Innovative Solutions to Address Needs of People on the Move for

Maternal Health, Sexual and Reproductive Health, and Gender-based Violence Services in the Arab States Region

Acknowledgment

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ALCS	Association de lutte contre le SIDA
CHV	Community Health Volunteers
CP	Child Protection
EMH	Emergency Midway House
EU	European Union
FOO	Fondation Orient Occident
FP	Family Planning
GBV	Gender-based Violence
HIV	Human Immunodeficiency Virus
IAWG	Inter-Agency Working Group
IMC	International Medical Corps
IOM	International Organization for Migration
IRC	International Rescue Committee
MCH	Mother and Child Health
MH	Maternal Health
MHPSS	Mental Health and Psycho-social Support
MOH	Ministry of Health
MoPH	Ministry of Public Health
MWTF	Migrant Worker's Task Force
NGO	Non-Governmental Organization
PHC	Primary Health Care
PSTIC	Psycho-social Services and Training Institute Cairo
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

FOREWORD

People are increasingly on the move for economic, political, humanitarian and other reasons. Migration is not a new phenomenon, but in the era of globalization has reached a new proportion. The number of people on the move has dramatically increased in the past few years, particularly in the Arab States region, which is witnessing several humanitarian crises. The human rights causes and implications of migration are manifold. Migrants, especially irregular migrants, are particularly vulnerable to human rights violations and abuses. They are also vulnerable to a lack of information and services in many areas, including sexual and reproductive health, maternal health and gender-based violence.

This report is a desk study intended to delve into the real-time needs of "people on the move" in the region, with specific attention to maternal health, sexual and reproductive health and gender-based violence needs. The report also includes a horizon scan of potential or existing innovative solutions that UNFPA or others might have in the pipeline, or already in place, to address identified target group needs.

Since access to protection and other types of services can be challenging, not the least due to the often-precarious legal status of the concerned population groups, there is great potential in the role that innovation can play across the humanitarian sector. Innovation need not be a technological or in the form of a digital tool or serve per se, but rather a change in the way we think about issues, identify needs of target groups, design solutions to meet those needs and test solutions with beneficiaries to ensure we got it right. Innovation can be fueled by science and technology of course, but can also focus on improved ways of working with new and diverse partners, or can involve new social and business models or policies, creative financing mechanisms, or path-breaking improvements in delivering essential services and products.

I hope that this report contributes to the ongoing discussion on how we can continue to meet all the needs of "people on the move" and work better to ensure women and girls are protected regardless of their location and status, and that they receive the necessary health services they require throughout their journey, including full access to sexual and reproductive health services and information, as well as gender-based violence information and services.

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EXECUTIVE SUMMARY

Mixed migration in the Arab States region is a complex multidimensional phenomenon as the region hosts a combined 34% of the world's population of the forcibly displaced[1] who need access to protection and basic social services including maternal health (MH), sexual and reproductive health (SRH) and gender-based violence (GBV) information and services. Since access to protection and other types of services can be challenging, not the least due to the often precarious legal status of the concerned population groups, the role that innovation can play across the humanitarian sector is noteworthy. Innovation is as a matter of fact, attracting considerable attention, with its potential to open up new ways to meet the various needs of "people on the move".

In order to find out more information about the real-time needs of "people on the move" in the region, with specific attention to maternal health, sexual and reproductive health and gender-based violence needs, the UNFPA Arab States Regional Office (ASRO) has commissioned this two-parts report which consists of: (a) a mapping/needs assessment in the form of a desk review, to more precisely gauge what those needs might be at various points journey of "people on the move"; and (b) a horizon scan for potential or existing innovative solutions that UNFPA or others might have in the pipeline, or already in place, to address identified target group needs.

Part One of this report presents the results of the desk review that aims to identify sexual and reproductive health, maternal health and GBV needs among "people on the move" in Egypt, Iraq, Jordan, Lebanon, Morocco and Sudan, with a focus on youth and women of reproductive age. Part Two identifies and highlights existing innovative practices that might promote the health of "people on the move". Drawing on the horizon scan findings, the report concluded with recommendations to the international development community on the need to partner on already proven solutions that would address the MH, SRH and GBV needs of "people on the move" but also considers the design and implementation of new potential solutions.

In terms of **Methodology,** the research team first conducted for Part One of the report a desk review of the international literature to build a framework. Then the researchers mapped migrant and refugee needs in the selected countries to identify gaps in support for maternal health, sexual and reproductive health as well as GBV

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1   The UN Refugee Agency. Forced displacement in 2016: Global trends. 2017.

services according to the framework specified by the international literature. Thirty-three documents were selected in order to assess migrant and refugee needs in the six countries reviewed. Seven papers specifically targeted maternal health, reproductive health and/or GBV.

Part Two of the report relies on a thematic review of innovations to meet the needs of "people on the move" in MH, SRH and GBV. The research team dealing with this section of the report consulted a wide range of specialized and institutional websites as well as multiple online bibliographic databases.

Finally, for the purpose of this study, the term "people on the move" is used to refer to irregular Mixed Migrants; refugees and asylum seekers. Focus of target groups for the study include: i) youth (people aged 15 to 24); ii) adult migrants (15 to 49 years of age) targeted by sexual and reproductive health programmes; and iii) women of reproductive age (aged 15-49).

The **results** of the desk review on "people on the move" found that there are disparities in information depending on the countries and the thematic axes. Access to information about laws and health proved to be the weakest axis, an indication that governments should increase their efforts to ensure that data related to migrants is systematically collected as part of routine information systems. The desk review also found that UNFPA and other development actors/partners should explore the development and use of new information and communication technologies to facilitate access to information for people on the move. Based on this insight from the desk review, Part Two of the report brings forward proposed solutions that are largely related to technological innovations, innovative services and new organizational models. Information technologies offer a major asset that the different actors working in the field of migration can draw upon. Such technologies and platforms facilitate communication, coordination, and the collection and analysis of large amounts of data, enabling timely responses in migratory contexts, particularly when sudden-onset disasters occur. Given the complex settings in which health technologies are deployed and disseminated, the team's review of web-based technologies for health promotion suggests that evaluations of health outcomes and impacts may be very difficult but crucial to capture lessons learnt.

Finally, the **recommendations** present potential actions and considerations for the protection and promotion of MH, SRH and protection from GBV for people on the move, through innovative digital and non-digital tools. This includes: the promotion and support of connectivity and digital literacy for migrants; developing innovative solutions through partnerships with relevant stakeholders (UN agencies, NGOs, CSOs, universities, private sector, etc); working in synergy with already available services that help open the way to new services for "people on the move"; and involving health professionals in the development of new innovative solutions and training them on their use.

PART ONE:

Desk Review of Maternal Health (MH), Sexual and Reproductive Health (SRH), and Gender-based Violence (GBV) needs of People on the Move in Jordan, Lebanon, Iraq, Egypt, Sudan and Morocco

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I. Context & Background

The objective of the first section of this report is to present findings of a desk review of data collected on the needs of people on the move in the Arab Region. The section specifically focuses on the needs of people on the move in relation to sexual and reproductive health, maternal health and GBV services. The findings of this first part, as well as those of the second section of the report focusing on a horizon scan of solutions and services already being utilized by people on the move, was intended to add to the literature on the target group in the Arab States Region as well as determine how the UNFPA Arab States Regional Office can or should move forward with the development of innovative approaches to address the sexual and reproductive, maternal health and GBV needs of "people on the move" in the region.

According to the International Organization for Migration (IOM), "*Migrant is an umbrella term, not defined under international law, reflecting the com-*

mon lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes a number of well-defined legal categories of people, such as migrant workers; persons whose particular types of movements are legally-defined, such as smuggled migrants; as well as those whose status or means of movement are not specifically defined under international law, such as international students".[2]

The terms "migrant" and "immigrant" are widely used and interchangeable without reference to specific sources[3]. In contrast, the terms "refugee" and "asylum-seeker" are more likely to be defined using internationally standardized references[4]. According to the IOM, mixed migration includes the irregular nature of and the multiplicity of factors driving such movements, and the differentiated needs and profiles of the persons involved. According to the IOM, mixed flows have been defined as "complex population movements including refugees, asylum seekers, economic migrants and other migrants[5]". Unaccompanied minors, environmental migrants, smuggled persons, victims of trafficking and stranded migrants, among others, may also form part of a mixed flow.[6]

Throughout this report the term migrant/refugee is used to cover all those comprising the mixed migration flows. If the caseload mentioned refers only to refugees or asylum-seekers, it will be clearly stated.

By 2019, the number of people on the move was estimated at 272 million, including 41.3 million displaced people because of various conflicts around the world.[7] Mixed migration in the Arab region is an extremely complex phenomenon with different dimensions. In 2016, 40% of refugees, internally displaced persons and asylum seekers were from this region.[8] Arab countries also host 34% of the world's forcibly displaced people.[9] These include single women, pregnant women, lactating women and unaccompanied children.[10] All of these categories consist of particularly at-risk

2   IOM. Who is a migrant? [24/12/2019]. Available from: https://www.iom.int/who-is-a-migrant.

3   WHO. What is a migrant? How definitions affect access to health care 2017 [22/04/2019]. Available from: http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2017/03/what-is-a-migrant-how-definitions-affect-access-to-health-care

4   Ibid.

5   Susan F. Martin, Sanjula Weerasinghe, Abbie Taylor. Humanitarian Crises and Migration: Causes, Consequences and Responses, Routledge, 2014

6   IOM. What is Mixed Migration? [30/12/19]. Available from: https://www.iom.int/files/live/sites/iom/files/Country/docs/Mixed-Migration-HOA.pdf

7   IOM. World Migration Report 2020. 2019.

8   The UN Refugee Agency. Forced displacement in 2016: Global trends. 2017.

9   Ibid.

10 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

individuals who need to be protected and cared for in an effective and coordinated manner that includes access to maternal health (MH), sexual and reproductive health (SRH) and gender-based violence (GBV) services. Unfortunately, these people on the move face a variety of legal, cultural, political, financial and health system obstacles when it comes to accessing these services.[11]

Despite the difficulty of obtaining consistent data disaggregated by gender, age and marital status as to the well-being of migrants and their need for MH, SRH and GBV services in the Arab region, UNFPA has carried out a series of projects to determine the needs of the most vulnerable and the most at risk. These include the Youth Mixed Migration Project and the Youth, Peace and Security (YPS) focus groups. The former was conducted in partnership with the Mixed Migration Monitoring Mechanism Initiative for the purpose of:[12]

- Describing the drivers of youth migration, including push and pull factors;

- Exploring sexual and reproductive health (SRH) vulnerabilities as well as the knowledge and service needs of young migrants in urban centres;

- Generating real-time data on the experience of young migrants, particularly with regard to sexual and reproductive health of adolescents/youth, GBV and socio-economic empowerment;

- Providing key actors and data planners with data to inform service delivery and advocacy efforts.

The YPS project (and related focus groups) was among the first fully dedicated to the important and positive role young adolescent men and women play in the maintenance and promotion of international peace and security.[13]

The report offers no guarantee that it has covered all the themes or acquired all the data inherent to people on the move. This desk review aims to identify SRH, MH and GBV needs among "people on the move" in Jordan, Morocco, Sudan, Lebanon, Egypt, and Iraq with a focus on youth (15-24 years old) and women of reproductive age (15-49 years old), and to explicitly identify gaps in available information on this important topic at the country level.

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11 Ibid.

12 UNFPA. Youth Migrants in the Arab Region: Situation Analysis of Boys and Girls, 2018.

13 Youth4Peace. Inter-Agency Working Group on Youth & Peacebuilding [22/04/2019]. Available from: https://www.youth4peace.info/About_WGYPB

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II. Methodology

For the purpose of this study, the target group "People on the Move" was defined as mixed migrants (economic migrants and refugees) as well as asylum-seekers with a focus on youth aged 15 to 24 and women of reproductive age (15-49 years).

The research team first developed a framework for analysis, based on a desk review of the international literature, to be used to analyse and map the selected documents for each of the six countries.

The research team searched in Medline, Cochrane Library, Google Scholar and JSTOR databases using the following research equation:

(((("needs assessment"[MeSH Terms]) OR ("health services needs and demand"[MeSH Terms]))) AND (((("maternal health"[MeSH Terms]) OR "sexual health"[MeSH Terms]) OR "reproductive health"[MeSH Terms]) OR "gender based violence"[MeSH Terms])) AND (((("transients and migrants"[MeSH Terms])) OR "refugees"[MeSH Terms]) OR ("emigrants and immigrants"[MeSH Terms]))

Publications up to ten years old were included in the research, given the scarcity of published materials specifically addressing maternal health, sexual and reproductive health and GBV needs for people on the move. We completed our research for this part of the report by reviewing the different publications and guidelines published on institutional sites such as those of WHO, UNFPA, IOM and UNHCR.

The framework used to analyse the needs of people on the move has three main axis grouped around 13 dimensions:

3. The first axis is about the right to information. Access to information is essential so that migrants can make informed decisions related to MH, SRH and GBV needs. In the context of migration, timely access to information can save lives. This includes their right to access information related to laws & services, and migrant health literacy.

4. The second axis is about access to healthcare. According to the Universal Declaration of Human Rights and WHO's 1978 Alma Ata convention, universal access to healthcare is a basic human right. However, there are variables which can affect migrants' access to healthcare. These factors often come down to the availability of resources (structural, human and financial), geographical and cultural factors and the extent to which social support is available.

5. The third axis concerns service adequacy and migrants' perceptions and experiences of health care services. This axis assesses the adequacy and quality of services, taking into account migrants' experiences of the health structure. It touches on a range of aspects such as healthcare quality, stigma & judgment and GBV concerns.

Table 1 below summarizes the framework used to analyse the articles related to the six countries that were studied.

