residing in Japan and the Republic of Korea. Financial

<sup>12</sup> Kiyohara H, Teshima Y, Hoshino HA, Kanda M, Matsuoka S, Iwamoto A et al. (2022). Three myths of disseminating COVID-19 information to vulnerable migrants in Japan: lessons learned during the pandemic. *Trop Med Health*. 50(1):13. doi:10.1186/s41182-022-00404-9.

support was received from the IOM Development Fund. Stakeholders in the two countries that contributed to the development of the handbooks included experts from NGOs, universities, government-affiliated institutions, clinics and hospitals working in the field of migration health.

The Migrant Health Working Group organized a study tour in Japan and the Republic of Korea and conducted a pilot test for the practical use of the handbooks among Vietnamese migrant workers residing in the two countries. During the visit, bilateral meetings with Korean and Japanese stakeholders established partnerships and received technical inputs that have also now been incorporated into the handbooks.

The migrant-friendly health handbooks aim to equip Vietnamese migrant workers with the necessary knowledge to survive and thrive in the new destination. The handbooks present the following key information in a culturally and linguistically sensitive manner:

- where and how to seek health care services in the destination country, including health insurance enrollment and availability of interpretation services at health care facilities;
- access to infectious disease services;
- occupational health;
- sexual and reproductive health (SRH), such as prevention of unintended pregnancies and protection from sexual abuse and exploitation; and
- mental health.

In Japan, the Bureau of International Health Cooperation of the National Centre for Global Health and Medicine and the coalition Migrants' Neighbour Network and Action formed a technical working group to design the handbook. The process of the handbook development provided a great opportunity to expand and strengthen the network of stakeholders in various fields and sectors. Cross-border collaboration between Japan and the Republic of Korea facilitated the exchange of ideas.

“ The migrant-friendly health handbooks aim to equip Vietnamese migrant workers with the necessary knowledge to survive and thrive in the new destination. ”

## Case study

# 23

Country:  
**Italy**

**Title:** mobile clinic providing health care for migrant labourers in Foggia, Apulia

Italy has long been a landing destination for many undocumented migrants, coming mainly from Africa. Apulia is one of the principal destinations for many migrants who take part in seasonal agricultural harvesting work. Many undocumented migrants, consequently, inhabit informal villages known as ghettos, characterized by a lack of adequate basic services including accommodation and housing, sanitary facilities, running water, electricity, heating and access to safe food. Ghetto conditions are underpinned by a lack of workers' rights, illegal recruitment, overwork, violence and slavery. Access to the national health system is difficult unless an emergency happens.

It is in this context that Doctors with Africa CUAMM, an NGO working for the promotion and protection of health in Africa, is operating a multidisciplinary clinical campervan service that travels four times a week to deliver basic sanitary assistance to the migrant villages in Foggia. It carries a team of a doctor, a nurse, a social-sanitary operator, a cultural mediator, a psychologist and a driver. Building on activities commenced in 2015, the team has operated in its present format since public funds were allocated in March 2020. Doctors with Africa CUAMM aims to address social and health needs through the following actions:

- primary health care, including treating detected pathologies and dispensing medications where necessary;
- purchasing and distributing personal protective equipment and personal hygiene products;
- assisting and referring to health facilities in the territory;
- in-depth screening and specialized monitoring of specific pathologies;
- direct training and distribution of multilingual information to increase social and health literacy;
- mental health promotion via a psychologist specialized in working with migrant populations;
- identifying and managing referral of patients needing psychiatric care; and
- assisting and mediating with legal documentation status and primary care.

Since 2020, screening activities for HIV and hepatitis C have started and in 2022 gynaecological screening was begun.

The project faces several challenges in delivering services to undocumented migrants. These include resourcing medications free of charge for a large number of patients; a lack of access to in-depth diagnostic examinations; language and cultural differences; a high prevalence of mental disorders and social isolation; and establishing trust with a largely seasonal migrant population with high turnover.

However, as the service has been running for a number of years, patient trust and collaboration has grown. This is facilitated by the inclusion of a cultural mediator and provision of support to accompany patients when attending hospital for in-depth examinations. The service is additionally facilitated by cooperation and support across a local network.

“ Access to the national health system is difficult unless an emergency happens. ”

# 3

## PRIORITY

**Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms**





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Priority 3 advocates for the mainstreaming of refugee and migrant health by preventing and mitigating the impact of inequality in health and health care access, in accordance with international human rights obligations, and collaboratively working to lower or remove health care access barriers. Achieving this requires ensuring that health care professionals have resources and capacity to deliver appropriate services: mobilizing resources; training migrant health volunteers; effectively managing and supporting strategic partnerships, intercountry, intersectoral and interagency; and coordination and communication across countries. Sensitivity to and promotion of health-supporting activities for women, children and young people is an additional focus. There are 13 case studies presented for Priority 3.

The first six case studies (24–29) provide examples of how health care professionals are supported in developing capabilities and capacity to provide refugee- and migrant-sensitive health care. Case study 24 describes a new online education and training programme for Syrian health workers and community health workers who provide services in

refugee health centres in Türkiye, supporting the development of capabilities in caring for refugees and migrants. Case study 25 outlines an intercountry collaborative approach to designing and delivering an online training programme in migrant health that is delivered across numerous countries. Case study 26 describes a national online multidisciplinary training course that supports the development of knowledge and skills to provide care that meets the needs of refugees and migrants in Portugal. Case study 27 provides details of an interagency approach to providing specific training for migrant health volunteers in Thailand as a means to grow the capacity to provide refugee- and migrant-sensitive health care. Case study 28 describes the implementation of a training programme for regional coordinators of migrant health in Italy. This initiative provides training and a platform for regional coordinators to discuss issues and support local processes in implementing national migrant health guidelines. Case study 29 describes an integrated approach to providing cultural competence education and training for health care professionals working across a range of settings, including NGOs, in New Zealand.



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The next five case studies present examples of mechanisms for mainstreaming refugee and migrant health through strengthening partnerships and collaboration across sectors and countries. Case study 30 outlines a UNHCR-coordinated interagency and intersectoral collaborative approach to ensure that refugees and other people of concern were included in COVID-19 responses and vaccination plans across countries. Case study 31 describes the development of an interministerial working group in Viet Nam that provides national direction on the design and implementation of migrant-friendly health interventions and policies across sectors. It demonstrates a multisectoral approach in collectively supporting refugee and migrant health. Case study 32 describes a countrywide interagency steering group that brings together experts from health and immigration sectors to provide oversight on improving health care access and providing advice regarding the specific health needs of asylum seekers in the United Kingdom. Case study 33 describes an integrated multiagency intervention in Mozambique to provide essential access to health care services

for internally displaced people (IDPs) and health education regarding the prevention of communicable diseases. This initiative involved collecting and managing standardized and shared evidence to inform strategic decision-making in responding to the changing needs of displaced populations moving into and within the country. Case study, 34, from Columbia, is an initiative that aims to empower women and girls in migrant communities in accessing health care and understanding and exercising their SRH rights (SRHR).

The final two case studies demonstrate the importance of addressing vulnerabilities associated with specific population groups, mainly children on the move and their families. Case study 35 describes efforts to support the needs of displaced children in Jordan, while also strengthening existing health and nutrition services. Case study 36 describes the implementation of the Refugee and Migrant Child–Health Initiative in Bosnia and Herzegovina, Bulgaria, Greece, Italy and Serbia to safeguard the health of refugee and migrant children.



## Case study

## 24

Country:  
**Türkiye**

**Title:** digital learning platform for Syrian health workers in Türkiye

As a result of the COVID-19 pandemic and the accompanying domestic movement and social contact restrictions in Türkiye, in-person on-the-job training for health workers was suspended. A WHO Distance Learning Platform was established incorporating digital learning and communication technologies (such as Zoom and Moodle) to deliver training to Syrian health workers and host community health workers providing services in refugee health centres.

With support from the WHO Türkiye Office, the Ministry of Health's technical departments prepared the course design, layout and content. There are currently six courses in the online training platform:

- health information systems for medical examination records
- GBV and early childhood development
- occupational health and safety
- psychosocial support in emergencies
- NCD management
- the WHO Mental Health GAP Programme.

Each course consists of separate modules that are completed sequentially. The modules are completed online and consist mainly of video lectures, animations, additional course materials and presentations, followed by small activities, case discussions and quizzes for an interesting and challenging learning experience.

Modules are delivered in both Arabic and Turkish and have pre/post-tests to assess learning progress and achievement. The modular nature of the courses allows for continuous improvement and enrichment with other modules and courses. Initial user suggestions and testing were integrated into developing and revising the modules.

The platform is the first of its kind in Türkiye. The benefits of digital learning included reduced training costs and flexible access for trainees. The platform has potential for being a so-called go-to training programme for health workers, providing services to refugees and host communities in Türkiye and across the WHO European Region.

“ The modular nature of the courses allows for continuous improvement and enrichment with other modules and courses. ”

## Case study

## 25

Country:  
**Uganda**

**Title:** migration governance and health with online courses on health and migration

This initiative aimed to enhance intercountry and interdisciplinary conceptualization and knowledge around health and migration governance, with a particular focus on low- and middle- income countries. An online course on health and migration, Migration Governance and Health in Austria

and Uganda, was developed and implemented between 2020 and 2022. The curriculum was based on previous courses developed by the IOM in 2015 and on a stakeholder analysis, and required an assessment to be completed in 2021. The training was delivered to 353 participants across 17 low- and

middle-income countries from 2021 to 2022, including Türkiye and 16 from the WHO African Region: Burundi, Cameroon, Democratic Republic of the Congo, Kenya, Namibia, Nigeria, Rwanda, Sierra Leone, Somalia, South Africa, South Sudan, Sudan, United Republic of Tanzania, Uganda, Zambia and Zimbabwe.

The courses were delivered by 21 trainers across 11 countries and comprised 17 sessions on a range of topics, including foundations of and research on migration and health; global and African perspectives on migration health governance; regular and irregular migration in the context of south–south and south–north migration; COVID-19 impact; rights to health and social protection for migrants; gender issues; mental health and well-being; physical health, including communicable diseases and NCDs; and humanitarian and complex emergency settings.

The course was developed collaboratively by Makerere University, Kampala, Uganda; the Centre for Health and

Migration, Vienna, Austria; and the IOM. The initiative was funded by the Austrian Federal Ministry of the Interior. It was additionally supported by experts from the Migration Health and Development Research Initiative at Wits University, Johannesburg, South Africa; Kyambogo University, Kampala, Uganda; Queen Mary University London, United Kingdom; Vienna Medical University, Austria; the Joint United Nations Programme on HIV/AIDS, WHO, the IKEMBA Foundation and Lancet Migration.

Implementation challenges included COVID-19-related travel restrictions, which resulted in the virtual development of all project phases and activities. Consequently, some participants reported difficulties accessing online sessions due to poor Internet connection. Implementation facilitators included leadership support from Makerere University; experienced, committed experts facilitating training sessions; project partners who were sensitive to cultural differences; and flexibility in adapting the implementation plan in the context of COVID-19.

“ The courses were delivered by 21 trainers across 11 countries and comprised 17 sessions on a range of topics. ”

## Case study

# 26

Country:  
**Portugal**

**Title:** fostering integration by addressing health equity (Phase II)

Equity of access to health services is a fundamental precondition for positive health outcomes and healthy populations. As part of Fostering Integration by addressing Health Equity – Phase II, an online training course for Portuguese primary health care workers (medical doctors, nurses, psychologists, social workers, secretaries and other administrative personnel) was jointly developed by the Directorate-General of Health, a public body of the Portuguese Ministry of Health, and IOM Portugal. The initiative was financed by the Asylum, Migration and Integration Fund.

The aim of the training course was to improve primary health care workers’ skills in addressing migrant health

needs as part of a wider goal to improve equitable access to health care for migrants, eliminate potential access barriers and promote intersectoral cooperation.

The course comprised four modules, each developed in close partnership with experts in the particular areas:

- migration and health (types of migration, social determinants of health, common health needs and vulnerabilities of refugees and migrants);
- intercultural mediation;
- psychosocial aspects of migration; and
- access and right to health in Portugal (common barriers and constraints to access health services; rights and duties).

The course was offered through a free online learning platform and took approximately 12 hours to complete. It was a blended format with a mix of asynchronous self-directed learning activities that trainees could pace and access according to their schedules, and four online synchronous sessions to clarify and extend learning through practical cases with experts.

The course had two editions: the first ran from June to September 2021 (targeted exclusively to primary health care workers). This was completed by 276 participants. Training evaluation was strongly positive and linked with self-reported increased confidence and knowledge. A second edition from January to May 2022 was completed by 781 participants representing a broader range of

students and sectors including health care workers, academics, researchers, NGO workers and social services and organizations.