Table (1): Analytical framework for the literature reviewed

Axis	Definition	Dimension	Definition
Axis 1: Right to Information	Access to information concerning the right of access to health	Access to information about law and services (legal information & access to fundamental rights)	Access to information about migrants' rights and obligations and how to enforce them
		Migrant health literacy	Access to information to empower individuals to gain access to, understand and use information in ways which promote and maintain good health
Axis 2: Access to Healthcare	Ease with which an individual can obtain needed medical services	Availability of sufficient personnel (including trained healthcare providers)	Healthcare providers focussed on managing migrants' specific concerns and their health problems

Axis	Definition	Dimension	Definition
		Availability of financial resources	
		Cost & financial assistance	Economic situation of migrants and their access to financial aid
		Geography & Logistics barriers	Geographical contexts for access to healthcare
		Access to resources (drugs/ supplies/ FP commodities)	Access to drugs/ supplies/ FP commodities
		Migrant health legislation	Law or set of laws related to the right to health of migrants
		Cultural and linguistic concern barriers	Individual values, beliefs, and behaviours about health and well-being
		Integration & social support	Existence of social ties
Axis 3: Adequacy and migrants' perception/ experiences of health care & GBV services	Adequacy and quality of services taking into consideration migrants' experiences of health structure	Healthcare quality (including specialized services, proper medical care & advice, communication and gender concerns)	Degree to which health care services for individuals and populations increase the likelihood of positive health outcomes
		Stigma & judgment	Devaluing people or groups based on a real or perceived difference which constitutes a barrier to effective and equitable healthcare
		GBV services	Includes facilities for the reception and care of GBV survivors and prevention measures & protection against GBV

Mapping the needs of people on the move in Egypt, Jordan, Lebanon, Iraq, Sudan and Morocco was based on the framework above. The Research Team searched for published literature using the stated research equation, adding the name of the country concerned as a keyword. Research Team members also searched the data baseline provided by the UNFPA team and other UN agencies. The Team also consulted other literature such as the official reports of the UNFPA Youth Mixed Migration Project, Youth Peace and Security (YPS) focus groups and others as well as reports of UNFPA's institutional partners dealing with the issue (i.e. Health Ministries, NGOs, civil society association). PhD and master theses that had been defended in several universities were also consulted.

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III. Desk Review Results

The initial search retrieved 65 documents ranging from general and situation reports to published articles, produced between 2012 and 2018. The study team examined the content of each for comprehensiveness and relevance. This allowed the team to whittle down the initial 65 to 33 core documents. Seven papers specifically targeted maternal health, reproductive health and/or GBV.

Analysis of literature data was carried out according to a thematic approach (axis by axis) with a description of each of the six countries within each axis.

Axis 1: Right to Information

a. Law and services (legal information and access to fundamental rights)

One of the fundamental axes regarding the vulnerability of people on the move concerns their access to information about the right of access to health.

This vulnerability is accentuated when it applies to youth or women with reproductive health or maternal health issues or problematic situations related to GBV.

Generally, people on the move are unaware of their rights, the authorities' inability to protect them. Additionally, there are the critical life situations that can prey upon their vulnerabilities such as being forced to share rooms with members of the opposite sex or, in the case of Unaccompanied and Separated Children (UASC), finding themselves at risk of potential exploitation by having to live with adults they are not related to. These are just two examples where circumstances affect their ability to meet their own needs and protect themselves. Women and youth are the most affected by linguistic and socio-cultural barriers and gender inequality.[14]

It has been reported that some initiatives in **Egypt** have attempted to offer access to health information for people on the move but have encountered problems of sustainability. Studies of refugees in Cairo highlighted communication and information as critical obstacles to accessing healthcare services. Misinformation, rumours, mistrust - all serve to hamper migrant access to official or correct information about access to health.[15]

b. Migration health literacy

i. Access to information related to health and services (treatment, preventive measures, and screening)

Health literacy is another dimension affecting migrants' access to vital information about health in general and SRH, MH and GBV in particular.

Broadly, this refers to an individual's ability to "gain access to, understand and use information in ways which promote and maintain good health", for them, their families and their communities. In operational terms, it means they are able to find information and services, to communicate their needs and preferences and respond and process the meaning and usefulness of the available information and services, understanding the choices, consequences and context of the information and services and capable of deciding what information and which services match their needs and preferences so that they can act.[16]

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14 De Vito E, De Waure C, Specchia ML, Ricciardi W. Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region. 2015 ; European Union Agency for Fundamental Rights. Migrants in an irregular situation: access to healthcare in 10 European Union Member States. 2011.

15 Refugees UHCf. Urban refugee protection in Cairo: the role of communication, information and technology. 2012.

16 Rudd RE. The evolving concept of Health literacy: New directions for health literacy studies. Journal of Communication in Healthcare. 2015;8(1):7-9.

The literature reviewed about sexual and reproductive health shows that migrant women lack knowledge on certain SRH aspects. Some studies revealed that, regardless of cultural group or affinity, many women had little knowledge about SRH because of taboos associated with menstruation and sexuality. This has significant implications for migrant and refugee women and leaves them vulnerable and exposed to SRH problems like sexually transmitted infections and unintended pregnancies.[17]

In addition, available evidence points to young women and girls having limited knowledge about contraceptive methods, STIs and HIV/AIDS.[18]

In Jordan and Lebanon, migrants, women especially, seem unaware about the availability and benefits of SRH services, including reproductive health and family planning.[19] In **Egypt**, there mainly was a lack of information about available SRH and GBV services, including HIV services.[20]

ii. Access to information on SRH (puberty, menstruation, pregnancy, contraception, and HIV transmission)

In both **Jordan** and **Lebanon**, information is provided on family planning (mainly on contraceptive methods), however, women and men have limited knowledge on the usage of contraceptive methods.[21] Moreover, migrants did not express demand for family planning services.[22] In **Morocco**, migrants have a satisfactory level of knowledge about STIs including HIV but are unaware of family planning services and its capacity to meet their needs.[23] No information was found in Egyptian, Iraqi and Sudanese publications/journals about these sub-dimensions.

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17 Metusela C, Ussher J, Perz J, Hawkey A, Morrow M, Narchal R, et al. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. International journal of behavioral medicine. 2017;24(6):836-45.

18 Ivanova O, Rai M, Kemigisha E. A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa. International journal of environmental research and public health. 2018;15(8).

19 Ay M, Arcos González P, Castro Delgado R. The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan. International Journal of Health Services. 2016;46(3):566-89 ; Bardaweel SK, Akour AA, A AL. Impediments to use of oral contraceptives among refugee women in camps, Jordan. Women & health. 2019;59(3):252-65 ; Cherri Z, Gil Cuesta J, Rodriguez-Llanes JM, Guha-Sapir D. Early Marriage and Barriers to Contraception among Syrian Refugee Women in Lebanon: A Qualitative Study. International journal of environmental research and public health. 2017;14(8); Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74.

20 Kergoat Y. The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt: Free University of Amsterdam; 2013.

21   Bardaweel SK, Akour AA, A AL. Impediments to use of oral contraceptives among refugee women in camps, Jordan. Women & health. 2019;59(3):252-65.

22 Ay M, Arcos González P, Castro Delgado R. The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan. International Journal of Health Services. 2016; 46(3):566-89.

23 HIV integrated behavioral and biological surveillance surveys-. In: diseases DoEafa, editor. 2013.

Axis 2: Access to Healthcare

The key determinant governing access to healthcare for migrant populations is migrant mainstreaming into the health care system. Here lies a role for healthcare personnel, which should be able to take into account the unique circumstances and specific needs of migrants. The economic plight of migrant populations and their limited access to financial aid often feature in the literature as barriers to their access to healthcare. As to legislation and policies, these are the sovereignty of states, leaving international actors to play a supportive role, despite efforts by the UN and international actors to uphold international standards. National legislation and practices should comply with international standards (respect for human rights, including health-related rights, e.g.). Finally, it is important to pay attention to existing support services that extend beyond clinical management to focus on provision of psychosocial support or services.

a. Human resources and health workforce

Articles from **Jordan**, **Lebanon** and **Egypt** have flagged the issue of a shortfall in human resources dedicated to dealing with migrants' health problems, as well as high turnover of trained staff. This trend has been attributed to doctors lacking motivation. Low salaries for doctors in the public health sector offer little incentive to spend extended time in public service. Such employment terms and working conditions are similarly unattractive to other health workers, including the relentless pressure healthcare providers must work under, day in, day out.[24]

In **Lebanon**, fluctuations in the numbers of physicians began before the Syrian refugee crisis, the outcome of a mismatch in supply and demand that resulted in persistent oversupply. By contrast, the number of nurses working in the Lebanese health system increased steadily and was not affected by the Syrian crisis.[25] Meanwhile, a diverse and qualified workforce of Syrian health professionals that included physicians, nurses, midwives, psychologists, and health administrators was practicing informally.[26]

24 Kergoat Y. The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt: Free University of Amsterdam; 2013; International Medical Corps. Understanding the mental health and psychosocial needs, and service utilization of Syrian refugees and Jordanian nationals: A qualitative & quantitative analysis in the Kingdom of Jordan. 2017 ; Krause S, Williams H, Onyango MA, Sami S, Doedens W, Giga N, et al. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. Conflict and health. 2015;9(1):S4 ; Mourtada R, Schlecht J, DeJong J. A qualitative study exploring child marriage practices among Syrian conflict-affected populations in Lebanon. Conflict and health. 2017;11(Suppl 1):27.

25 Ammar W, Kdouh O, Hammoud R, Hamadeh R, Harb H, Ammar Z, et al. Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health. 2016;6(2):020704-.

26 Ismail SA, Coutts AP, Rayes D, Roborgh S, Abbara A, Orcutt M, et al. Refugees, healthcare and crises: informal Syrian health workers in Lebanon. International Institute for Environment and Development, 2018.

In **Jordan**, the analysis revealed that among trained health care providers, too few specialized in RH and GBV, which meant that there was limited awareness of the profile and health risks among health workforce or health care professionals.

In **Lebanon**, where there were few trained staff in reproductive health, UNFPA and other partners have supported the Ministry of Public Health by providing training for health professionals on the clinical management of rape at Primary Health Care centres and in selected referral hospitals.[27]

Because **Iraq** lacks sufficient doctors trained in primary health care, IOM has drawn up a rapid-response roster of qualified professionals from all branches of health service provision as part of ongoing efforts at capacity-building.[28]

In **Egypt**, the low awareness of the profile and health risks faced by refugees led to 239 healthcare professionals being trained as part of the regional refugee resilience plan (3RP) designed to provide better protection and support for Syrian refugees and host communities in the country.[29]

In **Morocco**, the national training module on migrant health issues for health professionals includes an SRH component.[30]

Despite consulting many sources plus a thorough review of documents relating to Sudan, no relevant information was found about human resources.

b. Public financial resources for health care

The problem of financial resources is mentioned in several documents as an obstacle to offering health care for migrants in **Jordan** and **Egypt**. Problems related to financing health care for refugees plus the scarcity of primary health care structures were cited,[31] and attributed to health sector budget deficits including the inability of donor countries to provide the necessary funding mainly because of the Syrian migration crisis.[32]

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27 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

28 Ibid.

29 UNHCR. Egypt Regional Refugee & Resilience Plan 2017-2018. 3RP, 2017.

30 IOM. Formation des professionnels de santé des établissements de soins de santé primaire de la région de Casablanca-Settat 2018. Available from: https://morocco.iom.int/news/casa-blanca-formation-des-professionnels-de-sant%C3%A9-des-%C3%A9tablissements-de-so-ins-de-sant%C3%A9-primaire.

31 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74.

32 International Medical Corps. Understanding the mental health and psychosocial needs, and service utilization of Syrian refugees and Jordanian nationals: A qualitative & quantitative analysis in the Kingdom of Jordan. 2017.

In **Lebanon**, there was no change in public spending on health observed. The budget of the Ministry of Public Health (MoPH), along with all public funds, increased at the same annual rate as in preceding years. However, throughout the Syrian crisis, which resulted in an influx of Syrian refugees into Lebanon, funding from international donor funding fluctuated, and fell far below the amounts required to meet refugee health needs.[33] Throughout the crisis, the Lebanese health system was able to sustain the level of financing of services at primary, secondary and tertiary care levels while maintaining MoPH contracts with primary healthcare centres.[34]

Despite consulting many sources (UNFPA, IOM, UNHCR, WHO, national institutions and NGOs) plus documents relating to **Iraq, Morocco and Sudan**, no relevant information was found about the availability of financial resources.

i. Cost and financial assistance

The cost factor represented one of the main barriers to access to healthcare. Studies in all countries have reported the economic difficulties migrants face.

In **Jordan**, refugees require a registration certificate from UNHCR in order to benefit from the agreed rates.[35] A small percentage of refugees received financial assistance from UNHCR.[36] Many services require payment including services as hospitalization and tertiary care. Only primary healthcare (PHC)services are free.[37]

In **Lebanon**, refugees and displaced persons have access to all PHC services for a nominal fee, which is maintainable due to the contributions from donors and humanitarian partners.[38] UNHCR finances secondary and tertiary care for Syrians in Lebanon covering 75 per cent of fees for emergency cases.[39] However, because of decreased funding, UNHCR partners are forced to prioritize only life-saving interventions when covering hospitalization fees or SRH services and resources in Lebanon.[40]

33 Ammar W, Kdouh O, Hammoud R, Hamadeh R, Harb H, Ammar Z, et al. Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health. 2016;6(2):020704-.

34 Ibid.

35 Al-Rousan T, Schwabkey Z, Jirmanus L, Nelson BD. Health needs and priorities of Syrian refugees in camps and urban settings in Jordan: perspectives of refugees and health care providers. Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit. 2018;24(3):243-53.

36 Ibid.

37 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74; The UN Refugee Agency. UNHCR Service Guide. 2018.

38 The UN Refugee Agency. Forced displacement in 2016: Global trends. 2017.

39 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

40 Ibid.

In **Iraq**, free services are limited to PHC. Regardless, some refugees are referred to private clinics in the absence of a dedicated primary health care system.[41]

In **Egypt**, some benefits were free for refugees and for some profiles such as migrants with mental disorders or GBV survivors. Under the regional refugee resilience plan, 1,164 Syrian survivors of sexual and gender-based violence (SGBV) received integrated care. Despite the support provided by the Ministry of Health (MoH) for primary health care, the high cost of secondary and tertiary health care services requires Syrian refugees in need of such services to incur significant out-of-pocket expenditures.[42] Moreover, deliveries and obstetric care at public hospitals entail user fees.[43] WHO has financed the provision of secondary and tertiary health services through four specialized medical centres.[44] WHO also provided regular medical consultations at PHC centres. In 2015, UNHCR and WHO successfully approached the MoH to offer Syrian refugees both specialized and emergency care in 20 MoH hospitals at the same rates charged to Egyptians.[45]

In **Morocco**, the MOH has provided free access to all PHC services since 2008.[46] Consultations in public primary health centres were free for migrants and refugees. UNHCR and IOM ensured medical coverage for migrants and refugees, including expenses related to prescription of drugs, lab tests and hospitalization.[47]

In **Sudan**, medical fees discourage irregular migrants from pursuing medical care.[48] However, advocacy efforts that had been in place finally paid off through a high-level agreement to include urban refugees within the same health insurance scheme that provides coverage for nationals.[49]

ii. Geography and logistics

Geographical accessibility was cited rarely as a factor of concern in accounts about overall healthcare access in **Jordan** and **Lebanon**. Yet a few documents have raised

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41 Cetorelli V, Burnham G, Shabila N. Health needs and care seeking behaviours of Yazidis and other minority groups displaced by ISIS into the Kurdistan Region of Iraq. PloS one. 2017;12(8):e0181028.

42 UNHCR. Egypt Regional Refugee & Resilience Plan 2017-2018. 3RP, 2017.

43 Ibid.

44 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

45 UNHCR. Egypt Regional Refugee & Resilience Plan 2017-2018. 3RP, 2017.

46 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

47 UNHCR. Fact sheet Morocco 2019 [22/04/2019]. Available from: http://reporting.unhcr.org/sites/default/files/UNHCR%20Morocco%20Fact%20Sheet%20-%20February%202019.pdf.

48 Migration MH. Country Brief Sudan 2018 [22/04/2018]. Available from: http://www.mixedmigrationhub.org/wp-content/uploads/2018/05/Country-Profile-Sudan.pdf

49 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

the issue of how geographical remoteness and lack of transport can delay care, in-cluding SRH services.[50]

iii. Access to resources (drugs/supplies/FP commodities)

Some migrants and refugees in **Jordan** have pointed-out problems with accessing medicines, citing difficulties encountered with out of stock reproductive health sup-plies and the lack of medicines and medical equipment.[51]

In **Lebanon**, despite financial constraints, the MOPH managed to increase expen-ditures on drugs in response to the rise in demand over recent years. In order to achieve this and to be able to direct external funds to priority cases, the MOPH collaborated closely with various donors.[52] With support from UNFPA, the MOPH provides family planning supplies and commodities to all its centres for improved re-productive health. [53]However, some refugees have commented on the unavailability of certain contraceptives.[54]

In **Iraq**, the MOH has stock-piled medication and medical supplies in order to ensure in the event of a crisis that it is in a position to help maintain the supply chain to functional medical units and locations in need.[55]

Despite consulting many sources (UNFPA, IOM, UNHCR, WHO, national institu-tions and NGOs) and other documentation, no relevant information was found about this dimension with regard to Morocco, Egypt and Sudan.

iv. Migration health legislation

The scarcity of information about this aspect seems common to many of the coun-tries reviewed. In **Lebanon**, there was no clear government policy. The fragmen-

50 Ay M, Arcos González P, Castro Delgado R. The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan. International Journal of Health Services. 2016;46(3):566-89; Keeshin BR, Cronholm PF, Strawn JR. Physiologic changes associated with violence and abuse exposure: an examination of related medical conditions. Trauma, violence & abuse. 2012;13(1):41-56.

51 International Medical Corps. Understanding the mental health and psychosocial needs, and service utilization of Syrian refugees and Jordanian nationals: A qualitative & quantitative analysis in the Kingdom of Jordan. 2017; Heaman M, Bayrampour H, Kingston D, Blondel B, Gissler M, Roth C, et al. Migrant wom-en's utilization of prenatal care: a systematic review. Maternal and child health journal. 2013;17(5):816-36.

52 Ammar W, Kdouh O, Hammoud R, Hamadeh R, Harb H, Ammar Z, et al. Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health. 2016;6(2):020704.

53 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

54 Cherri Z, Gil Cuesta J, Rodriguez-Llanes JM, Guha-Sapir D. Early Marriage and Barriers to Contraception among Syrian Refugee Women in Lebanon: A Qualitative Study. International journal of environmental research and public health. 2017;14(8).

55 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

tation of health system governance prompted the MOPH to request international agencies to consider a more integrated approach to planning, financing and service delivery by embedding refugee health care within the national health system. To help develop such an approach, the MOPH established a steering committee that includes major international and local partners to guide the response.[56]

In **Egypt**, UNHCR launched an advocacy strategy in 2013 that includes 52 workshops and training sessions for Egyptian authorities, judiciary and civil society. Participants receive instruction on how to respond to mixed migration needs, including detention- and border-monitoring, as well as specific support services for the most vulnerable asylum-seekers and for refugee victims of trafficking in Egypt.[57]

In **Morocco**, documents revealed a legislative void on issues related to violence among migrants.[58]

Despite consulting many sources (UNFPA, IOM, UNHCR, WHO, national institutions and NGOs) and specific documents dealing with Jordan, Iraq and Sudan, no relevant information could be found about this dimension.

v. Cultural and linguistic barriers

A search of various documents (the global UNFPA website and those for each of the countries, plus UNHCR, IOM, and scientific literature) turned up no material dealing with either the cultural or religious aspects of health issues. **Egyptian** and **Moroccan** sources did document problems arising when migrants have no understanding of the local language and how this constitutes a barrier to healthcare access.[59] A notable example was the lack of interpreters, key to enabling migrants convey their specific needs to health care providers.[60]

56 Ammar W, Kdouh O, Hammoud R, Hamadeh R, Harb H, Ammar Z, et al. Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health. 2016;6(2):020704.

57 UNHCR. Sexual and Gender-based Violence Prevention and Response In Refugee Situations in the Middle East and North Africa. 2015.

58 Keygnaert I, Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, et al. Sexual violence and sub-Saharan migrants in Morocco: a community-based participatory assessment using respondent driven sampling. Globalization and Health. 2014;10(1):32 ; van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC health services research. 2013;13:77.

59 Kergoat Y. The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt: Free University of Amsterdam; 2013; HIV integrated behavioral and biological surveillance surveys-. In: diseases DoEafa, editor. 2013.

60 Kergoat Y. The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt: Free University of Amsterdam; 2013

vi. Integration and social support

In **Jordan**, the International Medical Corps (IMC) supported Jordanian Health Aid Society urban clinics located in areas with known concentrations of Iraqi refugees. Interaction between Iraqis and non-Iraqis in clinic waiting rooms and health education sessions has opened up networking opportunities and has helped promote social inclusion for Iraqis in urbanized Jordanian communities.[61]

In **Iraq**, the need for psycho-social rehabilitation along community lines was noted because of increased health problems noted among people on the move.[62]

In **Egypt**, Cairo's Psycho-social Services and Training Institute (PSTIC), an implementing partner of UNHCR, was set up in 2009. PSTIC aimed to ''increase the psycho-social and mental health support presently offered to refugees''. It sought to offer quality mental health and psycho-social support (MHPSS) services to refugees and asylum seekers in their own languages, taking into account their own culture and traditions. To achieve this, PSTIC launched nine-month training programmes for refugees and asylum seekers nominated by their peers, which aimed at building their capacity to become psycho-social workers. Trainees were instructed in a range of skills and activities enabling them to integrate these activities and approaches into existing programmes including health, social welfare, and legal services.[63]

In **Morocco**, the MOH introduced a peer health education approach for the promotion of migrant psycho-social well-being.[64] A pool of peer educators was identified from various NGOs and communities in the country. NGOs also drew on the Community Health Worker approach to assist migrants.

In **Sudan**, specifically in Khartoum, Ethiopian and Eritrean irregular migrants typically relied on community networks for support.[65]

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61 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

62 Cetorelli V, Burnham G, Shabila N. Health needs and care seeking behaviours of Yazidis and other minority groups displaced by ISIS into the Kurdistan Region of Iraq. PloS one. 2017;12(8):e0181028.

63 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

64 Ibid.

65 Migration MH. Country Brief Sudan 2018 [22/04/2018]. Available from: http://www.mixedmigrationhub. org/wp-content/uploads/2018/05/Country-Profile-Sudan.pdf.

Axis 3: Adequacy and Migrants' Perception and Experiences related Health and GBV

This third axis of the analysis of migrant needs in MH, SRH and GBV services focusses on migrant experiences with health services and their relevance to migrant needs. Elements reviewed include: quality of healthcare; medical care and appropriate counselling; communication with healthcare professionals; gender concerns, stigma and judgment with the focus on GBV services.

a. Healthcare quality

i. Specialized services

In **Jordan**, women refugees reported being dissatisfied with the quality of SRH services. This was attributed to the increased number of refugees seeking care and the fact that care providers were overwhelmed.[66] Some women also expressed concern about the quality of the treatment they received.[67]

In **Lebanon**, the Ministry of Public Health has developed a basic maternal and child health care package to be implemented at PHC centres for a flat fee that covers at least four antenatal care visits, delivery and post-natal care, and provision of vaccines for children up to two years of age, in accordance with the national immunization calendar.[68]

In **Iraq**, the MOH has provided health services in multiple modalities in accordance with different needs and locations, revitalized selected PHC centres and hospitals, and has upgraded and supported field hospital services.[69] The Ministry also provided a comprehensive package of PHC services including reproductive health and communicable disease treatment for IDPs.

In **Egypt**, quality health care at public health facilities remains the major barrier for Syrian refugees seeking such services. Taking this into account, UNICEF implemented an integrated support for the Mother and Child Health (MCH) model and

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66 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74; Krause S, Williams H, Onyango MA, Sami S, Doedens W, Giga N, et al. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. Conflict and health. 2015;9(1):S4; Alnuaimi K, Kassab M, Ali R, Mohammad K, Shattnawi K. Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. International nursing review. 2017;64(4):584-92.

67 Alnuaimi K, Kassab M, Ali R, Mohammad K, Shattnawi K. Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. International nursing review. 2017;64(4):584-92.

68 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

69 Ibid.

strengthened MOH capacity to provide quality health services for Syrian mothers, girls and boys.[70]

In **Morocco**, responding to migrant demand for systematic screening for Sexually Transmitted Infections, the National Programme for the Prevention of Sexually Transmitted Infections and AIDS organized HIV testing with support from NGOs.[71] UNHCR and its partners, *Fondation Orient Occident* (FOO) and *Association de lute contre le SIDA* (ALCS) provide access to reproductive health services, mother-child care, HIV/Aids prevention and treatment, etc.[72]

No relevant information could be found about specialized services delivered to refugees in Sudan despite consulting a range of sources (UNFPA, IOM, UNHCR, WHO, national institutions and NGOs) as well as country-specific documents.

ii. Medical care and services

In **Jordan**, some health professionals have expressed the need for counselling about child marriage as part of the drive to avoid certain neonatal complications.[73] They also stressed the need for family planning counselling since refugees tend to neglect family planning due to economic, security and health issues they face,[74] so much so that 28% of women had unplanned pregnancies.[75]

In **Lebanon**, the Migrant Workers' Task Force (MWTF), a grassroots volunteer organization advocating for improved treatment and social advancement of the migrant worker community, offers peer education sessions on sexual and reproductive health (encompassing modules on female and male anatomy, menstrual cycle, hygiene, sexually transmitted infections, HIV/AIDS and protection).[76]

In **Morocco**, some migrant women said that while their newborn deliveries were performed at public hospitals (the issue of cost was not raised), antenatal care was provided on the premises of NGOs working in the country.[77]

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70 UNHCR. Egypt Regional Refugee & Resilience Plan 2017-2018. 3RP, 2017.

71 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

72 UNHCR. Fact sheet Morocco 2019 [22/04/2019]. Available from: http://reporting.unhcr.org/sites/default/files/UNHCR%20Morocco%20Fact%20Sheet%20-%20February%202019.pdf

73 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74 ; Alnuaimi K, Kassab M, Ali R, Mohammad K, Shattnawi K. Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. International nursing review. 2017;64(4):584-92.

74 Alnuaimi K, Kassab M, Ali R, Mohammad K, Shattnawi K. Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. International nursing review. 2017;64(4):584-92.

75 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74

76 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

77 HIV integrated behavioral and biological surveillance surveys-. In: diseases DoEafa, editor. 2013.

Despite widespread consultations and research with many sources (UNFPA, IOM, UNHCR, WHO, national institutions and NGOs) as well as a review of documentation relating to Egypt, Iraq and Sudan, no relevant information was found regarding this field.

iii. Communication

In **Jordan**, some people pointed out there is a need to communicate about stigma in mental health care in order to mitigate this phenomenon.[78] The same applies to the often taboo subject of sexual violence in the community,[79] with some stakeholders pointing out the need to raise awareness about GBV.[80]

Refugees in **Lebanon** expressed the need for health education in SRH. Nurses engaged in outreach and health education activities about family planning work closely with services provided in the centres.[81] Meanwhile, the Migrant Worker's Task Force organizes "health day" events that provide migrants an opportunity to get a general check-up and to undergo voluntary HIV tests. In waiting rooms, patients are exposed to slide shows and informational sessions on health issues, including presentations about protection and the treatment of sexually transmitted infections such as HIV.[82]

In **Egypt**, WHO conducts community health awareness sessions for newly arrived refugees as well as capacity building for Syrian communities. However, since there weren't enough health education sessions available, community health volunteers (CHVs) promoted health awareness, health seeking practices along with enhanced access to and better utilization of MOH primary health care services for women, girls, boys and men.[83] A participatory-approach workshop was organized in order that teachers and refugee students could explore and solve issues raised by students such as the discrimination and sexual abuse some were exposed to when travelling to school.[84]

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78 Al-Rousan T, Schwabkey Z, Jirmanus L, Nelson BD. Health needs and priorities of Syrian refugees in camps and urban settings in Jordan: perspectives of refugees and health care providers. Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit. 2018;24(3):243-53.

79 Krause S, Williams H, Onyango MA, Sami S, Doedens W, Giga N, et al. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. Conflict and health. 2015;9(1):S4.

80 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74.