Based on the number of health care workers who took part and completed the training, it was considered a success. Success was credited to the distance-learning format, which allowed participants to take advantage of the well-known benefits of the e-learning system, complemented by synchronous sessions providing real-time interaction between participants across the country and several experts. The e-learning course was successfully developed and implemented at the national level during the COVID-19 pandemic, with participants reporting that the course was very useful and relevant.

“ The e-learning course was successfully developed and implemented at the national level during the COVID-19 pandemic, with participants reporting that the course was very useful and relevant. ”

**Case study**

**27**

Country:  
**Thailand**

**Title:** supporting migrant health volunteers as an integral mechanism to promote the health of migrants

The COVID-19 pandemic significantly impacted migrants in Thailand, through both health status and the ability to generate income necessary for accommodation, food, essential hygiene items and personal protection equipment. It also further exacerbated issues with underinclusion of migrants in the health system, such as access to COVID-19 vaccines, testing and treatment.

This initiative aimed to respond to issues that emerged from COVID-19 and its effects on the state of health of migrants residing in Thailand. It emphasized the prevention and management of SARS-CoV-2 transmission among migrant communities while simultaneously strengthening the capability and synergy of relevant stakeholders in public health emergency preparedness and response.

A key element was the inclusion of migrant health volunteers; these are regarded as both important and effective stakeholders to support improved migrant health

and health care access through their familiarity and ties with the community and use of migrants' languages. Their work acts as a conduit to support communication between migrant communities and those providing health services.

This initiative included several elements to equip migrant health volunteers, including training and provision of SARS-CoV-2-protective supplies. The focus of the training was on both increasing their health literacy and equipping them with COVID-19-related information, including symptom monitoring, case reporting and hygiene equipment instructions. Training was delivered by IOM in collaboration with the local NGO World Vision Foundation Thailand. The training was adapted from the Ministry of Public Health's national health volunteer training curriculum, involving district health authorities and medical staff from the local hospital. Migrant health volunteers were additionally provided with 14 450 hygiene kits, surgical masks and alcohol gel bottles.

Thereafter, trained migrant health volunteers assisted in a range of health interventions relating to COVID-19 management and improving the well-being of migrants more generally. This included acting as intermediaries between migrants and health service staff/health authorities at field hospitals, vaccination sites and quarantine facilities; conducting health education sessions; and active case finding in migrant communities.

The migrant health volunteer project has helped to reduce transmission of communicable diseases, for example

by supporting community case identification; to assist migrants in accessing health care services, for example via interpreting at field hospitals and quarantine sites; and to facilitate collaboration between the NGO and district health offices. There have also been several challenges. Despite the Government's recognition of migrant health volunteers, they are yet to be fully integrated into the country's health system. Some stayed in Thailand temporarily and hence stopped working as volunteers once they had to return to their homes.

“ Migrant health volunteers were additionally provided with 14 450 hygiene kits, surgical masks and alcohol gel bottles. ”

## Case study

# 28

Country:  
**Italy**

**Title:** Project Footprints – training the public health workforce on the development of regional coordination plans for migrants' health and the implementation of a CoP

Migration represents an open challenge for the Italian health system, not only in terms of quantification and analysis of needs, but above all in terms of an adequate service organization.

Access to care for refugees and migrants in Italy is protected. Art. 32 of the Italian Constitution guarantees the right to health to every individual irrespective of their nationality or migratory status. Despite this, and in the context of a decentralized health system, the interpretation and implementation of legislation on access to care for foreigners are highly inhomogeneous on the ground, both across and even within regions.

Improved governance and coordination for migrants' health across health service levels, stakeholders and sectors is, therefore, key to reaffirm the universality and equity principles of the Italian health system. Health planning and service organization at all levels must fully include foreigners and be oriented by the organizational principles of the NHS, such as the centrality of the person and the public responsibility for the protection of health. There needs to be collaboration between levels of government of the NHS, an enhanced professionalism of health workers and the integration of health and social services.

Project Footprints was proposed by the Ministry of Health and funded through the Asylum, Migration and Integration Fund of the EU. The objective was to overcome the fragmentation existing at local and regional levels in terms of approaches, access modalities and health service organization in the area of migration and health; and to strengthen regional governance on these issues by defining uniform operational arrangements for the coordination of public health aspects concerning the migrant population. This was done through training of regional coordinators for migrants' health; provision of support for local processes of implementation of national guidelines and recommendations; and the creation of a CoP to encourage discussion and exchange among regional coordinators.

Results of the programme included:

- the definition of a national training model focused on coordination and governance aspects of migrants' health and based on the training provided in the framework of the programme and validated through participants' feedback;
- strengthening of governance and coordination skills of 90 regional coordinators for migrants' health;

- development of a validated national format document to be used as a basis for developing contextualized regional coordination plans on public health aspects related to migrant populations;
- the development of a methodology for regional and local level interventions aimed at activating strengthened governance and coordination mechanisms; and
- the construction of a web-based CoP among regional coordinators for the area of migration and health.

The Project faced challenges, including differing responses and sensitivities at regional level, changes in regional governments and the outbreak of the COVID-19 pandemic; these limited implementation opportunities. However, despite implementation challenges, the initiative set in motion a process that continues in several regions.

“ There needs to be collaboration between levels of government of the NHS, an enhanced professionalism of health workers and the integration of health and social services. ”

## Case study

# 29

Country:  
**New Zealand**

**Title:** training for health professionals working with migrants and former refugees in the Waitematā CALD service

The population of New Zealand (Māori: Aotearoa) has become very diverse in terms of ethnicity, culture, religion and language and there were record levels of net migration before the COVID-19 pandemic. New Zealand was expected to receive 1500 former refugees per annum under its national quota refugee programme from 1 July 2020; however, COVID-19 impacted the intake numbers.

Cultural diversity is highly prevalent in urban cities, particularly Auckland, where almost 50% of the population are Māori, African, Asian, Latin American or Middle Eastern; 44% were born overseas. There are over 180 ethnicities, 157 religions and 170+ spoken languages.

International and New Zealand studies show that culturally and linguistically diverse populations have disparities in health status and experience varying barriers to health care services. These populations underutilize health services when compared with other population groups, even when adjusted for income and health conditions. Cultural competence education has been shown to be an effective strategy in immigrant-receiving societies to respond to structural inequalities and inequities in health care access and outcomes for people from culturally and linguistically diverse backgrounds. It was in this context that the

Culturally and Linguistically Diverse Service (CALD Service) was developed, which provided competency training for the health workforce to cover culturally and linguistically diverse needs. The service started in the Auckland Region in 2008 and was rolled out nationally in 2015. In 2019 the Waitematā District Health Board developed eCALD, a culturally and linguistically diverse online training for health providers working in the emergency quota refugee regions. The CALD Service uses an integrated approach of face-to-face and online learning platforms to deliver training to health professionals working in the primary and secondary health sectors across New Zealand. The service was expanded to include health professionals working in the NGO sector from 2022. The aims of CALD and eCALD training programmes are to improve the patient experience and health and equity outcomes for culturally and linguistically diverse groups across New Zealand.

The eCALD programme is the first of its kind in New Zealand. The primary success factors are that the programme:

- receives funding and endorsement from the New Zealand Government (via the commissioning team of Health New Zealand (Te Whatu Ora));

- operates under the umbrella of the Waitematā’s Institute for Innovation and Improvement, where innovation and improvement are core values;
- involves culturally and linguistically diverse migrant and refugee members, patients and clinicians in developing and reviewing the courses and resources;
- meets health professionals’ registration bodies standards for competencies related to cultural awareness and cultural and linguistic diversity; and
- is endorsed by the health professionals’ registration bodies.

The eCALD education programme is digitally enabled. Learners can access courses and resources via a secured

learning management system, which tracks registrations, enrollments, online study, course completion and evaluation. It provides a dashboard for learners to enrol onto courses, start or resume their online course(s), and retrieve certificates, journals and learning records.

By July 2022 over 49 000 people had enrolled for courses. The online, face-to-face and remote course evaluation results show all six performance measures achieving 80% and above. Learners have been overwhelmingly positive about the impacts on their cultural awareness and increased confidence in engaging with culturally and linguistically diverse patients.

“ International and New Zealand studies show that culturally and linguistically diverse populations have disparities in health status and experience varying barriers to health care services. ”

**Case study**

**30**

Country:  
**Multinational**

**Title:** inclusion of refugees and other people of concern in national COVID-19 vaccine rollout

Prior to the COVID-19 pandemic and in line with the Global Compact on Refugees, the UNHCR purposefully pursued an approach to promote greater inclusion of refugees and other persons of concern (PoC) into national health policies, plans and systems. UNHCR’s biannual survey on the inclusion of refugees into national health systems and programmes shows encouraging progress. In 2021, of the 47 surveyed countries with a national health plan, 36 (77%) included refugees, compared with 29 (62%) in 2019. In 2021 access to services was generally similar to that for nationals for primary health care (94%), but to a lesser extent for secondary care (83%).

The COVID-19 pandemic has emphasized the need for inclusive health policies and systems, and leaving no one behind. With the onset of the pandemic, long-standing relationships with hosting governments and progress towards inclusion provided a sound platform for advocating

for inclusion of PoC in national COVID-19-preparedness and response plans and national deployment and vaccination plans (NDVPs). UNHCR has worked closely with national authorities and partners to include refugees and other PoC in national COVID-19 response plans and in NDVPs. In many refugee-hosting countries, UNHCR has supported national health systems: increasing testing capacity; establishing isolation facilities in government or camp health facilities; training staff; procuring essential medicines alongside personal protective equipment, oxygen concentrators and ventilators; and designing risk communication and community engagement initiatives for refugee communities. At the county level, UNHCR has engaged with ministries of health, UNICEF, WHO and the COVID-19 Vaccines Global Access (COVAX) facility, advocating for refugees to be included in NDVPs in the first phase of the national strategy in line with other priority groups (such as health workers and elderly people).



UNHCR systematically monitored the inclusion of refugees in NDVPs, as well as where and when PoC started to receive vaccinations. In December 2020, of the 58 countries providing information, 28 (54%) reported that refugees and/or other PoC were included in their NDVPs, and by March 2021, 120 of the 157 (76%) countries reporting information had confirmed inclusion. By the end of June 2021, 160 out of 162 (99%) reporting countries had confirmed inclusion in NDVPs, while 94 (58%) confirmed actual vaccination of refugees. By the end of 2021, 162 (100%) reporting countries had confirmed inclusion and 138 (85%) had confirmed actual vaccination.<sup>13</sup> To date, UNHCR has confirmed vaccination of refugees in 153 countries.

Most States were committed to the inclusion of PoC based on established relationships with governments, overall progress towards inclusion and the recognition that vaccination of all people within a territory is needed to reduce the spread of SARS-CoV-2 and the impact on health systems. However, despite political willingness, many States lacked the domestic resources to include PoC. This was addressed through solidarity mechanisms, notably the COVAX facility and the Humanitarian Buffer,

whereby additional vaccine doses were provided to include the refugee population if they remained excluded from national rollouts.

UNHCR participated in the Interagency Working Group supporting the design of the COVAX Humanitarian Buffer and was part of the decision-making body on applications. Refugees are often hosted in remote border regions where there can be logistical challenges that hamper vaccine rollouts. Additional financing is required to accelerate outreach to communities in more remote locations, and this is being addressed with the support of the COVID-19 Vaccine Delivery Partnership. Administrative barriers in some contexts were addressed through advocating with States for waiving the requirement for documentation, simplifying registration on electronic platforms and mass mobile outreach vaccinations.

While much remains to be done to reach global COVID-19 vaccination coverage targets, encouragingly, States have adopted refugee-inclusive policies and plan building on progress on inclusion prior to the pandemic.

“ The COVID-19 pandemic has emphasized the need for inclusive health policies and systems, and leaving no one behind. ”

## Case study

# 31

Country:  
**Viet Nam**

**Title:** promoting the health of migrants through the establishment of the interministerial Migrant Health Working Group

The Vietnamese Ministry of Health has committed to implementing World Health Assembly resolution 70.15 on promoting the health of refugees and migrants, which was endorsed in May 2017.

In 2019 the Ministry of Health, IOM and WHO jointly conducted a situation analysis of migrant health.<sup>14</sup> This

aimed to identify migrants' needs and the gaps and priorities for future migrant health planning in Viet Nam. The findings revealed limited information-sharing among different ministries that oversee the health of migrants. Inefficiencies had arisen due to a lack of formal interministry partnerships; and issues with communication and cooperation mechanisms had created inefficiencies.

<sup>13</sup> UNHCR (2022). UNHCR Covid-19 vaccine access report 2021. Geneva: United Nations High Commissioner for Refugees (<https://www.unhcr.org/uk/protection/operations/623b18244/unhcr-covid-19-vaccine-access-report-2021.html>, accessed 10 December 2022).

<sup>14</sup> IOM (2020). Situation analysis of migrant health in Viet Nam. Ha Noi: International Organization for Migration (<https://publications.iom.int/system/files/pdf/sa-migrant-health-viet-nam.pdf>, accessed 10 December 2022).