81 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

82 Ibid.

83 UNHCR. Egypt Regional Refugee & Resilience Plan 2017-2018. 3RP, 2017.

84 Ibid.

In **Morocco**, peer educators were trained about communication techniques and how to work with communities in addressing such problems.[85]

No relevant information was found about this field with regard to Iraq or Sudan, despite the team's best research efforts.

iv. Gender sensitivity concerns

In both **Jordan** and **Lebanon**, studies revealed a marked scarcity of female doctors. Syrian refugees indicated they felt more comfortable with female gynecologists.[86] Despite the research team's best efforts, including a review of documents relating to the other countries, no relevant information was found about gender-sensitivity concerns.

b. Stigma and judgement

In **Jordan**, several references mention the shame women feel when having to discuss their sexual health.[87] Migrants and refugees also cited the stigmatization and discrimination they experienced at the health facility level in Jordan, especially when consulting about mental health problems.[88] Some also mentioned their fear of reporting abuses they encountered.[89] Given reports of sexual violence in Syria and the strong possibility of under-reporting for reasons such as those cited above, greater attention should be paid to the need for specialists in the fields of obstetrics and gynecology.[90]

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85 IOM. Atelier national de formation des éducateurs pairs au profit des leaders des communautés de migrants et des travailleurs sociaux des associations partenaires 2016. Available from: https://morocs co.iom.int/news/atelier-national-de-formation-des-%C3%A9ducateurs-pairs-au-profit-des-leaders-des-communaut%C3%A9s-de.

86 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74 ; Keeshin BR, Cronholm PF, Strawn JR. Physiologic changes associated with violence and abuse exposure: an examination of related medical conditions. Trauma, violence & abuse. 2012;13(1):41-56 ; Reese Masterson A, Usta J, Gupta J, Ettinger AS. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. BMC Women's Health. 2014;14(1):25.

87 Alnuaimi K, Kassab M, Ali R, Mohammad K, Shattnawi K. Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. International nursing review. 2017;64(4):584-92.

88 Tappis H, Lyles E, Burton A, Jordan Health Access Study T, Lebanon Health Access Study T, Doocy S. Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan. Maternal and child health journal. 2017;21(9):1798-807 ; Al-Rousan T, Schwabkey Z, Jirmanus L, Nelson BD. Health needs and priorities of Syrian refugees in camps and urban settings in Jordan: perspectives of refugees and health care providers. Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit. 2018;24(3):243-53.

89 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74.

90 Ay M, Arcos González P, Castro Delgado R. The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan. International Journal of Health Services. 2016;46(3):566-89.

In **Lebanon**, some women reported that they avoided consulting gynecologists, and were therefore unable to benefit from SRH care, simply because they feared the associated stigma.[91] Women refugees also complained of experiencing discrimination or inadequate treatment at the health facility level.[92]

In **Egypt**, discriminatory practices meant that access to secondary healthcare facilities favoured Egyptian citizens with Syrian refugees being treated differently. Also, some health care providers displayed a discriminatory attitude when dealing with some people.[93]

No relevant information about this dimension could be found despite consulting many sources (UNFPA, IOM, UNHCR, WHO, national institutions and various NGOs) as well as documents relating to Iraq, Morocco and Sudan.

c. GBV services

Gender-based violence (GBV) is defined as "any harmful act that is perpetrated against a person's will, and that is based on socially-ascribed differences between males and females".[94] GBV can be broadly defined and divided into five categories:[95]

- Sexual violence (rape, sexual assault, sexual harassment),

- Physical violence (hitting, slapping, beating),

- Emotional violence (psychological abuse),

- Denial of resources, opportunities or services (includes economic violence)

- Harmful practices (forced marriages, female genital mutilation).

91 Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74 ; Mourtada R, Schlecht J, DeJong J. A qualitative study exploring child marriage practices among Syrian conflict-affected populations in Lebanon. Conflict and health. 2017;11(Suppl 1):27.

92 Cherri Z, Gil Cuesta J, Rodriguez-Llanes JM, Guha-Sapir D. Early Marriage and Barriers to Contraception among Syrian Refugee Women in Lebanon: A Qualitative Study. International journal of environmental research and public health. 2017;14(8) ; Tappis H, Lyles E, Burton A, Jordan Health Access Study T, Lebanon Health Access Study T, Doocy S. Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan. Maternal and child health journal. 2017;21(9):1798-807.

93 Kergoat Y. The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt: Free University of Amsterdam; 2013.

94 IASC. Guidelines for integrating Gender-based Violence interventions in humanitarian action. 2015.

95 Ibid.

i. Facilities for the reception and care of GBV survivors

In **Jordan**, 678 specialized staff from government institutions and humanitarian organizations were trained on GBV Standard Operating Procedures (SOPs) and referrals to multi-sectoral services.[96] Safe spaces have been adapted to ensure accessibility for male survivors. Orientations on GBV SOPs target all sectors of the community (women, girls, men and boys) including community and religious leaders.[97]

In **Lebanon**, the NGO ABAAD, a resource centre for gender equality, established the Al-Dar Emergency Midway House (MWH) to provide safe, temporary shelter to survivors and those at risk of SGBV. There are now three MWHs administered by ABAAD in Lebanon. MWHs provide emergency shelter, case management and referrals to tailored services, including medical services, psycho-social and legal assistance, and vocational training and language classes. Male SGBV survivors, including men and boys aged 12 to 18 are referred to a select number of separately administered shelters that welcome them – e.g. Mission De Vie and UPEL.[98] In 2014, UNHCR significantly improved mechanisms to address sexual exploitation and abuse-related complaints in Lebanon by training 679 individuals including UNHCR staff, along with personnel from a partner organization, Refugee Outreach Volunteers.[99]

In **Iraq**, socio-political and economic developments created conditions that enabled perpetrators of violence and made it harder for GBV survivors to access services and seek justice and help.[100] The GBV Sub-Cluster Strategy objectives include improving capacity for timely delivery of quality, multi-sectoral response for GBV survivors.[101]

In **Morocco**, UNHCR assisted SGBV survivors among mixed, migratory movements.[102] However, several structural and organizational concerns have affected the support for SGBV survivors, among them: a lack of care structures for migrant survivors of violence; healthcare workers' general lack of familiarity with many of the issues involved plus structural difficulties about long-term monitoring, compounded by inadequate staffing and resources, which account for a shortfall in requisite skills for appropriate interventions by health workers, including a dearth of psychological support.[103]

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96 UNHCR. Sexual and Gender-based Violence Prevention and Response In Refugee Situations in the Middle East and North Africa. 2015.

97 Ibid.

98 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

99 UNHCR. Sexual and Gender-based Violence Prevention and Response In Refugee Situations in the Middle East and North Africa. 2015.

100 UNFPA. A report on the GBV assessment in conflict affected governorates in Iraq. 2016.

101 Ibid.

102 UNHCR. Sexual and Gender-based Violence Prevention and Response In Refugee Situations in the Middle East and North Africa. 2015.

103 Keygnaert I, Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, et al. Sexual violence and sub-Saharan migrants in Morocco: a community-based participatory assessment using respondent driven sampling. Globalization and Health. 2014;10(1):32.

In **Sudan**, transiting migrants lack access to basic services such as medical, psycho-social and legal assistance. Also, they are often vulnerable to exploitation and abuse by migrant smugglers, who subject them to trafficking or forced labour. As part of its migrant protection and assistance programme aimed at promoting self-reliance among migrant communities,[104] the Migrant Research Centre in Gedarif is working with IOM to address the immediate needs of migrants for protection and assistance while also collaborating with local governmental bodies and NGOs to ensure that migrants have access to information that meets their specific needs.

ii. Prevention measures & protection against GBV

In **Jordan**, under the auspices of the child protection (CP) and SGBV sub-working group, UNFPA, UNHCR, UNICEF, Save the Children International, and the International Rescue Committee (IRC), as part of the Amani campaign helped promulgate guidance for refugee populations using posters featuring key messages for communities, children and parents about how to better protect children and adults from harm and violence.[105] A specialized branch of the police, the Family Protection Department, was set up to respond to domestic violence, while a number of government agencies and NGOs, including the Ministry of Social Development and the National Commission for Women, have established an SGBV network.[106]

In **Lebanon**, UNHCR Lebanon has supported refugee outreach volunteers, mobile outreach teams and safety audits and assessments to expand the reach of SGBV prevention and response efforts.[107] UNHCR's partners provided essential information on SGBV prevention and response, including the availability of essential services for survivors, which is capable of reaching up to 11,000 members of refugee and host communities each month.[108] UNHCR has worked in partnership with the Danish Refugee Council (DRC) and the local NGO KAFA ("Enough Violence and Exploitation") to launch a pilot programme that involves men and boys in core SGBV prevention and response activities. The latter include helping develop awareness-raising materials that are language and culturally appropriate.[109]

In **Iraq**, a strategy was implemented to strengthen coordination and advocacy on GBV prevention and response among GBV sub-cluster members. This also involved

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104 IOM. More Help for Vulnerable Migrants as IOM Opens Sudan's Second Migrant Resource Centre 2019 [22/04/2019]. Available from: https://sudan.iom.int/news/press-releases/more-help-vulnerable-migrants-iom-opens-sudan%E2%80%99s-second-migrant-resource-centre.

105 WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

106 UNHCR. Sexual and Gender-based Violence Prevention and Response in Refugee Situations in the Middle East and North Africa. 2015.

107 Ibid.

108 Ibid.

109 Ibid.

other humanitarian actors and clusters, among them, Iraqi civil society, UN, government authorities and communities working together to build up community resilience in order to prevent and mitigate acts of GBV and harmful traditional practices.[110]

In **Egypt**, the UNHCR-chaired Inter-Agency Working Group (IAWG) was the main coordination mechanism overseeing six sectorial, working groups comprising representatives from UN agencies and international and national NGOs. Others involved include sub-working groups on Child Protection and Response to Sexual and Gender-based Violence (SGBV). UNHCR and partners provide special assistance and psycho-social support to children at risk, survivors of SGBV and those who have experienced or witnessed conflict, violence or trauma. UNHCR supported community theatre activities to mobilize young people to take an active role in SGBV prevention. UNHCR Egypt also promotes the empowerment of refugee women through the "Graduation Project" funded by the Safe from Start global initiative, which offers lifelong learning and skills training.[111] UNHCR and its implementing partners conducted sensitization sessions on child abuse and child sexual abuse prevention using age-appropriate learning methodologies for children and simultaneous sessions for their caregivers.[112]

In **Morocco**, UNHCR provided regional training on lesbian, gay, bisexual, transgender and intersex (LGBTI) protection issues, including migrants.[113]

In **Sudan**, a study recommended improving access for female irregular migrant workers to helpful, gender-sensitive migration information and education in order to help protect their rights.[114] In furthering this, it was proposed to implement laws and policies applicable to migrants as well as establishing a network among governmental and non-governmental organizations for the effective protection and recovery of victims of trafficking.[115]

110   Cignacco E, Zu Sayn-Wittgenstein F, Senac C, Hurni A, Wyssmuller D, Grand-Guillaume-Perrenoud JA, et al. Sexual and reproductive healthcare for women asylum seekers in Switzerland: a multi-method evaluation. BMC health services research. 2018;18(1):712.

111   UNHCR. Sexual and Gender-based Violence Prevention and Response In Refugee Situations in the Middle East and North Africa. 2015.

112   Keeshin BR, Cronholm PF, Strawn JR. Physiologic changes associated with violence and abuse exposure: an examination of related medical conditions. Trauma, violence & abuse. 2012;13(1):41-56.

113   UNHCR. Fact sheet Morocco 2019 [22/04/2019]. Available from: http://reporting.unhcr.org/sites/default/files/UNHCR%20Morocco%20Fact%20Sheet%20-%20February%202019.pdf.

114   Elmagboul N, Dauod S, Tawaldi S. Exploitation and violence against Ethiopian female irregular migrant domestic workers in Khartoum State. Ahfad Journal. 2017;34(2).

115   Tsega AH. The Nexus between Migration and Human Security: The Case of Ethiopian Female Migration to Sudan. International Journal of Humanities and Social Sciences. 2016;10(7):2531-7.

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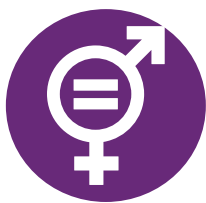
IV. Reflections on Study Findings

The results obtained show that the literature exploring and identifying overall health needs of people on the move, and specifically maternal health, sexual and reproductive health and gender-based violence (MH, SRH and GBV), is generally lacking and/or relatively poor. Moreover, most of the documents reviewed failed to address the specifics with regard to MH, SRH and GBV needs, integrating them instead into a more general framework, without reference to age, gender, marital status or migrant status. Quality of data also differed from one country to another and from one region to another.

Research on the health needs of people on the move is better documented in Jordan and Lebanon than in the other countries covered in this desk review. Contextualized as geo-politically significant, the Syrian and Iraqi conflicts have been the focus of widespread media and international interest, which may explain why the refugee crisis in Jordan and Lebanon has spawned a larger number of studies.

The presence of a critical mass of researchers from renowned academic institutions has boosted the study of migration-related issues in Lebanon and Jordan.

Moreover, the axes explored for purposes of this desk review were treated in an unbalanced way. The area of greatest attention was the adequacy and perception of health services, especially GBV services. This may be explained by the fact that violence against women and girls is among the most common human rights violations in the world. We note that this dimension has been studied to different degrees in all six countries in this desk review. The results showed that, overall, institutional (governmental and non-governmental) and civil society efforts have been deployed to limit and prevent this issue. Nonetheless, the response remains inadequate given the need for increased protection that was reiterated in country after country by different stakeholders.

Moreover, the need to inform and educate people on the move about relevant laws and available services and to promote and improve health literacy has been neglected despite the previously cited lack of access to information being one of the major drawbacks confronting people on the move. Much greater efforts are a must if people on the move are to have access to the kind of information they clearly need. Advocacy activists must impress upon government authorities the importance of deploying the necessary means, including technological means. to reach the widest audience. . A number of initiatives to improve the lives of refugees have been introduced in some countries. For example, a British company has devised "Techfugees", a technology enabling refugees to communicate with family and friends, to transfer money, and to translate, learn and geo-locate.[116] It has been described aptly as a "relief buoy for refugees".