The findings demonstrated that many of the solutions to improving migrants' health did not lie exclusively in the health sector but also in other sectors, such as labour and immigration. This suggested a need for a multisectoral approach to effectively address today's numerous migration-related health challenges. This requires collaboration across different sectors and integrating migrants' health issues into different sectoral policies to avoid exclusion and ensure positive health outcomes for both migrants and their families.

In response, the Migration Health Working Group was officially established by the Minister of Health of Viet Nam in May 2021. This interministerial group now serves as a national technical coordination mechanism to enable relevant departments across different ministries to manage migrant health issues and coordinate with relevant stakeholders to foster the design and implementation of migrant-friendly health interventions and policies. The Migration Health Working Group consists of representatives from various ministries, relevant government agencies and United Nations agencies. It is chaired by the Director of the General Office for Population and Family Planning at the Ministry of Health and the Chief of Mission, IOM Viet Nam. The Ministry of Health, IOM and WHO also provide secretariats for the Group.

Specifically, the Working Group aims to:

- provide technical assistance and participate in the development of policies, programmes and plans related to migrant health;

- promote participation, connection and information sharing about migration and migrant health;
- develop and implement a coordinated action plan on migrant health;
- strengthen capacity of the Working Group members; and
- facilitate communication, dissemination and social mobilization activities on migration and migrant health in Viet Nam.

Although Government funding for the Working Group is still limited, financial support from IOM and WHO has allowed the Working Group to proactively implement several migrant health interventions in Viet Nam. These include a series of talk shows and workshops, with migrant participation to raise public awareness about migrant health, and developing migrant-friendly handbooks for the health of Vietnamese migrant workers overseas (see Case study 22), which are used during pre-departure health training for migrant workers and while they are in a destination country.

The Migration Health Working Group has actively contributed to drafting a migrant health programme that covers a wide range of migrant health interventions up to 2030; this is currently under legislative review for the Health Minister's approval. The Working Group continues to seek more funding opportunities to scale up migrant health interventions in the country.

“ The Migration Health Working Group has actively contributed to drafting a migrant health programme that covers a wide range of migrant health interventions up to 2030. ”

## Case study

# 32

Country:  
**United Kingdom**

**Title:** a cross-government forum, the National Asylum Seekers Health Steering Group, to provide system leadership for addressing the health and well-being of asylum seekers

Asylum seekers are at risk of a complex range of physical and mental health issues arising from experiences before, during and after migration. Before and during migration,

experiences can include the physical effects of war and torture; mental health problems related to trauma, uncertainty and stress; exposure to communicable diseases;

and malnutrition. Asylum seekers' health is further shaped by their post-migration journey. Contributory post-migration factors include, but are not limited to, economic status, living conditions, health care access, language barriers, discrimination and stigma, community integration and negotiating threats to identity.

The United Kingdom's Home Office has a statutory requirement under the Immigration and Asylum Act 1999 to arrange accommodation for asylum seekers and their dependants in the United Kingdom who would otherwise be destitute. There are several challenges to ensure that the health needs of asylum seekers are met, such as GP registration and delivery of initial health assessments covering matters such as vaccination, maternity care and mental health care. National- and local-level mechanisms are required to ensure asylum seekers' health and well-being needs are recognized and integrated into the United Kingdom health care system.

It is in this context that the Home Office and the Office for Health Improvement and Disparities jointly chair the

National Asylum Seeker Health Steering Group, established in 2021, which brings together experts from across the health sector and immigration to consider the specific health and well-being needs, barriers and solutions for people seeking asylum status in the United Kingdom. It consists of various workstreams, including access to care, mental health, maternal health, safeguarding and data. The key actors are:

- Office for Health Improvement and Disparities;
- United Kingdom Health Security Agency;
- NHS England;
- devolved administrations (Scotland, Wales and Northern Ireland); and
- Health and Social Care Northern Ireland.

The Steering Group provides advice about, and oversight of, all the health and well-being needs of asylum seekers in the United Kingdom in order to improve their access to health care and public health services and improve health outcomes, thus facilitating integration.

“ Strong system leadership is required to ensure that national- and local-level mechanisms are in place to ensure asylum seekers' health and well-being needs are recognized and integrated into the United Kingdom health care system. ”

## Case study

# 33

Country:  
**Mozambique**

**Title:** integrated health response to the humanitarian crisis in Cabo Delgado Province, addressing primary health, GBV and MHPSS for both IDPs and host communities

The southern districts of Cabo Delgado Province, Mozambique, have seen increased numbers of IDPs due to the conflict caused by non-state-armed groups since October 2017. This conflict has caused up to 4129 reported

fatalities from organized political violence, 1791 of which were due to targeting civilians. This intervention focused on these districts and efforts to establish IDP relocation and resettlement sites.<sup>15</sup>

<sup>15</sup> Cardona-Fox G, De Meneghi G, Occa E, Atzori A (2021). Work with the community or go home: local engagement in Mozambique. *Forced Migr Rev.* 67:20–22.

The integrated intervention aimed to provide basic essential health services and to support the local health system in offering routine services to IDPs and host communities. The project additionally aimed to improve the knowledge and practices of the displaced and Indigenous populations regarding the prevention of communicable diseases, both to reduce spread of diseases and to reduce the pressures on overworked health structures. In terms of policy, the interventions aimed to define, standardize and share evidence on GBV and MHPSS in order to contribute to the development of evidence-informed national strategies.

The key actor was the NGO Doctors with Africa CUAMM, which implemented the intervention in collaboration with, and with support from, various United Nations agencies and private foundations, and in close and constant relationship with authorities at all levels: central ministries and provincial, district and community authorities.

The main activities were intended to increase access to essential health services in remote areas, including monitoring and follow-up, with a focus on pregnant women and malnourished children. This widespread work of identification, counselling, referral and follow-up for GBV and MHPSS is a necessary intervention for vulnerable communities fleeing conflict.

Documenting interventions through real-time mobile phone-based data collection systems and tools shared with local health authorities has helped to support the local health system in making strategic evidence-informed and data-driven decisions.

An operational research component investigated the cultural determinants of endemic diseases, and qualitative and participatory research with dedicated focus groups also provided a more in-depth knowledge of the local reality in epidemiological and behavioural terms. The research component was carried out jointly with the National Institute of Health; the project was facilitated through a coordinated humanitarian response mechanism across agencies and services, operated through thematic clusters in order to plan coverage and extent of interventions by geographical areas.

The project highlighted several challenges, including major logistical difficulties related to the context of changeable insecurity. This required operational flexibility to meet the needs of a continuous flow of displaced populations, both those fleeing areas affected by conflict and relocating for access to subsistence and those seeking reunification with family and community. Other challenges included coordinating responses with local authorities, obtaining credentials to work in the territory and transparency in data management processes.

“ The integrated intervention aimed to provide basic essential health services and to support the local health system in offering routine services to IDPs and host communities. ”

Case study

34

Country:  
**Colombia**

**Title:** support for government institutions to approach women, adolescents and girls in contexts of vulnerability to prevent GBV and protect women

In Colombia, implementation of the Information, Education and Communication Strategy across sectors has increased understanding of SRHR among migrant women and adolescents, as well as host communities.

This strategy aimed to promote and empower these populations in SRHR, with a gender perspective. The interventions focused on:

- empowering women and girls from communities and local institutions to promote SRHR and to exercise their voice and agency;

- increasing access to comprehensive gender-responsive SRHR services to women and girls; and
- enhancing access to health care and referrals services for women and girls in host communities, Venezuelan migrants, and survivors of GBV and sexual exploitation.

“ This strategy aimed to promote and empower these populations in SRHR, with a gender perspective. ”

## Case study

# 35

Country:  
**Jordan**

**Title:** supporting the needs of displaced children while strengthening existing health and nutrition services

Among the more than 761 000 refugees and asylum seekers registered with UNHCR in Jordan at the beginning of July 2022, 46% were children under the age of 18. Achieving UHC is among the goals of the Government’s National Health Strategy, including providing all Jordanians and residents with a minimum health care package. Currently, around 70% of Jordanians are covered under a civil insurance scheme, but barriers remain to extending coverage to vulnerable Jordanians as well as to refugees. In an effort to mainstream refugees into the national health system, refugees have been granted access to medical centres and hospitals run by the Ministry of Health at the same rate as non-insured Jordanians if they are able to present a UNHCR asylum seeker certificate for non-Syrian refugees or a UNHCR asylum seeker certificate plus a valid Ministry of the Interior card in the case of Syrian refugees. Free-of-charge services that are provided to refugees in various health centres and Government hospitals affiliated to the Ministry of Health include preventive and curative services for mothers and children at the maternal and child centres of the Ministry of Health, treatment for thalassaemia, a genetic disease, and treatment for certain diseases of public health concern, including SARS-CoV-2 or other diseases requiring isolation.

In this regard, UNICEF, in partnership with the Ministry of Health, provides essential primary and secondary health care services for children under 5 years of age.<sup>16</sup>

The immunization service in Azraq Refugee Camp is partially handed over to the Ministry of Health to facilitate integration within the national system. The other services provided include nutrition clinics where children under 5 years and pregnant and lactating women are screened for malnutrition. In addition, women of reproductive age receive vaccination against tetanus. Further, parents and caregivers of children under 5 years of age receive counselling on proper infant and young child feeding practices. The paediatric ward in Azraq Camp provides primary and secondary care. A key enabler in this setting is the community volunteers, who collaborate with both UNICEF and Government stakeholders to raise awareness about diseases. They were instrumental in the response to the global COVID-19 pandemic, engaging with the community on infection prevention and control and to address vaccine hesitancy.

The National Health Strategy is based on three pillars: opportunities for families to be economically self-sufficient through the labour market; empowerment of the population through education, health care and supportive social services; and targeted social assistance that allows the poor to maintain a basic level of consumption with dignity. All three pillars of the National Health Strategy are underpinned by UNICEF’s focus on reaching the most vulnerable children and women of reproductive age in Jordan, regardless of

<sup>16</sup> UNICEF (2021). Country office annual report 2021: Jordan. New York: United Nations Children’s Fund (<https://www.unicef.org/media/117081/file/Jordan-2021-COAR.pdf>, accessed 10 December 2022); UNICEF Jordan (2022). Vaccines work! Amman: UNICEF Jordan (<https://www.unicef.org/jordan/stories/vaccines-work>, accessed 10 December 2022); UNICEF Jordan (2022). Health and nutrition. Amman: UNICEF Jordan (<https://www.unicef.org/jordan/health-and-nutrition>, accessed 10 December 2022).

whether they are from host communities, refugees, living in informal tent settlements or from the Dom minority group.

UNICEF works to support the Government to strengthen and build the resilience of the national health system, including by identifying modalities to expand existing services to cover refugees. This entails a study to assess the costs and financial impact of expanding the civil insurance programme to vulnerable Jordanians and Syrian refugees, including exploring different modalities to create the fiscal space for expansion, from identifying efficiency gains through to introducing taxes on harmful products such as tobacco. UNICEF has also invested in primary health care by subsidizing health care fees for refugees when they access Government-run primary health care centres and by implementing a community-oriented primary health care-strengthening project to focus on prevention and link communities to primary health care services, with the goal of reducing the strain on secondary and tertiary care centres, which are heavily overutilized.

UNICEF also works to support delivery of health services through a cross-sectoral approach, for example through

school health programmes targeting particularly double-shift schools which host Syrian refugees. School health programmes are a key tool to access the growth and health status of children and to educate them on healthy behaviours.

Among the existing and persisting gaps is a need to integrate mental health services within primary health programmes and implement tailored approaches to meet the needs of different groups of children and young people. This includes establishing screening and referral mechanisms, as well as creating safe spaces for young children or integrated mental health services linked to SRH programmes for adolescent girls and boys.

Additional resources are also needed to strengthen the primary health care platform and initiate a shift from a heavy reliance on secondary and tertiary care towards investing in preventive health care. Currently, primary health care services remain underutilized, whereas curative-based care services are overcrowded and create financial constraints, which in turn impact the degree to which UHC can be realized in Jordan.

“ In an effort to mainstream refugees into the national health system, refugees have been granted access to medical centres and hospitals run by the Ministry of Health at the same rate as non-insured Jordanians. ”

## Case study

# 36

Region:  
**Western Balkan route**

**Title:** implementation of the Refugee and Migrant Child-Health Initiative (Bosnia and Herzegovina, Bulgaria, Greece, Italy and Serbia) to safeguard the health of refugee and migrant children

Serbia forms part of the Balkan route, a major migration route into Europe characterized by mixed-migration movements. While arrivals have significantly decreased since the European migrant crisis in 2015, Serbia remains an important transit country for refugees and migrants en route to central and northern Europe. Children on the move and their families have often travelled extended periods of time without accessing health services. Many come

from countries where the health infrastructure has been destroyed or was unable to cater to their needs, leading them to missing out on basic health services, such as routine childhood immunizations.

While children on the move can receive health services at primary health care centres, gaps remain when it comes to capacity of service providers, inaccessibility of health

information and lack of community engagement with refugees and migrants to encourage health-seeking behaviour.

The Refugee and Migrant Child-Health Initiative has been implemented by UNICEF and partners in Bosnia and Herzegovina, Bulgaria, Greece, Italy and Serbia over a period of 27 months, with funding from the EU. The Initiative was set up to strengthen national health systems so that they could meet the needs of children on the move and stimulate public demand for strong national health systems.

The Initiative is based on three main components:

(i) improving awareness and knowledge of children on the move and their families about health services, including through health literacy packages informing where and how to access services and information about different types of services, ranging from immunization to feeding practices, mental health services, child protection and GBV services; (ii) strengthening the capacity of the national system and service providers to deliver health services so that children on the move can access a range of services from routine immunization to MHPSS, and that migrants can access maternal and newborn health services; and (iii) strengthening the implementation of health policies.

The Initiative was designed to create a strong linkage between health care, child protection and GBV services, for example by making MHPSS services an integral part of health care strengthening, as well to ensure that health services respond to the needs of survivors of GBV. This includes reinforcing the early detection, prevention of and response to GBV among refugee and migrant women and girls in collaboration with civil society, reception centre

staff and other frontline workers, and strengthening referral pathways to specialized services, from medical and mental health through to legal services.

For example, in Serbia, the Initiative has applied a particular thematic focus to the prevention and early detection of substance abuse among adolescents as requested by the Commissariat for Refugees and Migrants, and in partnership with the National Institute for Public Health of Serbia. This has included a focus on MHPSS responses, an area in which UNICEF has collaborated with WHO and the Ministry of Health. The Mental Health Working Group has served as a vital coordination mechanism to identify and provide specialized services for individuals requiring mental health support but also as a referent group of professionals supporting the design of the related research and policy documents.

Community-based psychosocial support programming in asylum and reception centres carried out by UNICEF and partners has provided structured workshops, as well as creative and recreational activities.

Providing a continuum of care for children on the move is challenging. Children on the move and their families often arrive without health records, including records of previous immunization, diagnosis or treatments. In practice, this means health service providers rely on information provided by parents, caretakers or the children themselves, which is particularly problematic for unaccompanied children on the move, who often do not know their treatment history. Lack of medical records and frequent relocation further disrupt and delay treatment, particularly impacting those with chronic or life-threatening conditions.

“ Many come from countries where the health infrastructure has been destroyed or was unable to cater to their needs, leading them to missing out on basic health services, such as routine childhood immunizations. ”

# 4

## PRIORITY

**Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage**





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Priority 4 advocates that the social determinants of health for refugees and migrants can be addressed through joint, coherent multisectoral action in all public health policy responses based on all relevant SDGs, particularly SDG 3 (ensure healthy lives and promote well-being for all at all ages) and SDG 10 (reduce inequality within and among countries), including UHC. There are seven case studies presented for Priority 4.

Case studies 37 and 38 are examples of projects that focus on the social determinants of health for refugees and migrants and target enhanced access to health and social care within and across and sectors. Case study 37 describes the work of a multiagency migrant health network, which collaboratively discusses issues that affect the holistic health of refugees and migrants. This network was instrumental in developing an online portal where resources and expertise are accessed across sectors, thus working towards a collective approach to supporting migrant health. Case study 38 provides details of a live migrant health guide that offers guidance to health care professionals in the United Kingdom regarding migrants' entitlements to health care services and health needs.

The five remaining case studies are presented as examples of projects that support the

reduction of inequalities within and among countries, including efforts to achieve UHC. Case study 39 describes a cross-border multicountry regional programme that collaborates across sectors in increasing accessibility and use of health care services for refugees and migrants and is working towards UHC in six countries (Egypt, Libya, Morocco, Sudan, Tunisia and Yemen). Case study 40 provides details of a collaborative cross-sectoral approach adopted in Nepal for reducing inequalities by increasing access to COVID-19 vaccinations for migrants. Case study 41 is an example of an intersectoral collaboration that aims to reduce barriers experienced by undocumented migrants in Thailand in accessing universal health and social care. A key focus here is the development of a database of disaggregated data on migrant workers that will integrate across health, social, education and justice systems. Case study 42 outlines a project that is part of a wider effort to progress UHC and the SDGs in Sri Lanka, detailing how enrollment onto the National Health Protection Plan supports free access to health care. Finally, Case study 43 describes the establishment of a new health insurance modality providing free access to health care for 6000 asylum seekers and refugees with health vulnerabilities and socioeconomic needs in Costa Rica.



## Case study

## 37

Country:  
**United Kingdom**

**Title:** multiagency network and associated portal created to support the health and well-being of migrants

Health inequalities for migrant populations in the south-west of England (United Kingdom) is an ongoing problem. This project aims to address the issues that were identified as contributing to this ongoing problem:

- limited shared resources/information and single points of reference for sharing of experiences and good practices for those working with migrants;
- lack of multiagency forum for shared discussion, raising of current and future challenges and resource sharing;
- lack of a forum for escalation of reported challenges to migrant health in the region; and
- no website or other one-stop online location for information and resources accessible to NHS staff and external stakeholders.

A multiagency network was set up that included representatives from local authorities, community groups, voluntary organizations, the Office for Health Inequalities and Disparities, public health, academia and those with lived experience. Several representatives also came from the NHS, including from primary care, integrated personalized care, community nursing, commissioning, dentistry and safeguarding.

The objective of the network was to connect each of the disparate bodies in order to efficiently cascade resources, best practice and experiences back to each of the seven integrated care systems in the region. Subsequent to setting up this initiative, requests were received from outside of the region as there were no national resources on the NHS platform that perform a similar function. This new multiagency network and multidisciplinary forum provides opportunities for members to raise issues encountered within their own operational or strategic remit and to co-produce a common response or initiate an escalation process in seeking a response from national or international resources. There are a number of examples

where such issues were raised and how they were responded to.

- Identification of a lack of oral health and dentistry provision resulted in communication with the commissioning body to create an awareness of the wider health and well-being impact of the lack of such services on individuals and the increased burden that it generated for already overstretched acute and emergency services.
- The lack of documentation in different languages to inform those whose first language is not English about health care systems and services was identified. As a result, verified translations were provided by international organizations such as Doctors of the World to cover, for example, the COVID-19 vaccination programme and the guides to the NHS. These were produced in a range of languages as specific migrant needs developed, such as Arabic (for the Syrian re-settlement programme), Chinese (for the Hong Kong programme), Farsi (for Afghan refugees) and most recently Russian and Ukrainian (for those fleeing Ukraine).
- Access was initiated to resources such as health assessments, immunology guidelines and translated materials for those from specific countries.
- Initial stages were initiated for discussion of “making every contact count” interventions, exploring opportunities for improving behavioural risk factors in asylum seekers, and sharing best practices.
- Research, practice and policy collaborations have been nurtured and examples have been included in research funding bids (for example a successful bid to the National Institute for Health and Care Research under the Health and Social Care Delivery research awards has enabled the co-design of a peer-led community approach to support mental health in refugees.<sup>17</sup>

<sup>17</sup> National Institute for Health and Care Research (2022). Forced to flee. Co-designing a peer-led community approach to support the mental health of refugees. London: National Institute for Health and Care Research (<https://fundingawards.nihr.ac.uk/award/NIHR134589>, accessed 9 December 2022).

The developed resources and others are freely available on a newly constructed online portal hosted by the NHS but available to all working in the field. Separate sections of the portal are dedicated to specialist areas by locality or sector, for example primary or secondary care.

The change of location/address for a refugee or migrant is a challenge in ensuring integration and continuity of care. The lack of access to medical records for refugees and migrants, such as vaccination and allergy history, and the difficulties with data linkage across the United Kingdom Home Office and health and care services because of General Data Protection Regulations are problematic.

“ The objective of the network was to connect each of the disparate bodies in order to efficiently cascade resources, best practice and experiences back to each of the seven integrated care systems in the region. ”

## Case study

# 38

Country:  
**United Kingdom**

**Title:** Migrant Health Guide, giving evidence-informed advice and guidance on the health needs of migrant patients for health care practitioners

In 2021 approximately 17% of the United Kingdom population had been born overseas. Evidence suggests that health care professionals have a poor understanding of migrants' health needs and entitlements for the use of NHS services and this can impede migrants' access to health services.

The Office for Health Improvement and Disparities manage the Migrant Health Guide, which was first launched in 2014.<sup>18</sup> This is a free online resource supporting primary health care professionals in caring for migrant patients. It is widely used in the United Kingdom, and between March 2021 and March 2022 it received over 276 000 unique page views, 72% of these from the United Kingdom. The Migrant Health Guide contains a number of sections, including about entitlements to NHS services, health topics (COVID-19 and other communicable diseases and NCDs), guidance on health assessments for new migrant patients and over 100 country-specific health profiles. New guidance is published for new groups of refugees arriving in the United Kingdom, for example from Afghanistan and Ukraine. Other key topics include vaccination, guidance on language

interpretation and translation, women's health, children's health and information on data sharing between health and immigration authorities.

Evaluation of the Migrant Health Guide is conducted at regular intervals to gather feedback from a wide range of stakeholders and health partners on awareness, knowledge, attitudes and preferences in order to inform improvements and ensure that it is fit for purpose. Recent developments to the Guide include:

- creation of bite-size animations on NHS entitlements and immunizations;
- creation of, and regular updates to, a COVID-19 webpage (available in 40 languages), such as inclusion of the message that testing, treatment and vaccination (including boosters) for SARS-CoV-2 are free of charge irrespective of immigration status; and
- creation of a new webpage on social prescribing for migrants, informed by a rapid evidence review and call for evidence on social prescribing approaches.

<sup>18</sup> Office for Health Improvement and Disparities (2021). Migrant health guide. London: Office for Health Improvement and Disparities (<https://www.gov.uk/government/collections/migrant-health-guide>, accessed 9 December 2022).

Numerous factors facilitate the publication of the Migrant Health Guide, including:

- access to a wide range of subject matter experts internally in the Office for Health Improvement and Disparities and in other agencies such as the United Kingdom Health Security Agency, academia and the voluntary and community sector;
- established internal processes and working arrangements with Government publishing teams to

ensure guidance aligns to accessibility standards and Government style conventions; and

- processes in place to regularly review, update and peer review page publications.

However, maintaining and developing this Guide is a resource-intensive exercise, which requires constant review of the published evidence, of global health dashboards and other sources of data.

“ This is a free online resource supporting primary health care professionals in caring for migrant patients. ”

Case study

39

Countries:

**Egypt, Libya, Morocco, Sudan, Tunisia and Yemen**

**Title:** fostering health and protection of migrants in vulnerable situations in the Middle East and north Africa

Migrant populations face structural challenges in accessing critical information on their rights, as well as for health services, well-being support and protection; barriers include immigration status, language barriers, lack of migrant-inclusive health policies and inaccessibility of services. This project aimed to improve vulnerable migrants' health and well-being and to advance towards UHC in Egypt, Libya, Morocco, Sudan, Tunisia and Yemen. Specifically, it supports national and local actors in collectively managing migration flows, with a focus on improving health and protection for vulnerable migrants. The project builds on the achievements and experiences over two phases, 2015–2018 and 2018–2020, during which the six countries implemented a set of tailored activities to support governments, assist vulnerable migrants and respond to their health and protection needs.

As a cross-border multicountry regional programme, the project applies the key Global Compact of Migration principles and advances health-related SDGs by engaging not only health sectors and governments but also non-health sectors and nongovernmental actors. Major contributors include the Ministry of Foreign Affairs of Finland, Sudan's Federal Ministry of Health, the National

AIDS Programme Egypt, the National School of Public Health Morocco and the Ministry of Health and Social Protection of Morocco.

The current phase of the project has contributed to the successful inclusion of regular and irregular migrants in the COVID-19 national vaccination campaigns in the six countries; the launch of the National Strategic Plan of Migration Health 2021–2025 in Morocco; the establishment of a migration health desk within Sudan's Federal Ministry of Health; the incorporation of migrants into the national AIDS programme in Egypt; and the reinforcement of the South–South cooperation approach through the training of a regional pool of trainers on migration health by the National School of Public Health of Morocco.

The following are intended results:

- national policies and strategies will make provisions for the health needs and rights of migrants and their communities in line with international, regional and national commitments;
- increased accessibility and use of health and protection services enabled for vulnerable migrants; and

- strengthened multisectoral partnership alliances created towards a harmonized and sustainable response to

the health needs of vulnerable migrants and their host communities.