The axis relating to access to care for people on the move shows how migrants/refugees have been treated differently from country to country. However, the cultural dimension has yet to be thoroughly discussed, even though the international literature considers this to be one of the main barriers when it comes to accessing care. Perhaps the problem was so obvious that it was deemed unnecessary to raise it. Technological advances could once again be the key by providing some interesting and innovative solutions to facilitate communication among peoples on the move as well as with caregivers and the relevant national and international organizations.

In conclusion, based on the preceding assessment, the desk review team recommends that the UN and other development partners should explore the development and use of new information and communication technologies to facilitate access to information for people on the move. Apart from allowing them to better integrate in host communities and facilitating their ability to communicate with others, this would allow them to have more say and more control about their own well-being and health.

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116   SciDev.net. «Techfugees» : La technologie au service des réfugiés 2017 [22/04/2019]. Available from: https://www.scidev.net/afrique-sub-saharienne/technologie/article-de-fond/techfugees-technologie-refugies.html.

PART TWO:

Innovations to Meet Needs of
"People on the Move"
related to MH, SRH, and GBV

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I. Context & Background

The social and health impacts of an unprecedented migratory surge of "people on the move" across borders have been felt around the world. Despite the huge jump in the numbers of migrants and refugees, all of them subject to significant trauma, many suffering from complex physical and mental health issues, insufficient attention has been paid to addressing their health needs. Indeed, coordinating an appropriate healthcare response to the influx of refugees and migrants in the Arab region is not easy. Besides the unique differences in the healthcare needs of "people on the move", politicians are also conflicted when dealing with issues of entitlements, and related cost and capacity constraints. The lives of displaced populations in urgent need of healthcare remain at risk given their inability to access healthcare when they need to. Their predicament becomes all the more acute considering that refugee stays can vary in duration

from months to decades.[117] This makes it all the more important to find durable, adaptable and innovative long-term solutions to meet the health needs of people as they traverse the onerous and dangerous pathways of their various migratory routes. New and innovative approaches may hold the answer to some of the profound humanitarian dilemmas their plight represents.[118]

Innovation offers the possibility of doing something differently with the aim of improvement at a system or sector level. In this sense, successful innovations based on adaptation and invention result in real and measurable improvements in efficiency, effectiveness, quality, or social and health outcomes/impacts of humanitarian action.

Approaching problems through innovation, whether via new solutions or new applications of existing products, technologies, services, and organizational models, offers the possibility of finding new ways to meet the health needs of migrant people and others like them on the move. Policymakers are beginning to embrace innovation, but much more can be done to help plug the gaps in the global response to the current migrant/refugee crisis, notably the vital issue of healthcare access. There is a need for innovative approaches that are viable, adaptable and inclusive in order to foster resilience and address the specific needs of all those affected.

Recently, UNFPA, both globally and through its Arab States Regional Office (ASRO), has looked to develop new solutions and/or adopt and implement solutions already proven to be effective in its continuing efforts to meet the health needs of the displaced and the migratory. Increasingly, UNFPA has focused on supporting activities to strengthen innovative solutions that enhance access to information and the care of migrants and refugees. Initiatives being considered include the establishment of fellowship programmes for young researchers interested in this field of activity.

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117   Blogs WB. How many years do refugees stay in exile? 2016. Available from: https://blogs. worldbank.org/dev4peace/how-many-years-do-refugees-stay-exile.

118   Obrecht A, T Warner A. More than just luck: Innovation in humanitarian action. Humanitarian Innovation Fund/ALNAP Study, 2016.

© UNFPA Syria

II. Methodology

For the second part of the report, a thematic review was conducted to assess innovations that meet the MH, SRH and GBV needs of displaced migratory people on the move. Research included visiting websites as follows:

- Websites specializing in new information and communication technologies relevant to the health needs of displaced "people on the move" (and other populations as appropriate);

- Websites dedicated to technological and non-technological innovations that apply to health needs of migrants/refugees on the move (and to other population groups as appropriate);

- Institutional websites (UNFPA, UNHCR, IOM, WHO, etc.)

In addition, report compilers searched for relevant articles in Medline and Google Scholar dealing with innovative solutions addressing the health needs of "people on the move" drawing on the following framework.

Table 2: Summary Analysis Framework

Axis	Dimension
Axis 1 : Right to Information	Access to information about law and services (legal informa-(tion & access to fundamental rights
	Migrant health literacy
Axis 2 : Access to Healthcare	Availability of sufficient number of human resources (including (trained healthcare providers
	Availability of financial resources
	Cost & financial assistance
	Geography & logistics barriers
	(Access to resources (drugs / supplies / FP commodities
	Migrant health legislation
	Cultural and linguistic concerns/barriers
	Integration & social support
Axis 3: Adequacy of and migrant perception and experience of health care & GBV services	Healthcare quality (including specialized services, proper med-(ical care & advice, communication and gender concerns
	Stigma & judgement
	GBV services

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III. Results

Literature data was analyzed thematically on an axis by axis basis, the different innovations and potential solutions in each described specifically in terms of their application and relevance to the health needs of refugee/migrant "people on the move". Most of the proposed solutions relate to technological innovations, innovative services and new organizational models. Information technologies bring a major asset to those working in the field of migration. A combination of IT capacity and user familiarity ensures a communication circuit that facilitates distance support, follow-up and feedback for service providers and migrants alike. IT availability and know-how enable service providers to keep track of migrant group movements and needs, just as those on the move must rely on their own IT resources in order to stay informed and provide updates on their progress and well-being.[119]

119   Aid & International Development Forum. Solutions That Are Saving Lives in Humanitarian Response 2015 [14/05/2019]. Available from: http://www.aidforum.org/disaster-relief/top-solutions-that-are-saving-lives-inhumanitarian-response

1. Connectivity a prerequisite for information technology (IT-based) innovations

Connectivity is a vital factor when determining the role information technologies can play in meeting the needs of migrants on the move. In 2016, a UNHCR study aimed at improving refugee access to mobile and internet connectivity[120] revealed just how critical refugees believed connectivity to be to their very survival. In Tanzania, for example, refugees were willing to sell up to one-third of their monthly food ration allowance in order to buy mobile phone airtime and data.[121]

Living without connectivity makes contact and sustained communication with loved ones difficult-to-impossible. Without access to up-to-date information about the situation in their home countries and/or countries of asylum, refugees are unable to make informed choices about how to improve their lives by, for example, accessing basic health and education services.

Once a refugee population has connectivity, organizations like UNHCR, UNFPA, and OIM are in a better position to innovate effectively and to improve the quality of services provided.

Access to the internet and mobile telephone services offers a powerful multiplier potential, boosting refugee well-being and that of the host communities as well.[122]

UNHCR's Innovation Service seeks to equip agency staff with the knowledge, resources, and skills to maximize their capacity and ability to apply structured innovation in solving the most pressing challenges.[123]

Strengthening connectivity for refugees and migrants offers one such approach simply by ensuring connectivity is both consistently available and affordable and by helping refugees and migrants to make the best use of it.[124]

The objective is to guarantee a network infrastructure that provides reliable advocacy platforms for government and mobile network operator infrastructures as well as for internet service providers and alternative technology companies.

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120 Otto K. Information and communication technologies for health systems strengthening: opportunities, criteria for success, and innovation for Africa and beyond2015

121 UNHCR. Connecting refugees : How internet and mobile connectivity can improve refugee well-being and transform humanitarian action. 2016.

122   Dekker R, Engbersen G, Klaver J, Vonk H. Smart Refugees: How Syrian Asylum Migrants Use Social Media Information in Migration Decision-Making. Social Media + Society. 2018;4(1):2056305118764439.

123 Otto K. Information and communication technologies for health systems strengthening: opportunities, criteria for success, and innovation for Africa and beyond2015.

124 UNHCR. Connecting refugees : How internet and mobile connectivity can improve refugee well-being and transform humanitarian action. 2016.

A further priority is to negotiate specific plans and discounts for refugees providing accessible or subsidized pricing (e.g. covering devices and mobile/Internet plans), and to deploy and expand community internet access centres .

A final objective concerns the use of connectivity for digital literacy, training and access to relevant services. Harnessing digital means to deliver training and other services when possible facilitates and speeds up development and effective dissemination of refugee-specific content.

2. Innovations improving access to information

Access of migrants to information is a key factor determining their access to care. For this reason, the innovations taken into consideration in the course of the review of relevant literature included various sub-categories dealing with access to information about migrant rights to health and health literacy.[125]

This included examining digital ways to provide migrants with access to information about their legal rights and related matters such as attaining a level of health literacy commensurate with the need to understand and articulate their own health issues.

2.1. Examples of innovations in law and services (legal information & access to fundamental rights)

2.1.1. The Mohajer app android/IOS (Iran, US, Canada and UK)[126]

The Mohajer App is an independent application created with the support of Afghan communities inside Iran to address their needs. The app was completed with the help of a group of paid and voluntary refugee-rights attorneys, advocates and technologists. Mohajer has two specific features. The "Get Informed" section provides information for users about Iran's immigration policy, the rights of Afghans in Iran, and resources that are available for concerns such as health, education, combatting discrimination, etc., -- a list that expands as users share their needs and what they have learned. The section also provides a list of support groups that this report's compilers verified directly. The "Submit Report" feature enables users to share their everyday experiences as Afghans in Iran and to support the larger community when it comes to addressing similar challenges. Importantly, information on the app is also accessible offline, so as to support those without regular internet access.

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125   WHO European Region. Strategy and action plan for refugee and migrant health in the WHO European Region. 2016.

126   Mohajer App Developer. Mohajer [https://play.google.com/store/apps/details?id=com.mohajerapp.mobile].

2.1.2. Integreat (Germany)[127]

Integreat is an information app and website tailored to the specific needs of both newcomer/users of the app and municipal administrations as content providers. It is a multilingual, offline, free mobile guide that provides newcomers with all relevant information in their native language as quickly as possible without internet access and stripped of confusing red tape. The resultant app, called *Integreat,* passes on all relevant information in multiple languages to the newcomers. It is a holistic service ecosystem for cities, districts and organizations to help integrate people with a flight or migration background.

2.2. Innovations in migrant health literacy

Health literacy is a social determinant of the health of populations and is especially important when it comes to the empowerment of migrant populations. Major innovations for health literacy are based on technologies that facilitate access to reliable information about migrant health and health system organization. These two levels are fundamental to guaranteeing a better understanding of health service needs and provision.[128]

Some examples of innovations in migrant health literacy follow:

2.2.1. Healthy start – Queensland Australia[129]

This is a preventative health education project delivered by medical and allied health students working with newly arrived refugees to increase their health literacy. The educational app project was developed by volunteer students with support from The Refugee Health Network of Queensland, Australia. The Network is a mechanism to build capacity, partnerships, and facilitate coordination of care across health, settlement agencies, communities, government and non-government sectors. The long-term aim is to improve the health and well-being of people with refugee backgrounds throughout Queensland. Teaching modules include General Health, Nutrition, Visiting the GP (General Practitioner), Accessing a Hospital, Men's Health and Women's Health. The modules were developed with the help of experts in the field. A qualitative evaluation suggests that those who took part in the programme felt they had benefited. All workshop participants "agreed" or "strongly agreed" that they had increased their knowledge about health in general, and that as a result they had the

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127   Tür an Tür. Integreat [https://play.google.com/store/apps/details?id=tuerantuer.app.integreat].

128   Kreps GL, Sparks L. Meeting the health literacy needs of immigrant populations. Patient education and counseling. 2008;71(3):328-32.

129   Refugee Health Network Queensland. Innovative Projects [08/05/2019]. Available from: http://www.refugeehealthnetworkqld.org.au/innovative-projects/.

confidence and motivation to look after and improve their own health. Moreover, on the post-workshop questionnaire, all respondents indicated they would recommend the programme to a friend.[130]

2.2.2. Shifra (Australia/USA)[131]

Shifra is more than a life-saving health intervention. It is a research project which aims to explore the social, cultural and geographic barriers to quality healthcare access that many refugees attest to having encountered. The Shifra web app is designed to improve access to quality sexual and reproductive health care. It provides local, evidence-based health information in multiple languages for communities with varying levels of language and health literacy. *Shifra* also directs users to trusted clinics where they can access care that is respectful and safe. Local health networks participate as a way of improving their existing services to meet the self-identified health needs found in *Shifra's* anonymous user trend data.

3. Innovation in access to healthcare

Migrant/refugee access to healthcare when on the move is affected by factors, ranging from lack of healthcare professionals and financial resources to the high cost of healthcare services and geographic barriers. Meanwhile, inventors, engineers and entrepreneurs are coming up with a range of ingenious solutions to improve healthcare access for migrants and refugees and others on the move.

3.1. Telemedicine as a remedy for addressing migrant healthcare access challenges

Recent developments in information and communication technologies, the advent of the internet especially, have led to a significant boom in telemedicine. A form of remote medical practice using information and communication technologies, telemedicine connects health professionals with each other and/or with patients. It facilitates diagnosis, preventive or post-therapeutic follow-up, requests for specialist opinions, therapeutic decision-making, and the monitoring of patient health status. It merges several components, including tele-consultation, which is defined as a medical act conducted in the virtual or screened presence of the patient who dialogues with the requesting physician and the specialist medical consultant(s).[132]

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130   Mater UQ Centre for Primary Health Care Innovation. The 'Healthy Start Program' Evaluation Report. 2016.

131   Shifra [10/05/2019]. Available from: https://www.shifra.io/.

132   Simon P, Acker D. La place de la télémédecine dans l'organisation des soins. Ministère de la Santé et des Sports. Direction de l'Hospitalisation et de l'Organisation des Soins 2008.

Telemedicine has proven its effectiveness by facilitating and broadening access to health care and by its widespread acceptance by users.

3.1.1. Telemedicine & geographic barriers

An American systematic review that analyzed data from 30 articles highlighted the importance of telemedicine in increasing access to healthcare by eliminating the need for proximity, especially in healthcare cases involving people living in remote areas.[133]

3.1.2. Telemedicine & cost-effectiveness

A recent evaluation of the diabetic retinopathy tele-ophthalmology screening programme in Manitoba showed an average cost savings of 1,007 Canadian dollars per tele-ophthalmology examination.[134] A recent French study on the clinical effects and costs of telemedicine for wound care management observed a shortened healing time in the telemedicine group (137 days) compared to a control group with standard practice (174 days) and travel cost savings of 4,583 Euros per patient over a period of nine months.[135] Elsewhere, a randomized, controlled trial about telemedicine in a remote area in Norway concluded that the practice is cost-effective both from a societal and a health sector perspective.[136]

3.1.3. Telemedicine & human resources

Telemedicine is a way to compensate for a lack of qualified personnel. Its effectiveness has been demonstrated in several studies carried out in developing countries, especially in Africa, where the general population faces numerous barriers, not least a shortage of appropriately skilled personnel.[137]

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133 Scott Kruse C, Karem P, Shifflett K, Vegi L, Ravi K, Brooks M. Evaluating barriers to adopting telemedicine worldwide: A systematic review. Journal of telemedicine and telecare. 2018;24(1):4-12.