“ This project aimed to improve vulnerable migrants’ health and well-being and to advance towards UHC in Egypt, Libya, Morocco, Sudan, Tunisia and Yemen. ”

Case study

40

Country:  
**Nepal**

**Title:** advancing the global health security agenda through strengthening capacity for rapid response to humanitarian and public health issues

This programme was introduced in Nepal during the second wave of the COVID-19 pandemic, which peaked between May and June 2022. Although a COVID-19 vaccination programme was in place in Nepal, a prioritized approach based on the WHO Strategic Advisory Group of Experts on Immunization classification delayed the reach of vaccine access to migrant and vulnerable population groups and subgroups. The national vaccine deployment plan was also dependent on an uninterrupted supply of vaccines to the country through the COVAX purchasing mechanism or bilateral support from international governments. To counter this, Nepal managed to obtain 6 million additional COVID-19 vaccine doses through diplomacy efforts.

IOM partnered with Government agencies to advocate and to improve access to COVID-19 vaccines among migrants and hard-to-reach populations. Coordination and collaboration for project implementation was threefold:

- the immunization section under the Department of Health services spearheaded the vaccination programmes and coordinated among national bodies;
- district health offices provided the vaccinators and vaccine support; and
- IOM supported the programme technically and financially and implemented the field-level activities in coordination and collaboration with an implementing partner, the Nepal Red Cross Society.

The Government of Nepal had set the target of reaching 40% of its total population by January 2022 and had allocated the other first doses to the remaining population subgroups who did not fall into prioritization categories set by WHO’s Strategic Advisory Group of Experts on Immunization (frontline workers, sanitation workers, police, traffic workers and older people). Despite the inclusion of migrants in the National Vaccine Deployment Policy, the migrant-focused vaccination programme remained challenging. Many informal workers who had migrated from India to Nepal lacked access to any formal identifier; therefore, they were still out of reach of the COVID-19 vaccination programme.

Strategies to increase access to COVID-19 vaccines for migrants were implemented.

- Vaccination booths were strategically placed at the exit points in Kathmandu (the bus parks where internal migrants congregate en masse to travel outside of Kathmandu valley).
- The vaccination campaign was continued on weekdays and during early morning hours to facilitate ease of access for migrants and hard-to-reach populations.
- Inbound migrants from India to Nepal were targeted at the point of entry in Province-1.
- Mandatory COVID-19 screening and free vaccine provision was instituted.
- Inclusion of undocumented migrants and those in informal sectors was advocated and supported plus the removal of administrative barriers.

Those who had received their first COVID-19 vaccine dose in India and were unable to receive the second dose in Nepal were provided with opportunities to receive their second dose. A total of 77 760 people (male, 42 523; female, 35 237) received the COVID-19 vaccine through the Nepal Vaccination Programme conducted between November 2021 and February 2022.

At the time of the project inception, the COVID-19 pandemic had resulted in partial lockdown and movement

restrictions, which caused challenges with the coordination of activities at central level. The authorization of Government bodies and mass vaccination administration were dependent upon the availability of vaccines at Government sources. The support from various Government bodies at federal, provincial and municipality levels was critical to the success of this project. Support received included for COVID-19 vaccine provision, deployment of vaccinators and administrative support.

“ A total of 77 760 people (male, 42 523; female, 35 237) received the COVID-19 vaccine through the Nepal Vaccination Programme conducted between November 2021 and February 2022. ”

Case study

41

Country:  
**Thailand**

**Title:** making progress towards UHC for migrants through participatory public policy focusing on creation of policy coherence for justice of health systems

UHC for Thai citizens was introduced in 2002. However, there are challenges in health coverage for migrants, particularly undocumented migrants, through the requirement for legal status to access affordable and adequate health services.

The Ministry of Labour’s Social Security Scheme for health insurance covers documented migrants in the formal sector, and the Ministry of Public Health’s Migrant Health Insurance Card Scheme covers undocumented migrants and their dependants who have registered with the Government. In practice, access to Migrant Health Insurance Cards by undocumented migrants is limited due to unclear policy messages, bureaucratic hurdles and inadequate interministerial coordination.

The COVID-19 pandemic further exposed several challenges in meeting migrant health needs:

- non-migrant-inclusive national development policy goals lead to incoherent policies across sectors and hinder UHC;

- service delivery, workforce distribution and coverage of health care units fail to meet the needs of migrant workers in areas with high migrant concentrations; and
- temporary health financing options offered to migrants were insufficiently funded for continued utilization by migrant health workers and volunteers.

To this end, the National Health Commission Office, as a policy facilitator, brought multiple actors to formulate the resolution on migrant health. A multistakeholder committee on migrant health policy development was set up with two mandates: to develop the resolution and to organize the health assembly process. The committee included representatives from the Ministry of Public Health, the National Health Security Office, the Thai Health Promotion Foundation, the Social Security Office under the Ministry of Labour, the Office of National Security Council, the Department of Provincial Administration under the Ministry of Interior, the International Health Policy Programme, the Institute for Population and Social Research, the Thai Health Promotion Foundation, the migrant working group Foundation for AIDS Rights, the Health System Research

Institute, the Thailand Development Research Institute and WHO.

As a result there was a call for the State to adopt a resolution for progressing migrant UHC. More specifically, the resolution that was approved by the Cabinet on 27 December 2022 and covered the right to health of migrant workers, called for four key actions: (i) integration of migrant worker issues into national development policies by developing the Migrant Worker Management Strategy and the Migrant Health Act; (ii) sustainable health insurance funding that incorporates migrant’s length of stay and socioeconomic status; (iii) increased primary care capacity to serve migrant workers in densely populated migrant communities; and (iv) development of

the migrant health database and information system and an awareness-raising campaign to address stigma and discrimination.

To address issues with health data capture and information systems, the health database for migrant workers should contain disaggregated data on gender, age, occupation and length of stay, and databases should be integrated across ministries. Such integration is key to developing an equitable migrant health system. A key challenge to implementing this resolution includes a need for consensus, collective action and solidarity across countries and territories, including migrant countries of origin, to improve migrant health and well-being.

“ As incoherent policies across sectors were identified, the health assembly concept and its participatory process was used to engage key stakeholders to formulate migrant health policy recommendations. ”

Case study

42

Country:  
**Sri Lanka**

**Title:** Inbound Health Assessment Programme and inclusion of migrants in the National Health Protection Plan

Sri Lanka launched its National Migration Health Policy in 2013, which highlighted the importance of access to essential health services for all migrants irrespective of their immigration status or country of origin; services should be provided in a dignified and humane manner and it should be ensured that the migration process does not endanger the health of migrants or the host community.

With increasing inbound migration to Sri Lanka, it was paramount to ensure that conditions of public health concern could be detected and managed appropriately. Conditions of public health concern also needed to be in line with national efforts concerning the control of communicable diseases, while promoting the health and well-being of migrants, minimizing their barriers to

accessing quality health services and facilitating their integration. The Inbound Health Assessment Programme in Sri Lanka was established as an evidence-informed approach to minimize the potential public health risks related to population mobility. It was formulated following research conducted into the development of the National Migration Health Policy and Intervention Framework in Sri Lanka, illustrating the benefits of a migrant-sensitive health assessment process.

The key stakeholders included the Sri Lanka Ministry of Health, Nutrition and Indigenous Medicine and the IOM. In collaboration with the Ministry of Health, a protocol was developed that stipulated the diseases to be covered and the migration health assessment process. The protocol also included technical instructions developed by the

Ministry of Health and guidance on the eventual flow of information to the Department of Immigration and Emigration.

The Inbound Health Assessment Programme applies to all long-term resident visa applicants soon after entry to Sri Lanka, as well as at the time of visa renewal. Prior to entry to Sri Lanka, resident visa applicants are provided with detailed information on the application process, including the need for the migration health assessment. Upon entry, an entry visa is issued by the Department of Immigration and Emigration, valid for one month, and an appointment for the migration health assessment should be scheduled by the applicant within seven days of arrival to the country. Informed consent is sought, with the provision of pre-test counselling and a detailed briefing on the background of the diseases being screened: TB, HIV, malaria and filariasis. Where positive results are detected, applicants are referred to the relevant national programmes for treatment and follow-up. Results of the migration health assessment observe strict confidentiality and data security measures.

Enrollment into the National Health Protection Plan follows completion of a migration health assessment, allowing access free of charge to emergency care, primary health care and treatment at government health institutions for diseases identified during the health assessment. Renewal occurs yearly, linked to the renewal of the residence visa. Therefore, through multisectoral engagement, access to health care is ensured for migrant populations, and continuity of care is facilitated through the strengthening and implementation of the monitoring, assessment and surveillance of all inbound migrants.

The main facilitating factors for implementation of this initiative were the development of an inclusive national migration health policy, the strong collaboration between all entities involved in the programme and the institutional capacity and experience of implementing an outbound health assessment programme. The interim visa issued by the Department of Immigration and Emigration enables migrants to access treatment and follow-up care, free of charge, while they continue to work or study.

“ With increasing inbound migration to Sri Lanka, it was paramount to ensure that conditions of public health concern could be detected and managed appropriately. ”

Case study

43

Country:  
**Costa Rica**

**Title:** collective health insurance under the temporary voluntary insurance modality for asylum seekers and refugees

In Costa Rica, asylum seekers and refugees may experience extreme poverty, resulting in their inability to pay for health care. Costa Rica offers health care services free of charge for emergency care, as well as to minors and pregnant and lactating women.

In 2020 the Government’s Social Security Fund, the national governing body of health services in Costa Rica, entered into an agreement with the UNHCR to provide medical insurance to 6000 refugees and asylum seekers with health

vulnerabilities and socioeconomic needs. As a result, beneficiaries could seek basic medical attention at local health centres throughout the country, securing their right to health. This project also has contributed to Costa Rica’s COVID-19 mitigation strategy.

The agreement was renewed several times and is currently agreed until at least December 2022. Under this agreement, access to health care is funded for 6000 refugees and asylum seekers at all care levels via a new health insurance



modality in the Costa Rican Social Security Fund for a year. Implementation was facilitated by inter-institutional

collaboration between Government bodies and the United Nations agency.

“ In Costa Rica, asylum seekers and refugees may experience extreme poverty, resulting in their inability to pay for health care. ”

# 5

## PRIORITY

**Strengthen health monitoring and  
health information systems**



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**P**riority 5 calls for health monitoring and information systems that support responsive and evidence-informed policy-making with an emphasis on promoting the SDGs at global, regional and country levels. Standardized systems of data collection and disaggregation facilitate comparable records to inform coordinated intersectoral and intercountry action and monitoring across origin and destination regions. These systems are underpinned by ethical, non-discriminatory and representative data obtained via informed culturally and linguistically appropriate consent processes that outline the purpose and potential benefits of providing data. There are three case studies presented for Priority 5, which provide examples of health data collection and monitoring initiatives developed to improve health outcomes among refugee and migrant populations. Case study 44

provides an example of a project that promotes activities to collect and integrate migrant data into existing intersectoral health and social care information systems, with the overall aim of reducing access barriers experienced by Venezuelan migrants in Peru. Case study 45 describes an initiative designed to reduce health access barriers secondary to fragmented health information systems in the United Kingdom. The activities include analysis and monitoring of health outcomes, morbidity, mortality and service utilization across several independent datasets for non-EU refugee and migrant populations. Case study 46 is an example of a cross-sectional study of demographics, vaccine records and health data for all United Kingdom-bound refugees undergoing routine pre-departure assessments. This was the first time the immunization coverage of refugees in the United Kingdom had been analysed.



## Case study

## 44

Country:  
**Peru**

**Title:** towards integration of the migrant population in health policies through creation of the Functional Unit of Health of Migrant and Border Populations in the Ministry of Health

By 2017 Peru was experiencing unprecedented incoming migration trends and had become a receiving country for migrant populations, mainly from Venezuela (more than 1 million people). In response to widening migrant populations, the Peruvian State promoted various mechanisms such as the continuity of the Intersectoral Work Table for Management and the approval of the National Migration Policy 2017 and 2025. In the health sector, the regulatory framework is aimed at guaranteeing access to health services for all people regardless of their nationality. This framework also recognizes that migrants are in a situation of vulnerability and the regulations seek to facilitate their entry into the public health system. Despite such developments, 75% of the migrant population self-medicate and do not access health services.

On 23 October 2020 the Functional Health Unit of Migrant and Border Populations was formed in the Ministry of Health of the Republic of Peru. The Functional Health Unit formulates and proposes public policy devices; monitors, supervises and evaluates their implementation; develops and updates health sector regulations; disseminates and generates information; and promotes social protection in terms of health for migrant and border populations. The activities of the Functional Health Unit have been possible because of support from the health sector for its continuity, as well as its interaction with other sectors, such as with the

Ministry of Foreign Affairs through the Intersectoral Table for Migration Management, and with international organizations such as IOM, UNHCR, WHO and the Working Group for Refugees and Migrants.

Since its formation, the Functional Health Unit has promoted activities that allow the integration of migrant populations in health services. Before the start of the vaccination process for SARS-CoV-2, efforts were made to include migrant populations in the target population as well as for institutions that have databases for the National Register of Universal Vaccination against COVID-19; and to accept any identification document for the registration of the vaccinated person. Furthermore, the introduction of nationality variables in health records is now operational, allowing for better monitoring of the health care needs of migrants.