134 Kanjee R, Dookeran RI, Mathen MK, Stockl FA, Leicht R. Six-year prevalence and incidence of diabetic retinopathy and cost-effectiveness of tele-ophthalmology in Manitoba. Canadian journal of ophthalmology Journal canadien d'ophtalmologie. 2017;52 Suppl 1:S15-s8.

135   Le Goff-Pronost M, Mourgeon B, Blanchere JP, Teot L, Benateau H, Dompmartin A. Real-world clinical evaluation and costs of telemedicine for chronic wound management. International journal of technology assessment in health care. 2018;34(6):567-75.

136 Buvik A, Bergmo TS, Bugge E, Smaabrekke A, Wilsgaard T, Olsen JA. Cost-Effectiveness of Telemedicine in Remote Orthopedic Consultations: Randomized Controlled Trial. J Med Internet Res. 2019;21(2):e11330.

137 Scott RE, Mars M. Telehealth in the developing world: current status and future prospects. Smart Homecare Technology and TeleHealth. 2015;3:25-37 ; Smith SE, Ludwig JT, Chinchilli VM, Mehta K, Stoute JA. Use of telemedicine to diagnose tinea in Kenyan schoolchildren. Telemedicine and e-Health. 2013;19(3):166-8 ; Were MC, Emenyonu N, Achieng M, Shen C, Ssali J, Masaba JP, et al. Evaluating a scalable model for implementing electronic health records in resource-limited settings. Journal of the American Medical Informatics Association. 2010;17(3):237-44.

3.1.4. Telemedicine & humanitarian crises

Initiatives to implement telemedicine practices in some regions experiencing humanitarian crises have emerged in recent years. Médecins sans frontière (MSF) began using telemedicine in 2010. Since first referral, the designated portal has logged 1,301 cases from 243 referral sites across the globe. The Central African Republic, Malawi and South Sudan top the list of countries using the referral services. In 2014, an initial evaluation by MSF of 300 field users showed that 91% found the portal helpful while 81% indicated patient management in the field had improved.[138]

UNHCR's Innovation Service has been looking at new ways to provide efficient and effective health services for the refugee community. Financial limitations caused by the burgeoning refugee crisis in other parts of the world meant that the new service had to find a sustainable method of managing its programme/assistance for the refugees. For instance, in a refugee camp in Nepal, UNHCR has supported a fellowship programme to deliver telemedicine. Initially, the programme relied on basic tools such as Skype (available on any type of mobile), before switching to better infrastructures incorporating reliable Wi-Fi connections and quality equipment such as large-screen TVs and high definition webcams plus solar generators to ensure backup power in the event of outages.[139] Healthcare delivery after dark was a recurring challenge since no doctor was on site at night. This left overnight patient care in the hands of medical assistants lacking the credentials to treat complicated cases. The upshot was that patients often had to be transferred to primary, secondary and tertiary health care centres in nearby towns, incurring costs much greater than would have been the case had they been treated at the camp clinic.[140] The compilers of this report remain unaware of any post-intervention evaluation having been performed as yet.

3.2. mHealth

An important component of eHealth, mHealth is defined as medical and public health practice supported by mobile phones, patient monitoring devices, personal digital assistants (PDAs), and other wireless devices.[141] The practice of mHealth initially grew out of making use of a mobile phone's core voice and short messaging service (SMS) utilities. It moved on to embrace more complex functions and applications including general packet radio service (GPRS), third and fourth generation mobile telecommunications (3G and 4G systems), global positioning system (GPS), and Bluetooth technology.[142]

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138   Walji M. Bringing telehealth to humanitarian settings. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2015;187(4):E123-E4.

139   UNHCR Innovation Services. Using telecommunications to improve clinical healthcare in refugee camps 2019 [08/05/2019]. Available from: https://www.unhcr.org/innovation/using-telecoms-to-improve-clinical-healthcare-in-refugee-camps/.

140   Ibid.

141   World Healh organization. mHealth: New horizons for health through mobile technologies. 2011.

142   Ibid.

Accordingly, as an increasing proportion of the population gains access to health information and services through mobile phone use, a vast array of mobile-based solutions have been developed to improve health access, knowledge and behaviours across a broad range of contexts and target groups. International Telecommunication Union (ITU) statistics show more than seven billion mobile phone subscriptions worldwide in 2015, over 70% of which were in low- or middle- income countries. According to WHO, expanding member state capacity to implement digital health, and in particular mHealth, can be key to achieving universal health coverage. This can be achieved by doing the following:[143]

- increasing access to quality health services through effective and timely sharing of health data, particularly for hard-to-reach populations;

- increasing access to sexual and reproductive health services and reducing maternal, child and neonatal mortality by strengthening the quality, coverage and affordability of validated health interventions;

- reducing premature mortality from non-communicable diseases and non-communicable disease co-morbidities by developing new ways to obtain information directly from the public in support of disease surveillance;

- increasing the safety and quality of care by providing secure access to vital information required by attending physicians at the time of care particularly in the event of disasters or humanitarian crises;

- increasing patient, family, and community engagement by making healthcare systems more responsive to people's needs and by putting patients and their families at the centre of healthcare systems.

Evaluation of initiatives related to the potential use of the mHealth are quite rare. Some examples of what this report's compliers found in the literature follow.

3.2.1. mHealth & cost-effectiveness

 A cost-effectiveness study of mHealth intervention by community health workers for reducing maternal and newborn mortality in a rural area of India strongly suggests that the mHealth intervention has proven to be very effective from the viewpoint of the Indian health system, and cost saving too from a societal perspective.[144]

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143   World Healh organization. mHealth : Use of appropriate digital technologies for public health. 2018.

144   Prinja S, Bahuguna P, Gupta A, Nimesh R, Gupta M, Thakur JS. Cost effectiveness of mHealth intervention by community health workers for reducing maternal and newborn mortality in rural Uttar Pradesh, India. Cost Effectiveness and Resource Allocation. 2018;16(1):25.

3.2.2. mHealh & human resources

A review of the few documented mHealth projects in India indicates that they make proficient use of human resources in overcoming gaps in qualified personnel in primary health care delivery systems. These projects suggest that efficient utilization of mHealth can offer solutions to emerging human resource challenges while simultaneously revamping healthcare delivery in resource-limited settings.[145] Elsewhere, an American systematic review of mHealth utilization highlighted the substantial benefits to healthcare workers when using mobile technology tools such as smartphones and tablets.[146] These technology devices are proving to be more and more acceptable and increasingly used in the context of care delivery. The evidence shows that the use of mHealth tools can improve communication between health workers and their patients, health workers and clinic staff, as well as between health workers and their supervisors. Moreover, mHealth learning as a component of training for health care professionals has resulted in improved compliance with treatment protocols among patients and, consequently, improved health outcomes.[147]

3.2.3. mHealth in humanitarian crises

3.2.3.1. UNRWA mHealth application

In 2017, UNRWA developed an mHealth programme for maternal and child health (MCH) drawing on the experience of a WHO/ITU initiative. A digitalized version of the Mother and Child Health Handbook that had been distributed to all Palestinian refugee mothers attending UNRWA health centres since 2008 was created.[148] The application has a built-in notification system to alert mothers about issues like their appointments. The app can work offline and updates the data displayed as soon as it is connected to the internet.[149] It includes health education content that mothers and expectant mothers can consult and reference as well as push notifications which can be forwarded based on pregnancy stage and/or the age of a mother's children. This mobile application has established its credentials as an essential, cost-effective, patient-centred, healthcare improvement asset that additionally provides assured equitable and sustainable healthcare services via ICT health applications.[150]

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145   Goel S, Bhatnagar N, Sharma D, Singh A. Bridging the Human Resource Gap in Primary Health Care Delivery Systems of Developing Countries With mHealth: Narrative Literature Review. JMIR Mhealth Uhealth. 2013;1(2):e25.

146   White A, Thomas DS, Ezeanochie N, Bull S. Health Worker mHealth Utilization: A Systematic Review. Computers, informatics, nursing : CIN. 2016;34(5):206-13.

147   Ibid.

148   Ballout G, Al-Shorbaji N, Abu-Kishk N, Turki Y, Zeidan W, Seita A. UNRWA's innovative e-Health for 5 million Palestine refugees in the Near East. BMJ Innovations. 2018;4(3):128-34.

149   Ibid.

150   Ibid.

3.2.3.2. eSahha project (Lebanon)

The eSahha project is a two-pronged mHealth interventional project targeting catchment areas of primary healthcare centres (PHCCs) located in Lebanese rural areas and Palestinian refugee camps, where access to health knowledge and health services is known to be limited.[151]

The overall eSahha intervention consisted of two related components, one community-based, the other PHC centre-based. The former included screening by trained community health personnel of the over-40 age group deemed more vulnerable to non-communicable diseases (NCDs). Screenings for hypertension (HTN) and diabetes were carried out in the catchment areas of eight intervention centres. The PHC component included training intervention PHC healthcare providers (physicians and nurses) in the use of eHealth tools. This included online modules offering clinical guidelines for treating diabetes and HTN; others offering provider-patient communication strategies to increase compliance; plus online forums and frequently asked questions dedicated to promoting peer-to-peer knowledge-sharing of treatment and communication techniques.[152] Significant improvements recorded in clinical measurements of NCD-related quality indicators QIs among diabetic and hypertensive patients in Lebanese rural areas and in the Palestinian refugee camps showed how deploying SMS capacity can make a difference in care and treatment of NCDs. The biggest impact registered was in improved blood pressure (BP) control, mean SBP, HbA1c poor control, and mean HbA1c among patients who for a one-year period received weekly SMS healthcare updates.[153]

3.3. Other innovations to facilitate access to healthcare services

3.3.1. Technological innovations

3.3.1.1. Drone

Using embedded software-controlled flight plans linked with onboard sensors and GPS, drones, once exclusively military assets, are now widely deployed for multiple purposes. Humanitarian aid organizations like UNHCR have incorporated the use of drones into their relief activities in some areas of conflict. Countries like Niger, Burkina Faso and Uganda increasingly rely on drones to help map huge populations of displaced people in their attempts to assess needs and figure out how best to get assistance to the uprooted and displaced. In addition, drones are now being used to

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151   Saleh S, Farah A, Dimassi H, El Arnaout N, Constantin J, Osman M, et al. Using Mobile Health to Enhance Outcomes of Noncommunicable Diseases Care in Rural Settings and Refugee Camps: Randomized Controlled Trial. JMIR mHealth and uHealth. 2018;6(7):e137-e.

152   Ibid.

153   Ibid.

evaluate environmental damage caused by displacement.[154] The Rwandan government deploys drones to cope with the challenges of the country's complicated terrain and an inadequate transport infrastructure, which hamper delivery of medicines and blood to hospitals. Drone deliveries help reduce deaths from AIDS, tuberculosis and malaria.[155] In Ethiopia, authorities use drones to release sterilized tsetse flies in breeding areas, the aim being to decimate tsetse fly reproduction rates as a means of combating sleeping sickness, the devastating disease transmitted by the insect.[156]

3.3.1.2. Iris scan system

UNHCR has partnered with the Cairo Amman Bank to pilot an iris scanning technology that would enable Syrian refugees in Jordan to access cash assistance more easily and safely via ATMs. Refugees no longer have to go to a UNHCR office and line up to receive their cash benefit assistance. The initiative has potential to improve the ability of refugees to pay for health—related services.

3.3.2. Redesign of organizational models

WHO is leading a global initiative in innovation for refugee health care improvement. The aim is to help overcome the many challenges refugees face in finding effective, tailored healthcare and to prompt current market leaders to re-evaluate their approaches to facilitate this. Systematically bringing together investment and expertise to re-verse-engineer products from "high-tech" to "low-cost" should be considered a matter of humanitarian urgency. Doing so demands breaking away from traditional business models that focus primarily on manufacturing unaffordable high end products.

3.3.3. Innovative services

3.3.3.1. Mama taxi (Kenya)

UNHCR has sponsored "mama taxis" in Kenya's Dadaab refugee camp, where some 35,269 refugees and asylum seekers are currently registered. These community-run cabs cater to women in need of a secure ride to healthcare facilities. UNHCR also offers delivery kits as part of its Minimum Initial Service Packages. The kits are provided to pregnant women and healthcare assistants in refugee camps to help ensure compliance with sterile procedures.[157]

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154 UNHCR. UNHCR uses drones to help displaced populations in Africa 2016 [12/05/2019]. Available from: https://www.unhcr.org/news/latest/2016/11/582dc6d24/unhcr-uses-drones-help-displaced-populations-africa.html.

155 Open Mind. The "Humanitarian" Drones Arrive 2017 [cited 12/05/2019]. Available from: https://www.bbvaopenmind.com/en/technology/future/the-humanitarian-drones-arrive/.

156 Ibid.

157 The Centre of Global Reproductive Health at Duke. Innovative Ways for Women in Refugee Camps to Find Maternal Health Care 2018 [08/05/2019]. Available from: http://dukecenterforglobalreproductivehealth.org/2018/08/24/innovative-ways-for-women-in-refugee-camps-to-find-maternal-health-care/.

3.3.3.2. Clinics on wheels

UNFPA has led the development of mobile "clinics on wheels", staffed and equipped to meet the needs of women unable to leave camp or undertake lengthy journeys to medical facilities distantly located. The mobile clinic is now a feature in many countries, including Mauritania (for Malian refugees), Myanmar, Rwanda (for refugees from Burundi) and Yemen.[158]

4. Innovations for cultural and linguistic integration and social support

Migration can be a complex and stressful process, involving as it does leaving a home country and adapting to a different environment, culture and life situation. Refugees and migrants are exposed to a series of traumas from the moment they first set out on their uncertain way, including the precarious ordeal they must negotiate while in transit and, following their arrival, the adjustments and struggle they must face in order to fully integrate into the social context of host countries.