The Functional Health Unit also coordinates actions for the organization of health campaigns for migrant populations, with the support of international organizations and civil society grassroots organizations in which affiliation to comprehensive health insurance is carried out. Health services are provided, such as immunization, screening for chronic and communicable diseases, and guidance and counselling for prevention and access to health.

“ 75% of the migrant population self-medicate and do not access health services. ”

## Case study

## 45

Country:  
**United Kingdom**

**Title:** the Million Migrant Study, a linked population-based cohort study of health care and mortality outcomes in non-EU refugees and migrants to England

In 2021 an estimated 9.6 million (17%) people living in England (United Kingdom) were born abroad, yet there is a limited understanding of how international migrants use the NHS or what are their subsequent health needs and mortality outcomes.

The inability to identify migrants in national data sources makes it difficult to evaluate morbidity and mortality outcomes or to assess changes in the mortality advantage during their residency in England. Where data sources exist, these have not been fully integrated or systematically analysed to provide a robust understanding of migrants' health needs and areas to improve health care access.

The Million Migrant Study is a linked population-based cohort study that aims to describe the hospital-based health care and mortality outcomes of 1.7 million non-EU refugees and migrants in England.<sup>19</sup> It has two objectives:

- to profile hospital-based health care performance by identifying existing health conditions and examining hospital admissions, re-admissions and the duration of hospital stay for these refugees and migrants compared with the general population in England; and
- to investigate mortality outcomes by health condition for non-EU refugees and migrants in comparison with the general population.

The Study is an intersectoral and intercountry initiative that involves the Office for Health Improvement and Disparities (formerly Public Health England); the United Kingdom Health Security Agency (formerly Public Health England); University College London, the London School of Hygiene & Tropical Medicine, the University of Bath and the University of Glasgow (United Kingdom); Cayetano Heredia University (Peru); and Doctors of the World (part of the Médecins du Monde network).

The Study links four data sources.

- **The TB pre-entry screening dataset for non-EU migrants.** This contains records for international non-EU migrants who resided in a country where TB is common (40 cases per 100 000 people) and who are planning to come and live in United Kingdom for more than six months. Data were taken for individuals who were screened by the United Kingdom pre-entry TB screening programme between 1 January 2006 and 31 December 2020. Screening was conducted either by the IOM or by international clinics recognized by the United Kingdom Home Office.
- **Refugee pre-entry health assessment.** Refugees undergo a health assessment that allows pre-departure information to be shared with local authorities and health services in the United Kingdom. The refugee health assessments used in this Study were conducted by the IOM between 1 March 2013 and 31 December 2020.
- **National hospital episode statistics.** These included both admissions and attendances.
- **Office of National Statistics death records.** These provided cause of death information on all deaths.

The Million Migrant Study has been facilitated by ongoing engagement with policy-makers, NGOs, refugees and migrants and the public throughout the design and conduct of the Study to ensure relevance and inform a pathway for impact. As part of the design phase, a public involvement workshop with international refugees and migrants took place to understand their views on the consent process, data linkage and analysis. National and international policy-makers were also involved in the design stage.

There are some challenges to this data linkage study. The absence of a national primary care dataset limits the ability to examine any contribution to health and care of individuals from primary, community or social care. There is no linkage of date with migrant subgroups: irregular

<sup>19</sup> Burns R, Pathak N, Campos-Matos I, Zenner D, Vittal Katikireddi S, Muzyamba MC et al. (2019). Million Migrants study of healthcare and mortality outcomes in non-EU migrants and refugees to England: analysis protocol for a linked population-based cohort study of 1.5 million migrants. Wellcome Open Res. 4:4. doi:10.12688/wellcomeopenres.2019.

migrants (entrants who enter, stay or work in a country without the necessary authorization, such as undocumented entrants, failed asylum seekers, visa overstayers, children born to irregular migrant couples), migrants entering on a temporary visa (such as tourists), EU and European Economic Area migrants, international migrants from low-incidence TB countries who will not have a pre-entry TB screening (such as from Chile, Egypt or the United States of America) and international migrants who arrived before the start of either health screening programme; consequently, findings cannot be generalized to these groups.

The Million Migrant Study will create a large representative dataset of non-EU migrants and resettled refugees who will be identifiable in routine administrative data, allowing for long-term follow-up of hospital-based health care use over time. However, without the data linkage from IOM datasets, these individuals would not have been identifiable in administrative hospital/health care data as important migration variables are not routinely collected. In order to explore these outcomes in all migrants, administrative health and social care data must be re-structured to collect data on migration status, such as country of origin, visa type and/or date of arrival.

“ The Million Migrant Study will create a large representative dataset of non-EU migrants and resettled refugees who will be identifiable in routine administrative data, allowing for long-term follow-up of hospital-based health care use over time. ”

## Case study

# 46

Country:  
**United Kingdom**

**Title:** a retrospective, population-based cross-sectional study of the immunization status of incoming refugees

The United Kingdom Refugee Technical Instructions define the United Kingdom-specific guidelines for vaccination of refugees during migration health assessments. These state that “where possible, the United Kingdom immunization algorithm for vaccination of individuals with uncertain or incomplete immunization status shall be followed”, which prioritizes vaccination with two doses of measles, mumps and rubella combined vaccine; three doses of the combination vaccine tetanus–diphtheria–pertussis–inactivated polio vaccine and *Neisseria meningitidis* B, C and ACWY conjugate vaccine (for individuals aged 10–25 years). They also advise that individuals with missing immunization records should be treated as unvaccinated and re-administered doses.

Historically in the United Kingdom, data for immunization status of refugees and migrants have been poor as migrant status is not routinely collected by the NHS, resulting in difficulties in targeting such catch-up vaccinations for those who are most in need.

The key actors in this retrospective study are:

- Office for Health Improvement and Disparities (government)
- the Migrant Health Research Group, St George’s, University of London (academic institution)
- the IOM (United Nations agency).

The study assessed vaccinations administered, immunization history on departure to the United Kingdom,

the alignment of resettled refugees with the United Kingdom Refugee Technical Instructions and the United Kingdom's immunization schedule.<sup>20</sup> It also investigated factors potentially associated with differing immunization histories. The study aligned with policy goals to strengthen refugee pre-entry health assessments and domestic initiatives to improve catch-up vaccination and immunization coverage among refugees resettling in the United Kingdom.

A retrospective cross-sectional study of demographics, vaccine records and health data of all United Kingdom-bound refugees (children < 10 years, adolescents aged 10–19 years and adults > 19 years) undergoing routine pre-departure IOM health assessments between 1 January 2018 and 31 October 2019 was completed.

This was the first time the immunization coverage of refugees being resettled in the United Kingdom had been

analysed. The results showed more than 10% of refugees depart on their journey to the United Kingdom with no recorded polio-containing vaccine and almost 20% with no recorded measles-containing vaccine, suggesting they will require catch-up vaccination services on arrival in the United Kingdom. Adult and adolescent refugees were less likely to have recorded immunizations for key vaccines compared with children, suggesting targeted initiatives on arrival to the United Kingdom are warranted.

The findings have implications for the expected vaccination coverage of other migrant groups arriving from similar countries and regions of origin. Pre-entry health assessments and domestic initiatives have the potential to improve vaccination coverage among refugees and other migrant groups – a key objective of the new WHO Immunization Agenda 2030 framework for action.

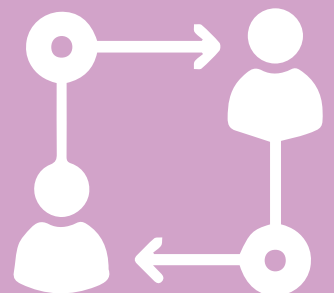
“Historically in the United Kingdom, data for immunization status of refugees and migrants have been poor as migrant status is not routinely collected by the NHS.”

<sup>20</sup> Deal A, Hayward SE, Crawshaw AF, Goldsmith LP, Hui C, Dalal W et al. (2022). Immunisation status of UK-bound refugees between January 2018 and October 2019: a retrospective, population-based cross-sectional study. *Lancet Public Health*.7(7):e606–15. doi:10.1016/S2468-2667(22)00089-5.

# 6

## PRIORITY

**Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health**





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**T**he objective of this priority is to support the generation, communication and impact of accurate, timely, evidence-informed and culturally sensitive information on the health needs of refugees and migrants, and on the impact of migration and displacement on the health of local communities and health systems. The scope of the priority encompasses the conduct and representativeness of refugee and migrant health research and widening the scope of the research; building research capacity, with particular attention to low- and middle-income countries and the global south; and engaging refugee and migrant populations in the research process. Priority 6 also covers the dissemination of evidence and communications with refugee, migrant and host populations, with an emphasis on dispelling misperceptions, stigma and discrimination and on translating research findings into policy and practice.

The following three case studies provide examples of accessible dissemination of health information and evidence-informed communication to refugee and migrant populations. Case study 47 describes a public health communication campaign that tailored the format and delivery of the message to

maximize impact, uptake and reach across target refugee and migrant populations in the Republic of Moldova. This TB-focused campaign was tailored to be gender and migrant sensitive and spanned a range of online and in-person or print formats, harnessing social media, public spaces and in-person flash mobs, including at refugee accommodation centres. Case study 48 is an example of a health communications project in Thailand that maximized reach and impact by galvanizing migrant health volunteers to disseminate evidence about COVID-19 vaccinations in order to improve vaccine literacy and uptake among migrant workers. The project demonstrates how effective and culturally responsive evidence dissemination is best achieved using information sources that are trusted, in this case nongovernmental community representatives. Case study 49 describes a project that generates local research data to inform policy and practice and that disseminates evidence-informed SRH information to both migrants and non-migrants living in migration-affected communities across six countries in southern Africa. The project shows approaches to maximizing reach and impact through community engagement and enabling community members to deliver health education interventions.



## Case study

## 47

Country:  
**Republic of Moldova**

**Title:** marking World TB Day through a gender lens to address TB among migrants

Although cases of regular TB have been declining in recent years, the Republic of Moldova is one of 30 countries with high rates of multidrug-resistant TB, where one third of new cases are with multidrug-resistant TB, making these patients difficult and expensive to treat. Moldovans who work abroad make up 15% of all TB cases in the country and are particularly vulnerable to TB, particularly those in irregular situations as they often do not know how to access health care services or are afraid to approach authorities abroad for fear of losing their jobs or being deported.

This project aimed to increase understanding of TB and possible infection, particularly among women and circular migrants.<sup>21</sup> Public information materials were placed in airports, hospitals, border crossing points and broadcast on

television, radio and via social media. These were developed to be gender and migrant sensitive and include information, education and communication materials relevant to women who have been affected by TB.

The project involved key Government partners, including the National TB Programme, the General Inspectorate of Border Police, the Ministry of Health and the Ministry of Interior. The team also organized several flash mobs in partnership with the Medical Student Association in the Republic of Moldova, including at refugee accommodation centres, targeting Ukrainian refugees and third-country nationals fleeing the conflict in Ukraine to raise awareness and facilitate implementation.

“ This project aimed to increase understanding of TB and possible infection, particularly among women and circular migrants. ”

## Case study

## 48

Country:  
**Thailand**

**Title:** increasing vaccine and health literacy among migrant workers

The first case of COVID-19 was recorded in Thailand in January 2020. With the concern for public health during the pandemic, Thai and non-Thai citizens were encouraged to receive COVID-19 vaccinations.

A vaccination programme was developed in June 2021. However, the Thailand Development Research Institute highlighted the issue of migrant workers' status in the programme and identified a lack of a specific registration programme for migrant workers to receive COVID-19 vaccines. Although the vaccine was available at any

<sup>21</sup> Vlădescu N, Vieru P (2022). A gender-focused qualitative study on health care-seeking behaviour and access to tuberculosis treatment among mobile populations from the Republic of Moldova. Chişinău: International Organization for Migration (<https://publications.iom.int/books/gender-focused-qualitative-study-health-care-seeking-behaviour-and-access-tuberculosis>, accessed 9 December 2022).

government hospital, vaccination post or mobile vaccination centre of every province, migrant workers still struggled to access the vaccine. Migrants were told they could use any identification card for COVID-19 vaccination registration; in reality, each hospital or centre requested different documents from them, particularly for undocumented workers. In addition, language barriers further hindered vaccination access, combined with a pre-existing wariness of government authorities and fear of detainment and deportation for undocumented migrant workers. The lack of access to comprehensive information contributed to a major delay in accessing COVID-19 vaccinations for migrant workers. This was a concern, considering that Thailand is home to more than 3 million migrant workers from the nearby countries of Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam.

Between November 2021 and July 2022, the World Vision Foundation of Thailand implemented the project Supporting the Royal Thai Government COVID-19 Vaccination Rollout for Migrant Workers. This project is funded by the Department of Foreign Affairs and Trade, Australia, through the IOM and WHO. Project beneficiaries were migrant workers from Cambodia, the Lao People's Democratic Republic and Myanmar who were employed in fish markets, construction sites and factories and living in the Bangkok, Nonthaburi, Pathum Thani and Samut Prakan Provinces. Findings from the knowledge, attitude and practice survey conducted at the beginning of the project indicated that 1440 migrant workers had not received the vaccination due to concerns related to finance, legal status, pre-existing health conditions, vaccine effectiveness and vaccination process.

Project activities were formulated and implemented in collaboration with Government agencies, civil society organizations, NGOs, community leaders, the Migrant Working Group, hospitals and the private sector. Key government partners included the Department of Disease Control, the Institute for Urban Disease Control, the provincial public health offices and subdistrict municipalities. In each province, partner collaboration was led by the provincial public health office and provincial hospitals.

The project aimed to promote vaccine literacy, provide access to vaccination and support adverse event following immunization monitoring for migrant workers. The project was conducted through: (i) using migrant health volunteers in migrant communities for outreach activity on vaccine literacy; (ii) increasing access to COVID-19 vaccination using mobile vaccine centres for migrants employed in the construction sector and coordinating with vaccination centres in the target provinces; and (iii) conducting monitoring for adverse events following immunization through telephone calls with migrant health volunteers.

Capacity-building training was provided for 227 migrant health volunteers on data collection, community engagement, general knowledge on COVID-19 vaccine and vaccination registration processes. Over the course of the project, a total of 6258 migrants were vaccinated; 2437 through provincial government vaccination centres and 3821 through mobile vaccination clinics. The Government's COVID-19 digital health application (Mor Prom) was used to monitor 1514 migrants for any adverse event following immunization. According to migrant workers' feedback, the migrant health volunteers were a helpful presence as frontline health workers in responding to questions and in being a trusted source of information. Migrant health volunteers provide translation support and relieved migrant workers, particularly undocumented workers, from the concern of directly engaging with government authorities.

Supportive collaboration from private and public key stakeholders, migrant community leaders and migrant health volunteers are factors that facilitated the project's implementation and success. All relevant stakeholders, including employers and private agencies, understood that migrant health affects public health and business profits. The presence of migrant health volunteers in migrant communities eliminated the language barrier, information misinterpretation and vaccine illiteracy, which are the main challenges for migrant populations in accessing and receiving the COVID-19 vaccination. However, required documentation for vaccine registration and the Mor Prom application utilization continues to be a challenge among migrant workers and their dependants.

“ The project aimed to promote vaccine literacy, provide access to vaccination and support adverse event following immunization monitoring for migrant workers. ”

## Case study

## 49

Countries:

**Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia****Title:** the Sexual Reproductive Health Rights and HIV Knows No Borders project

Sub-Saharan Africa has some of the worst SRH outcomes globally, which are heightened among migrant girls and women, many of whom are pressured into risky decisions for their survival while having limited choices and often limited information available to them regarding their sexuality and SRHR.

The Sexual Reproductive Health Rights and HIV Knows No Borders project covers six migration-affected countries in southern Africa: Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia.<sup>22</sup> It seeks to improve SRH (including HIV-related health) of both migrant and non-migrant adolescents and young people, sex workers and others who live in migration-affected communities. This is achieved by generating demand for SRH and HIV services; encouraging providers to make these services available, accessible and relevant; and by ensuring that services are supported by policy- and decision-makers at local, national and regional levels.

The project addresses environmental barriers (harmful traditional cultural practices and social norms) in accessing SRH–HIV services by engaging with communities and key populations through dialogues and sensitizations. Over 1500 policy-makers and community, religious and traditional leaders at national and regional levels were made aware of the issues affecting young vulnerable populations during migration, SRHR, sexual violence and GBV. A total of 19 community dialogue platforms were established, while 29 were strengthened.

Together with government structures of Eswatini, Lesotho, Malawi, Mozambique, South Africa and Zambia (ministries in charge of health, education, home affairs, social development and welfare, and national AIDS councils) and other civil society organizations, the project is implemented by IOM, Save the Children and other partners.

To ensure meaningful youth involvement, the project identified and supported local groups of young people,

migrants and sex workers with behavioural change communication strategies and leadership skills to carry out sensitizations around SRH, HIV and SGBV within the communities through innovative approaches. These included the Community-based Complaint Mechanism, a system that is deeply rooted in the community to aid known and potential SGBV survivors, facilitate survivor reporting and allegation referrals and to fulfil a prevention function through training and raising awareness.

Engagement with governments, Indigenous civil society organizations and community gatekeepers (community, traditional and religious leaders) has been paramount for the implementation of the project. The gatekeepers' presence at grassroots allows them to work from the bottom up, vitally complementing the top-down approach that is inevitably part of the national and provincial responsibilities of government.

In 2021 the project reached over 100 000 young vulnerable people, migrants and sex workers with health education on sexuality, HIV/AIDS, sexually transmitted infections, pregnancy and contraception through door-to-door visits and community events such as mobile clinics, outreach campaigns and community dialogues. Across all countries, a total of 817 change agents actively conducted health education on SRHR and HIV among non-migrants, migrants, young vulnerable people and sex workers. The project referred over 14 000 young vulnerable people, migrants and sex workers for health and non-health services. The health services provided included HIV testing and counselling, antiretroviral therapy, antenatal care, family planning, sexually transmitted diseases and cervical cancer screening and treatment, and SGBV support. Non-health services included immigration, social welfare, counsellors and the police. The project trained 567 individuals from service provider organizations to deliver responsive services for SRH, HIV, GBV and related issues to young vulnerable people and sex workers. A total of 516 young vulnerable people were trained in entrepreneurship,

<sup>22</sup> IOM (2020). SRHR-HIV Knows No Borders Project: final evaluation report (2020). Pretoria: International Organization for Migration (<https://migrationhealthresearch.iom.int/srhr-hiv-knows-no-borders-project-final-evaluation-report-2020>, accessed 9 December 2022).

financial literacy and vocational skills to link them to better livelihood opportunities.

The project was facilitated by the adoption of the electronic district health information system (DHIS2) data management system to collect and manage project health data at the community level. This presented an innovation that enabled the project team to reach out to more target populations and improved programme data quality.

The occurrence of the COVID-19 pandemic in 2020 was a significant barrier to many outcomes of the project in each country because of the associated measures that limited movements of the target populations. In most

countries, the COVID-19-associated travel restrictions proved to be a barrier to comprehensive sexuality education implementation in schools due to school closure and safety reasons; in Mozambique, access to health centres was restricted through fears of infection at the health facility. However, the project integrated COVID-19-response activities, particularly risk communication and community engagement in SRH-HIV implementation in the six countries. The project sustained advocacy for the inclusion of migrants and other key populations in national COVID-19 vaccination programmes, including migrant access to SRH-HIV services. For example, COVID-19 vaccination sites were set up in migration-affected communities in Zambia.

“ A total of 19 community dialogue platforms were established, while 29 were strengthened. ”

# Findings and policy considerations



This section is informed by the examples across the world on promoting the health of refugees and migrants that were received through the open call. These projects had been developed with government involvement at national, regional and/or local levels and were formulated and/or implemented after GAP adoption in May 2019. A total of 49 case studies were selected that would highlight key elements of each of the GAP priorities.

In addition, it is important to acknowledge that there are many other important projects underway around the world that were not submitted and, therefore, are not included in this publication. The intention is to develop a live repository or compendium of projects, which will facilitate ongoing collation of more examples of projects in order to optimize sharing and learning across Member States.

## Findings

Based on the submitted projects, the following general findings have emerged.

- The projects reflect different parts of the migratory journey from departure, transit and arrival, providing rich insights into the diverse ways that migration is a social determinant of health. The rich description of health projects across the migratory journey is essential for nuanced and comprehensive policies and programmes to promote the health of refugees and migrants around the globe.
  - Given the time frame for the open call, most projects related to COVID-19. These projects show some particularly strong, innovative examples of responsive, collaborative action for refugee and migrant health.
  - The most frequently mentioned facilitator for project activities related to partnerships based on relationships, trust and shared commitment to action. There were examples of partnerships across international borders and between international private and public sector actors.
- There were examples of partnerships across government departments and between statutory and non-statutory agencies at regional and national level. The capacity of refugees and migrants to be involved in partnerships and to contribute to emergency and humanitarian responses is also very clear and noteworthy.
- There were multiple challenges to project activities, including societal factors such as xenophobia and migrants' hesitancy to engage with statutory services and agencies, particularly if they are vulnerable in terms of legal status. There were also challenges in health care systems, including underresourcing and exhausted workforces and, in lower- and middle-income countries, lack of essential infrastructure such as electricity.
  - The fundamental importance of culturally and linguistically appropriate health promotion activities and public health service delivery was clear across projects. Translation and interpretation, along with the use of community members as peer health workers, were essential features of several projects.

- Most projects had a major focus on Priority 1, reflecting the important collaborative work that developed in response to the COVID-19 pandemic as a global crisis that demanded emergency and significant humanitarian responses.
- There were also a significant number of projects that had a major focus on Priority 3, particularly the element focusing on collaborative action.
- There were fewer projects with a major focus on Priorities 5 and 6, although some elements of activities in some projects provided valuable insights into how these priority areas can be operationalized.
- The pattern of project activity across the six priorities reflects the current status of refugee and migrant health around the globe: the emphasis has been on acute and emergency responses with a focus on communicable diseases. There is now a large body of experience about how to do that well and some of the innovation and learning during the COVID-19 pandemic and the more recent management of the health of Ukrainian refugees is adding substantially to that. To advance refugee and migrant health, it will be important to see an equal emphasis on the integration and mainstreaming of refugee and migrant health in inclusive health policies, health care systems and programmes with a heightened focus on NCDs.



## Policy considerations

**Policy considerations to support partnerships** to underpin all activities to promote the health of refugees and migrants are to:

- build on newly formed cross-border partnerships to optimize collaborative efforts to promote the health of refugees and migrants during migration journeys, with attention to communicable diseases and NCDs;
- examine ways to continue private and public partnerships that can promote health equity, through comprehensive health care infrastructure in all regions and access to health care services for all refugees and migrants;
- acknowledge and sustain whole-of-government approaches so that the health of refugees and migrants is not siloed in ministries of health but is given due consideration by ministries in charge of labour, justice and education, among others;
- encourage regional and national stakeholder networks focused on refugee and migrant health to promote coherent knowledge-sharing about health needs and effective service and policy responses; and
- build sustainable, consultative structures and mechanisms that optimize refugees' and migrants' involvement in health projects.

**Policy considerations for health service delivery** are to:

- strengthen international and national health policies so that they are inclusive of refugee and migrant health issues and can promote mainstreaming of refugee and migrant health in statutory and non-statutory service settings;
- sustain new practices in national settings in order to reduce legal and administrative barriers to health care for all refugees and migrants;
- invest in primary health care services to facilitate interdisciplinary and interagency working, because these services are crucial for comprehensive responses during public health emergencies;
- invest in NGOs that have a remit around refugee and migrant health to build capacity and community empowerment, particularly among the refugees and migrants who are in the most vulnerable circumstances;
- sustain and expand outreach services (such as mobile health services) that can bring primary health care into community settings to improve the accessibility of services for refugees and migrants;
- ensure that all health care services are adapted for cultural and linguistic diversity so that refugees and migrants have access to culturally appropriate, quality health services;

- invest in training and capacity-building of both refugees and migrants and health care providers to optimize health literacy and refugee- and migrant-sensitive health care service adaptation; and
- develop health passports for refugees and migrants, particularly those in vulnerable circumstances (women, children, migrants whose journeys are forced/irregular), to improve continuity of care from origin to destination.

**Policy considerations for evidence-informed policy**

are to:

- address the gaps in health information systems so that there is a standardized, comparable data collection based on ethical, informed consent that can be utilized to address health inequities; and
- support the generation of high-quality research about refugee and migrant health, with particular attention to research capacity-building in the global south.



# Conclusions



Given evidence that migration and displacement are key determinants of health and lead to health inequities, it is essential to develop knowledge and actions to optimize refugee and migrant health around the world. The WHO GAP is designed to do just that. Its six priority areas provide a comprehensive framework for advancing public health practice and policy that attend to the needs of refugees and migrants. This report provides case studies of good practice for the priority areas from Member States around the world. The case studies showcase health initiatives for all parts of the migratory journey and, frequently, crystallize the capabilities for inclusive and innovative public health through responses to the COVID-19 pandemic. Partnership and collaboration, within and across countries and within and across sectors, is the hallmark of the case studies.

The case studies show how central these features are to overcoming the societal, financial and political challenges faced in adapting and designing health services that are responsive to the health needs of refugee and migrants. Looking ahead, it is important to learn more about mechanisms to maintain and extend these partnerships and collaborations. It will also be important to see more examples of health initiatives that speak to all priority areas and all dimensions of each priority. Finally, it will be important to see health initiatives that mainstream refugee and migrant health and advance from the current focus on emergency and specialist health services. These developments will result in global public health activity for refugee and migrant health that is comprehensive, inclusive and equitable.