Linguistic needs are many and varied. They include documenting the language and literacy level of all patients, the provision of interpreters to ensure communication in the preferred language, extended appointment times to allow for interpretation and explanation, and simplified labels on prescriptions for easier understanding. Improved communication also helps counter xenophobia by dispelling fears and misperceptions among refugee, migrant and host populations about the health impacts of migration and displacement. Technological or organizational innovations, such as those that follow, aim to overcome the linguistic and cultural isolation of migrants and to make it easier for them to access health services. Technological innovations are also intended to give migrants a voice, to encourage exchanges between them and to assure them of psycho-social support in relation to their history and their lives.

Innovations designed to fight against stigma by raising public awareness in general focus on both conventional media and the increasingly important social media networks. Below are examples of innovations for cultural and linguistic integration and social support.

4.1. Portal zanzu.de (Germany)[159]

In Germany, the online Portal zanzu.de provides simple explanations in 13 different languages about sexual and reproductive health and rights, including the human body, pregnancy and birth, contraception, HIV/AIDS and other sexually transmitted

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158   UNFPA. Adolescent girls in disaster & conflict : Interventions for improving access to sexual and reproductive health services 2016.

159   Zanzu Portal [10/05/2019]. Available from: https://www.zanzu.de/de/.

infections as well as sexuality and relationships. Importantly, detailed information is available on respective rights and laws in Germany, as well as existing support and counselling services. The website also utilizes illustrations and integrated text-to-speech functions and special icons to make it more user-friendly for immigrants recently arrived in Germany who may lack adequate language skills to obtain quality information on issues of sexual and reproductive health. Based on a human rights approach, the online portal provides comprehensive information enabling people to live self-determined lives and make informed and responsible decisions. It is also accessible to practitioners and intermediaries such as physicians and counsellors who advise or treat adult immigrants professionally.

4.2. Refugees are[160]

Refugees Are is a platform to analyze news about refugees and refugee issues around the world. It classifies news as "negative" or "positive" in order to raise user awareness about the kind of language used by journalists and politicians when describing refugees and migrants. The aim is to alert refugees and others about how media coverage can inflame bias and anti-refugee xenophobia making it more difficult for people on the move to integrate and start their lives anew.

5. Specific Innovations addressing GBV

GBV in humanitarian settings is a life-threatening issue. It undermines dignity, causes immense pain, and is a threat to equality and development around the globe. There is growing recognition that affected populations can experience various forms of GBV during conflict and natural disasters, during displacement, and during and following return. Existing support structures and prevention mechanisms are often compromised, while the risk of abuse and violence of all kinds increases, in particular for women and girls. Yet the issue of GBV in emergencies remains overlooked too often at times of crisis and needs to be given due consideration in the context of humanitarian needs. This accounts for why it is necessary to seek new and innovative ways to meet GBV survivors' needs by setting out specific goals and tasks to improve GBV programming response in emergencies.

Some initiatives have emerged in recent years that aim to improve the research and evidence base for innovation and determine how it might benefit humanitarian performance in dealing with GBV.

Elrha, launched in 2009, set out to bridge the gap between academics and humanitarians. Originally an offshoot of Save the Children UK, Elrha evolved into an independent charity. Elrha's Humanitarian Innovation Fund (HIF) was set up in 2011

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160   Refugee Are [10/05/2019]. Available from: http://refugeesare.info/.

with the support of the UK Department for International Development (DFID), the Netherlands Ministry of Foreign Affairs and the Swedish International Development Cooperation Agency (Sida). Research conducted by HIF identified a number of gaps and limitations when it came to GBV programming in emergencies. Two overarching considerations were recognized as key to implementing an effective GBV programme in an emergency. In addition, four goal-driven, discrete, and significant challenges were pinpointed. Each Challenge Area has been broken down into actionable innovation challenges as follows:[161]

Table (3): Overview of the Four Challenge Areas and their Innovation Challenges

Challenge area	Innovation challenges
1. Improving monitoring and evaluation	1.1 Measure the impact of GBV programmes (operational challenge): Evaluate the impact and quality of existing or new GBV programmes by developing and implementing different assessment processes and tools, and identifying and monitoring relevant metrics.
	1.2 Develop real-time monitoring tools (operational challenge): Develop tools that easily integrate into the humanitarian system and enable the real-time collection of GBV data during an emergency. The data collected should be reliable and support GBV decision-making and the design of GBV programmes.
2. Increasing the availability and quality of GBV expertise	2.1 Create context-specific, skills-building opportunities for GBV in emergencies specialists (operational challenge): Build on existing initiatives to develop competent, relevant, context-specific GBV skills-building opportunities that lead to a locally-available pool of trained GBV in emergencies specialists.
	2.2 Develop a transparent and tailored recruitment process for GBV practitioners (systemic challenge): Ensure that vacancies for GBV specialists are publicly and widely circulated as part of a transparent recruitment process so that competent GBV experts with a strong understanding of the local culture and context can fill available opportunities.
	2.3 Reduce turnover of GBV practitioners (systemic challenge): Reduce turnover of GBV practitioners by improving the applicable work requirements including the conditions, schedule, and environment in which they are expected to perform.
3. Improving GBV coordination and prioritization	3.1 Enhance coordination among GBV practitioners (operational challenge): Design knowledge-sharing opportunities that connect GBV practitioners from across the world according to concrete needs, and result in new collaborations and cross-fertilizations.

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161   Elrha's Humanitarian Innovation Fund. Gender-based violence interventions: Opportunities for innovation. 2016.

Challenge area	Innovation challenges
	3.2 Strengthen advocacy skills of local GBV actors (operational challenge): Help key actors within the GBV sector, such as practitioners and local women's groups, to accurately identify local GBV priorities and effectively communicate them to relevant decision-makers.
	3.3 Encourage collaboration between humanitarian and development actors (systemic challenge): Develop opportunities for humanitarian and development actors to work together towards developing a more integrated and sustainable approach to offering GBV services in an emergency.
	3.4 Ensure a more stable flow of donor funding (systemic challenge): Help ensure a more stable flow of funding for effective GBV programming during emergencies by sensitizing donors about the link between humanitarian and development funding
4. Adapting standards for practical use in a variety of contexts	4.1 Develop context-specific roadmaps to help practitioners meet GBV minimum standards (operational challenge): Building on existing work around GBV minimum standards; working together with local communities to develop and disseminate context-specific, user-friendly, accessible materials to help practitioners meet GBV minimum standards in emergencies.

6. Research, data collection and monitoring of migrant health and services

The knowledge base about refugee and asylum seeker health issues should be strengthened by developing information and monitoring systems to promote comparative work across subsections of migrant and non-migrant populations; data-sharing should be coordinated among governmental and non-governmental agencies; the health effects of different phases of the asylum process should be studied and identified; initiatives should be assessed and rated for their long-term health impact.[162] Thanks to digitalization, it is now possible to process information to include personalized monitoring of individual migrants as well as aggregation and analysis. data so as to provide a broader and more responsive understanding of migrant needs and the challenges of delivering health services to them.[163]

In the field of research, many remote technologies such as satellite imagery, social media, and radio frequency identification (RFID) do not require a strong on-the-ground presence for data collection. Geospatial information systems (GIS) can help manage and collate field data to identify needs, detect emerging trends, and help with efficient resource allocation. Social media, SMS text messaging, and mobile

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162 TechChange. Refugee health: The potential of mobile health technology 2010 [11/05/2019]. Available from: https://www.techchange.org/2010/11/01/refugee-health-the-potential-of-mobile-health-technology/.

163 World Bank. Measuring and Monitoring in FCV Environments: Using New Methods and Technologies 2015. Available from: https://fcvindicators.worldbank.org/content/pilot-toolkit-measuring-and-monitoring-fcv-environments.

apps can identify user needs when and where traditional surveys are not feasible.[164] However, data security and citizen privacy are areas that require legal and policy attention to ensure that user data are properly protected.[165] Cooperation between the different enterprises engaged in this technological field is a must if a best practices framework is to be developed that can ensure data will move more effectively between systems and applications.[166] Examples of innovations in data collection and monitoring of migrant health and services include:

6.1. Iryo (Jordan)[167]

Iryo enables accurate medical history recording thanks to its decentralized data storage feature. This allows one copy to be kept on a local server, a second on the patient's mobile phone and a third in Iryo cloud. Thus, when a patient arrives at a new refugee camp that is equipped with the Iryo system, doctors and/or health care workers will be able to access newcomer records. Previously, medical workers in camps used Excel spreadsheets to record their patient notes, a process further complicated by inconsistent record keeping arising from the high turnover of medical workforce personnel.

6.2. Creating health monitoring and health information systems for refugees and migrants (Finland)168

In Finland, current guidelines for the voluntary initial health assessment for asylum seekers focus on screening for infectious diseases. There is, however, an increasing awareness of non-communicable diseases, in particular issues to do with mental health. The National Institute for Health and Welfare launched the TERTTU project (Developing the Health Examination Protocol for Asylum Seekers in Finland: a National Development Project 2017–2019) in collaboration with the Finnish Immigration Service to improve the current national health examination protocol for asylum seekers. The project aims at an evidence-based upgrade of the existing national health examination system towards a standardized protocol for use in migrant reception. It also aims at improving health monitoring for asylum seekers in Finland through systematic data collection on the health and service needs of newly arrived adults and children. This will result in an improved health record system and increased knowledge and understanding of the relevant health concerns and needs of asylum seekers at local, regional and national levels.

164   Church C. Technology for Evaluation in Fragile and Conflict Affected States2016.

165   Mesmar S, Talhouk R, Akik C, Olivier P, Elhajj IH, Elbassuoni S, et al. The impact of digital technology on the health of populations affected by humanitarian crises: Recent innovations and current gaps. Journal of public health policy. 2016;37(Suppl 2):167-200.

166   Humanitarian Practice Network. Innovating for access: the role of technology in monitoring aid in highly insecure environments 2016 [cited 11/05/2019]. Available from: https://odihpn.org/magazine/innovating-for-access-the-role-of-technology-in-monitoring-aid-in-highly-insecure-environments/.

167   Iryo [10/05/2019]. Available from: https://iryo.io/#about.

168   Tiittala P, Tuomisto K, Puumalainen T, Lyytikäinen O, Ollgren J, Snellman O, et al. Public health response to large influx of asylum seekers: implementation and timing of infectious disease screening. BMC Public Health. 2018;18(1):1139.

CONCLUSION AND RECOMMENDATIONS

Innovations in support of migrants can be divided into three categories: technological, organizational and service-oriented. The trend is marked by the proliferation of technological initiatives to meet the health needs of migrants.

Another trend concerns the actors involved in these initiatives, all of whom come from markedly different backgrounds and yet have managed breakthroughs thanks to digital solutions that help migrants. The rise of internet activism around issues of social justice, human rights, education, health equity, and sustainable environments is likely to continue to raise awareness, and pave the way for social change and health promotion for affected populations[169].

The findings highlight the fact that digital technologies facilitate communication, coordination, and the collection and analysis of large amounts of data, enabling timely responses in migratory contexts, particularly those involving sudden-onset disasters. These technologies most often impact through their ability to provide access to information; to explore health needs and facilitate access to health services and assistance; to maintain health records; and to enable follow-up, continuity, and improved quality of care by adopting a global, bio-psycho-social approach that is people-centred. Beyond the development of relevant technological solutions that meet the needs of migrant populations, it is essential to have the prerequisites in place – e.g. infrastructure and equipment plus the connectivity of populations and their digital literacy. These elements are mandatory for efficient and adaptable use of these solutions[170].

The World Bank has identified the following risks and limitations that should be considered with these technologies[171]:

- **_Bias_**: Technologies can make data collection faster and easier, but they can also introduce bias. Where cellphone ownership is concentrated in certain areas or among certain demographic groups, SMS-based surveys will disproportionately capture those groups and may not be appropriately representative of populations in need.

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169   Mihailidis P, Racin L, Gordon E. Digital Crossroads: Civic Media and Migration. ifa Edition Culture and Foreign Policy. 2016.

170   Leurs K, Smets K. Five Questions for Digital Migration Studies: Learning From Digital Connectivity and Forced Migration In(to) Europe. Social Media + Society. 2018;4(1):2056305118764425.

171   Garber K, Carrette S. Using Technology in Fragile, Conflict, and Violence (FCV) Situations. World Bank Group, 2018.

- **_Verification_**: Data collected using remote technologies often needs to be verified through other modalities to ensure accuracy and reliability. This process often involves some degree of "triangulation" involving other sources.

- **_Safety_**: While remote technologies can make data collection safer, some technologies may expose in-country teams to elevated risks. Since tablets can be resold at considerable profit, for example, survey teams using them can become targets for theft or attack. Armed groups have also been documented as harassing enumerators using tablet-based technology.

- **_Privacy_**: For technologies relying upon GPS data (cellphones, sensors, etc.) to track locations or population movement, care should be taken to ensure that all data is de-personalized and that any personal information collected is with consent. Authorities in many Arab spring countries have used social media posts to identify and target outspoken critics.

- **_Perception_**: Depending upon the context, the use of certain technologies, such as satellite imagery or GPS tracking, can be perceived as "spying" by populations or authorities, which makes it vital that these modalities be fully explained to local partners in advance to ensure local acceptance.

- **_Sustainability_**: Studies of mobile health pilot interventions have shown that many are often either discontinued or lack feasible plans for scale-up. This applies especially to service delivery projects that may incorporate technological solutions. For this reason, TTLs should consider barriers to scale-up and sustainability.

- **_Cost_**: Cost of technology deployment can vary widely. The cost of satellite imagery, for example, depends on the size of the land area or resolution to be analyzed. Many mobile platforms are free, but programmers and surveyors are not.

Very few evaluations exist of other uses of digital technologies in humanitarian and migratory contexts. Most review purpose and lessons learned, and come with no other evaluative framework. Specified criteria for assessment were often described, but the compilers of this report found neither methodologies nor evaluation reports for many of the technologies assessed.