# Annex 1.

## Development of a coding framework to operationalize WHO GAP priorities



This section provides additional detail of the approach take to analyse, synthesize and select some case studies from the example projects submitted across Member States. This process entailed three key stages which are summarized in the sections below and are based on the GAP.

1. Developing a coding framework to operationalize WHO GAP priorities.
2. Chart projects by WHO GAP priority and WHO region.
3. Select case studies from across WHO regions to illustrate efforts within each GAP priority.

The purpose of the coding framework was to determine how each project aligned with one or more of the WHO GAP priorities using a consistent and transparent approach. A framework analysis approach was applied.<sup>23</sup> This entailed developing, testing and applying a set of a priori codes according to each priority area. Table A1.1 shows the resources used in preparing the coding framework.

Cross-checking and synthesizing these resources supported contextualization, differentiation and operationalization of the six priorities. For example, integrating policy and practice content from the WHO *World report on the health of refugees and migrants* with priority 5 elucidated its focus on processes of obtaining informed consent and data representativeness as part of strengthening health monitoring and health information systems.<sup>24</sup> Similarly, integrating data from this report with Priority 6 highlighted an objective to build research capacity, including in the global south. The output of this process was a comprehensive text description for each priority area and a set of a priori codes (Table A1.2). The draft coding framework was tested and refined iteratively by the research team. Each researcher independently applied the codes to an initial set of projects that had been purposely selected to facilitate nuanced coding discussions. Projects were additionally coded by WHO region. Regular team discussions scrutinized coding consistency and the coding framework was updated accordingly. The remaining submissions were split and single-coded on a shared spreadsheet.

**Table A1.1. Defining the scope of the priority areas**

Document	Relevant content
WHO Global Action Plan on Promoting the Health of Refugees and Migrants, 2019–2023 Annex 5	Priority areas Objectives Secretariat options
World Report on the Health of Refugees and Migrants	Section 6.3 Policy/practice

<sup>23</sup> Spencer L, Ritchie J, Lewis J, Dillon L (2003). Quality in qualitative evaluation: a framework for assessing research evidence. London: Government Chief Social Researcher’s Office (<https://core.ac.uk/download/pdf/74376246.pdf>, accessed 10 December 2022).

<sup>24</sup> WHO (2022). World report on the health of refugees and migrants. Geneva: World Health Organization (<https://apps.who.int/iris/handle/10665/360404>, accessed 10 December 2022).

**Table A1.2. Comprehensive description and operationalization of GAP priorities**

GAP priority <sup>a</sup>	Text synthesis and operationalization codes	Interventions (including programmes/policies) to develop/implement <sup>b</sup> ways to
<b>Priority 1</b>	<ul style="list-style-type: none"> <li>● Meeting the immediate and longer-term (public) health needs of R&amp;M populations, with focus on risk groups, in a way that interfaces with national contexts</li> </ul> <p>[NB this excludes details of data, health information systems, access, capacity, reporting, UHC, SDH, intercountry collaboration, or delivery of sexual health interventions, which are emphasized more in other priorities]</p>	<ul style="list-style-type: none"> <li>● Develop or implement public health emergency preparedness and responsive mechanisms/humanitarian health responses/disaster risk reduction, inclusive of R&amp;M</li> <li>● Meet immediate and long-term health needs with focus on groups in vulnerable situations and in ways that interfaces with national contexts</li> <li>● May include developing, implementing national policies, guidelines, health promotion and/or models of care (e.g. communicable disease outbreak management, NCDs, SRH, mental health, rehabilitation, or palliative care)</li> </ul>
<b>Priority 2</b>	<ul style="list-style-type: none"> <li>● Improving continuity of care within and across jurisdictions through cross-border collaboration to develop protocols for care continuity and patient “tracking” across countries) (excludes the specifics of health information systems, information sharing across countries (Priority 5), more generalized intercountry action plans (specified better in Priority 3))</li> <li>● Integrating or ensuring continuity of care across sectors and settings, reducing silos and maximizing continuity of support for R&amp;M populations</li> <li>● Designing interventions to improve access to care in the long term for those who need it (with exception of child psychological support (Priority 3)) and to reduce access barriers</li> <li>● Ensuring a focus on mental health and chronic conditions (interventions for these are Priority 1)</li> <li>● Preventing occupational health and safety problems, including in industrial settings, although interventions are sensitive to national contexts (Priority 4 covers involving R&amp;M in social protection/security services and policies)</li> </ul>	<ul style="list-style-type: none"> <li>● Encourage integrated care and referral pathways across jurisdictions, settings and services to improve continuity of care</li> <li>● Support long-term access to essential support for migrants through cross-border dialogue, collaboration and protocols to ensure nobody is lost to follow-up</li> <li>● Reduce access barriers to health care (including physical, financial, informational, linguistic, cultural barriers)</li> <li>● Prevent occupational health (and safety) problems (e.g. through access to quality occupational and primary health care and social protection systems, including tools, policies, action plans, indicators, informational materials)</li> </ul>

**Table A1.2. contd**

GAP priority <sup>a</sup>	Text synthesis and operationalization codes	Interventions (including programmes/policies) to develop/implement <sup>b</sup> ways to
<p><b>Priority 3</b></p>	<ul style="list-style-type: none"> <li>● Increasing health professionals’ resources and capacity to deliver appropriate culturally sensitive care</li> <li>● Mobilizing resources for effective management and governance of health care</li> <li>● Addressing gender inequality in the health workforce and in delivery and access to health care</li> <li>● Training R&amp;M as health workers and including them as professional contributors to the healthworkforce</li> <li>● Including diaspora health workers in implementation of health and educational programmes</li> <li>● Supporting and enabling strategic partnerships, coordination, communication, information sharing and joint action/ implementation across countries and multisectoral stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>● Provide training, resources and governance to support health professionals (e.g. training in culturally sensitive care, initial training and continuous professional development)</li> <li>● Prevent/mitigate impact of gender-based inequality, including in training of health professionals and delivery of relevant services for women and young people (e.g. SRHR; psychological care for children)</li> <li>● Train R&amp;M, include diaspora health workers, to contribute to the health workforce and education programmes</li> <li>● Improve global R&amp;M coordination through strategic partnerships, communication and joint action/implementation with countries, United Nations agencies and others</li> <li>● Provide technical assistance, partnerships and communication to support multisectoral approaches</li> </ul>
<p><b>Priority 4</b></p>	<ul style="list-style-type: none"> <li>● Involving R&amp;M in social protection arrangements, social security programmes and WHO Health and Migration Programme</li> <li>● Implementing guidance, assessment and reporting tools around social and economic factors relevant to R&amp;M health (UHC and SDG context)</li> <li>● Identifying stakeholders relevant to partnerships, actions related to SDH, SDGs and UHC</li> <li>● Training personnel working with R&amp;M regarding SDH and related policies</li> <li>● Supporting planners and workers to implement affordable equitable health access</li> <li>● Implementing the WHO Global Code of Practice on International Recruitment of Health Personnel</li> </ul>	<ul style="list-style-type: none"> <li>● Include R&amp;M in social protection and social security programmes</li> <li>● Include R&amp;M in the WHO Health &amp; Migration Programme</li> <li>● Identify socioeconomic factors relevant to R&amp;M health and implement guidance, assessment and reporting tools for these</li> <li>● Identify stakeholders relevant to partnerships and actions related to achieving Priority 4</li> <li>● Train personnel and policy-makers working with R&amp;M regarding SDHs and related policies</li> <li>● Action the WHO Global Code of Practice on International Recruitment of Health Personnel</li> </ul>

Table A1.2. contd

GAP priority <sup>a</sup>	Text synthesis and operationalization codes	Interventions (including programmes/policies) to develop/implement <sup>b</sup> ways to
<b>Priority 5</b>	<ul style="list-style-type: none"> <li>● Creating health monitoring and information systems that include ethical, informed and representative data collection</li> <li>● Generating quality evidence to inform policy</li> <li>● Ensuring that the systems are informed by and monitor implementation of policy efforts in line with the SDGs and other relevant codes</li> <li>● Using informed consent processes, ideally in R&amp;M languages, for collecting data, providing assurance that data are non-discriminatory and explaining the benefits accruing from data collection for R&amp;M</li> <li>● Collecting health data with core variables as first step towards disaggregation</li> <li>● Using intersectoral and intercountry arrangements for standardized, comparable records to support coordinated action and monitoring (e.g. on health risks in countries of origin, transit and destination), with emphasis on continuity of care</li> <li>● Emphasizing also innovative means of gathering data (e.g. big data, artificial intelligence)</li> </ul>	<ul style="list-style-type: none"> <li>● Improve R&amp;M health monitoring systems and reporting (at global, regional, country levels) to generate representative, ethical data and evidence to inform policy and practice (underpinned by relevant policies)</li> <li>● Collect data using informed consent processes in the relevant languages</li> <li>● Provide explanations regarding non-discriminatory data collection and how/why collection will benefit respondents</li> <li>● Define core variables as a first step for data collection to facilitate disaggregation</li> <li>● Apply innovative approaches to gather R&amp;M data and improve intersectoral and intercountry arrangements for standardized, comparable records, with emphasis on ensuring continuity of care (e.g. possibility of health cards)</li> <li>● Utilize innovative sources for gathering data</li> </ul>
<b>Priority 6</b>	<ul style="list-style-type: none"> <li>● Building research capacity and widening scope of R&amp;M health research, including in the context of low- and middle-income countries and in the global south</li> <li>● Developing regional, country and global research networks, engaging R&amp;M populations in research process</li> <li>● Translating research findings into policy and practice and disseminating evidence across stakeholders in R&amp;M and host populations</li> <li>● Ensuring an emphasis on dispelling fear, reducing stigma and discrimination</li> <li>● Developing global status report, conference and action plan</li> </ul>	<ul style="list-style-type: none"> <li>● Build research capacity and widening scope of research</li> <li>● Develop regional, country and global research networks</li> <li>● Engage R&amp;M populations in research</li> <li>● Translate research findings into policy and practice</li> <li>● Disseminate evidence across R&amp;M and host populations with emphasis on dispelling fear, reducing stigma and discrimination</li> <li>● Prepare global R&amp;M health report, conference, action plans</li> </ul>

<sup>a</sup> Priority 1: promote the health of refugees and migrants through a mix of short-term and long-term public health interventions; Priority 2: promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures; Priority 3: advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee-sensitive and migrant-sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms; Priority 4: enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage; Priority 5: strengthen health monitoring and health information systems; Priority 6: support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health.

<sup>b</sup> Develop/implement covers associated training, resourcing, governance and communications.

## Annex 2.

# Selecting and charting projects by WHO GAP priority and region

A total of 72 examples of projects (policies, programmes and/or interventions) implemented across 39 Member States was received through the open call. These projects had been developed with government involvement at national, regional and/or local levels and were formulated and/or implemented after adoption of the GAP in May 2019.

Each project was analysed using the coding framework to ensure a comprehensive compendium of case studies aligned with WHO GAP priority and WHO region. Most projects aligned with more than one GAP priority and the relative strength of alignment was captured through a process of colour coding, for example to highlight “major”, “2nd major” and “minor” strength of alignment. All submitted projects were examined for alignment with each of the WHO GAP priority areas using the prepared coding framework.

Once charted, projects were examined to identify case studies for each WHO region that would illustrate key features of each of the priority areas in the context of refugee and migrant health.

The criteria for selecting case studies were based on appraisal of:

- representation of the six WHO regions (African, Americas, Eastern Mediterranean, European, South-East Asian, Western Pacific);

- demonstrated implementation of a specific policy/ programme/intervention to promote the health of refugees and migrants;
- showed intersectoral collaboration; and
- had evidence of sustainability or project scale-up.

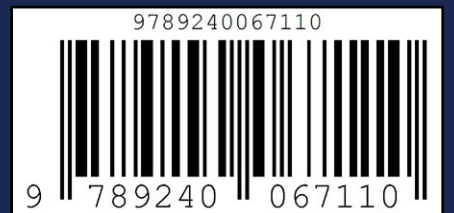
The application of the first criteria required additional attention because priority areas and regions were not evenly represented. Most of the projects aligned with more than one GAP priority area, reflecting the cross-cutting elements of health promotion activities in terms of aims, actors and activities. Similarly, there was a higher representation of projects from the WHO European Region than other regions.

Therefore, to ensure that all priorities and regions were represented in the case studies selected, a mix of projects were selected from each region that exemplified implementation of priority areas, even if the alignment was a relatively minor element of the overall project. This might mean, for example, that a larger project with main/major alignment with Priority 1 might be selected to exemplify Priority 5 if it contained a health information system component and there was no other Priority 5 example for that WHO region. A total of 49 projects were selected as case studies.





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