The review of web-based technologies for health promotion suggests that, given the complex settings in which health technologies are deployed and disseminated, evaluations of health outcomes and impacts may be very difficult.

The outcome of this thematic review suggests the following:

- The challenge of connectivity is a prerequisite for the use of information technology to meet the needs of "people on the move". Access to connectivity must

be promoted for migrants for whom this issue is vital. Connectivity for migrant populations is an important lever for reducing their social capital deficit;

- Digital literacy is an important issue to consider, especially if women are to fully benefit from the information and guidance opportunities offered by these innovations;

- The deployed innovations are often developed without adequately consulting potential beneficiaries, which can hinder their acceptability and general use when first introduced;

- Every effort should be made to ensure that technological or non-technological innovations are seen as complementary rather than as alternatives to traditional services; that they are intended for "people on the move", taking full account of the need to limit inequalities based on gender;

- It is necessary to have a broad consensus among all parties involved in the application and deployment of these technologically innovative solutions including health professionals, state institutions, NGOs and those developing the solutions. At all stages, it is important to ensure that "people on the move", the intended beneficiaries, are involved and consulted to ensure the sustainability of the solutions and that they match potential user needs and enhance their ability to adapt to future challenges;

- The field of digital solutions is currently experiencing a proliferation of new products without benefit of evaluation either before or after implementation. There is a pressing need for a framework identifying a mutually agreed process for the production of these solutions, one that above all respects issues of quality, efficiency, confidentiality, and ethics, while recognizing the importance of beneficiary participation and respecting host country regulations.

It seems relevant that international development stakeholders take a constructive approach to the development and adoption of innovations. The best innovations are often those inspired by experience and feedback. Organizations need to be both resilient and flexible enough to incorporate opportunities arising from the spate of new technological breakthroughs and to adapt them to fit the everyday life situations they find themselves dealing with.

Clearly rapid development of technological devices offer better access to information in general and health services in particular, especially for migrants, displaced, relocated or on the move. In this regard, internet access and the connectivity it offers migrants with their families or their network is as vital as access to food and shelter.

For development actors, the question is how they can best and most effectively harness the array of new information technologies and innovations in support of its activities on behalf of the vulnerable, the traumatized and the marginalized it aims to serve.

Stakeholders' activities in such areas as Sexual and Reproductive Health, Family Planning, HIV/AIDS, Maternal Health, and Youth are all likely to benefit from either the introduction of a technological component or a technology upgrade. In this sense, institutional innovation through technological means becomes part and parcel of an ongoing evolutionary process.

Some essential prerequisites that actors in the field should consider before embarking on the development of a technological solution:

- Connectivity is key for migrants in general and must be promoted as such. Where migrant populations are concerned, it is an important lever for reducing their social capital deficit;

- Digital literacy is another key. Most innovations require digital technology. Use of digital technology should be gender-oriented and take into account the specific obstacles confronting targeted populations, especially those facing women and youth in using digital tools.

- Partnership also has a vital role to play. Partnerships should be developed with relevant UN agencies such as UNFPA, UNHCR, IOM and WHO plus NGOs and civil society groups dealing with migrant and refugee issues, keeping in mind the importance of integrating public sector bodies such as universities or ministries with private sector ventures such as those involving young entrepreneurs active in the information technologies field.

- Developed solutions should be in synergy with available services and help open the way to new services specific to "people on the move". Health professionals should be involved in their development and schooled in their use.

- The development community should take into account the rapidly evolving world of information technology. The ever-evolving nature of emerging solutions (changing, adaptive, even volatile at times), presents a major challenge when it comes to ensuring sustainability and resilience. This makes it all the more important to come up with a framework identifying a mutually agreed process for the production of solutions. It should above all respect issues of quality, efficiency, confidentiality, and ethics. It should also recognise the importance of beneficiary participation and it should respect and comply with host country regulations.

REFERENCES

1. Aid & International Development Forum. Solutions That Are Saving Lives in Humanitarian Response 2015 [14/05/2019]. Available from: http://www.aidforum.org/disaster-relief/top-solutions-that-are-saving-lives-inhumanitarian-response.

2. Alnuaimi K, Kassab M, Ali R, Mohammad K, Shattnawi K. Pregnancy outcomes among Syrian refugee and Jordanian women: a comparative study. International nursing review. 2017;64(4):584-92.

3. Al-Rousan T, Schwabkey Z, Jirmanus L, Nelson BD. Health needs and priorities of Syrian refugees in camps and urban settings in Jordan: perspectives of refugees and health care providers. Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit. 2018;24(3):243-53.

4. Ammar W, Kdouh O, Hammoud R, Hamadeh R, Harb H, Ammar Z, et al. Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health. 2016;6(2):020704-.

5. Anadon LD, Chan G, Harley AG, Matus K, Moon S, Murthy SL, et al. Making technological innovation work for sustainable development. Proc Natl Acad Sci U S A. 2016;113(35):9682-90.

6. Ay M, Arcos González P, Castro Delgado R. The Perceived Barriers of Access to Health Care Among a Group of Non-camp Syrian Refugees in Jordan. International Journal of Health Services. 2016;46(3):566-89.

7. Ballout G, Al-Shorbaji N, Abu-Kishk N, Turki Y, Zeidan W, Seita A. UNRWA's innovative e-Health for 5 million Palestine refugees in the Near East. BMJ Innovations. 2018;4(3):128-34.

8. Bardaweel SK, Akour AA, A AL. Impediments to use of oral contraceptives among refugee women in camps, Jordan. Women & health. 2019;59(3):252-65.

9. Blogs WB. How many years do refugees stay in exile? 2016. Available from: https://blogs.worldbank.org/dev4peace/how-many-years-do-refugees-stay-exile.

10. Buvik A, Bergmo TS, Bugge E, Smaabrekke A, Wilsgaard T, Olsen JA. Cost-Effectiveness of Telemedicine in Remote Orthopedic Consultations: Randomized Controlled Trial. J Med Internet Res. 2019;21(2):e11330.

11. Cetorelli V, Burnham G, Shabila N. Health needs and care seeking behaviours of Yazidis and other minority groups displaced by ISIS into the Kurdistan Region of Iraq. PloS one. 2017;12(8):e0181028.

12. Cherri Z, Gil Cuesta J, Rodriguez-Llanes JM, Guha-Sapir D. Early Marriage and Barriers to Contraception among Syrian Refugee Women in Lebanon: A Qualitative Study. International journal of environmental research and public health. 2017;14(8).

13. Church C. Technology for Evaluation in Fragile and Conflict Affected States2016.

14. Cignacco E, Zu Sayn-Wittgenstein F, Senac C, Hurni A, Wyssmuller D, Grand-Guillaume-Perrenoud JA, et al. Sexual and reproductive healthcare for women asylum seekers in Switzerland: a multi-method evaluation. BMC health services research. 2018;18(1):712.

15. De Vito E, De Waure C, Specchia ML, Ricciardi W. Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region. 2015.

16. Dekker R, Engbersen G, Klaver J, Vonk H. Smart Refugees: How Syrian Asylum Migrants Use Social Media Information in Migration Decision-Making. Social Media + Society. 2018;4(1):2056305118764439.

17. Elmagboul N, Dauod S, Tawaldi S. Exploitation and violence against Ethiopian female irregular migrant domestic workers in Khartoum State. Ahfad Journal. 2017;34(2).

18. Elrha's Humanitarian Innovation Fund. Gender-based violence interventions: Opportunities for innovation. 2016.

19. European Union Agency for Fundamental Rights. Migrants in an irregular situation: access to healthcare in 10 European Union Member States. 2011.

20. Garber K, Carrette S. Using Technology in Fragile, Conflict, and Violence (FCV) Situations. World Bank Group, 2018.

21. Goel S, Bhatnagar N, Sharma D, Singh A. Bridging the Human Resource Gap in Primary Health Care Delivery Systems of Developing Countries With mHealth: Narrative Literature Review. JMIR Mhealth Uhealth. 2013;1(2):e25.

22. Heaman M, Bayrampour H, Kingston D, Blondel B, Gissler M, Roth C, et al. Migrant women's utilization of prenatal care: a systematic review. Maternal and child health journal. 2013;17(5):816-36.

23. HIV integrated behavioral and biological surveillance surveys-. In: diseases DoEafa, editor. 2013.

24. Humanitarian Practice Network. Innovating for access: the role of technology in monitoring aid in highly insecure environments 2016 [cited 11/05/2019]. Available from: https://odihpn.org/magazine/innovating-for-access-the-role-of-technology-in-monitoring-aid-in-highly-insecure-environments/.

25. IASC. Guidelines for integrating gender-based violence interventions in humanitarian action. 2015.

26. International Medical Corps. Understanding the mental health and psychosocial needs, and service utilization of Syrian refugees and Jordanian nationals: A qualitative & quantitative analysis in the Kingdom of Jordan. 2017.

27. IOM. Atelier national de formation des éducateurs pairs au profit des leaders des communautés de migrants et des travailleurs sociaux des associations partenaires 2016. Available from: https://morocco.iom.int/news/atelier-national-de-formation-des-%C3%A9ducateurs-pairs-au-profit-des-leaders-des-communaut%C3%A9s-de.

28. IOM. Formation des professionnels de santé des établissements de soins de santé primaire de la région de Casablanca-Settat 2018. Available from: https://morocco.iom.int/news/casablanca-formation-des-professionnels-de-sant%C3%A9-des-%C3%A9tablissements-de-soins-de-sant%C3%A9-primaire.

29. IOM. More Help for Vulnerable Migrants as IOM Opens Sudan's Second Migrant Resource Centre 2019 [22/04/2019]. Available from: https://sudan.iom.int/news/press-releases/more-help-vulnerable-migrants-iom-opens-sudan%E2%80%99s-second-migrant-resource-centre.

30. IOM. What is Mixed Migration? [30/12/19]. Available from: https://www.iom.int/files/live/sites/iom/files/Country/docs/Mixed-Migration-HOA.pdf.

31. IOM. Who is a migrant? [24/12/2019]. Available from: https://www.iom.int/who-is-a-migrant.

32. IOM. World Migration Report 2020. 2019.

33. Iryo [10/05/2019]. Available from: https://iryo.io/#about.

34. Ismail SA, Coutts AP, Rayes D, Roborgh S, Abbara A, Orcutt M, et al. Refugees, healthcare and crises: informal Syrian health workers in Lebanon. International Institute for Environment and Development, 2018.

35. Ivanova O, Rai M, Kemigisha E. A Systematic Review of Sexual and Reproductive Health Knowledge, Experiences and Access to Services among Refugee, Migrant and Displaced Girls and Young Women in Africa. International journal of environmental research and public health. 2018;15(8).

36. Kanjee R, Dookeran RI, Mathen MK, Stockl FA, Leicht R. Six-year prevalence and incidence of diabetic retinopathy and cost-effectiveness of tele-ophthalmology in Manitoba. Canadian journal of ophthalmology Journal canadien d'ophtalmologie. 2017;52 Suppl 1:S15-s8.

37. Keeshin BR, Cronholm PF, Strawn JR. Physiologic changes associated with violence and abuse exposure: an examination of related medical conditions. Trauma, violence & abuse. 2012;13(1):41-56.

38. Kergoat Y. The Egyptian Health System's Response to Refugees and Migrants in Post-Revolutionary Egypt: Free University of Amsterdam; 2013.

39. Keygnaert I, Dialmy A, Manço A, Keygnaert J, Vettenburg N, Roelens K, et al. Sexual violence and sub-Saharan migrants in Morocco: a community-based participatory assessment using respondent driven sampling. Globalization and Health. 2014;10(1):32.

40. Krause S, Williams H, Onyango MA, Sami S, Doedens W, Giga N, et al. Reproductive health services for Syrian refugees in Zaatri Camp and Irbid City, Hashemite Kingdom of Jordan: an evaluation of the Minimum Initial Services Package. Conflict and health. 2015;9(1):S4.

41. Kreps GL, Sparks L. Meeting the health literacy needs of immigrant populations. Patient education and counseling. 2008;71(3):328-32.

42. Le Goff-Pronost M, Mourgeon B, Blanchere JP, Teot L, Benateau H, Dompmartin A. Real-world clinical evaluation and costs of telemedicine for chronic wound management. International journal of technology assessment in health care. 2018;34(6):567-75.

43. Leurs K, Smets K. Five Questions for Digital Migration Studies: Learning From Digital Connectivity and Forced Migration In(to) Europe. Social Media + Society. 2018;4(1):2056305118764425.

44. Mater UQ Centre for Primary Health Care Innovation. The 'Healthy Start Program' Evaluation Report. 2016.

45. Mesmar S, Talhouk R, Akik C, Olivier P, Elhajj IH, Elbassuoni S, et al. The impact of digital technology on health of populations affected by humanitarian crises: Recent innovations and current gaps. Journal of public health policy. 2016;37(Suppl 2):167-200.

46. Metusela C, Ussher J, Perz J, Hawkey A, Morrow M, Narchal R, et al. "In My Culture, We Don't Know Anything About That": Sexual and Reproductive Health of Migrant and Refugee Women. International journal of behavioral medicine. 2017;24(6):836-45.

47. Migration MH. Country Brief Sudan 2018 [22/04/2018]. Available from: http://www.mixedmigrationhub.org/wp-content/uploads/2018/05/Country-Profile-Sudan.pdf.

48. Mihailidis P, Racin L, Gordon E. Digital Crossroads: Civic Media and Migrati on. ifa Edition Culture and Foreign Policy. 2016.

49. Mohajer App Developer. Mohajer [https://play.google.com/store/apps/details?id=com.mohajerapp.mobile].

50. Mourtada R, Schlecht J, DeJong J. A qualitative study exploring child marriage practices among Syrian conflict-affected populations in Lebanon. Conflict and health. 2017;11(Suppl 1):27.

51. Obrecht A, T Warner A. More than just luck: Innovation in humanitarian action. Humanitarian Innovation Fund/ALNAP Study, 2016.

52. Open Mind. The "Humanitarian" Drones Arrive 2017 [cited 12/05/2019]. Available from: https://www.bbvaopenmind.com/en/technology/future/the-humanitarian-drones-arrive/.

53. Otto K. Information and communication technologies for health systems strengthening: opportunities, criteria for success, and innovation for Africa and beyond2015.

54. Prinja S, Bahuguna P, Gupta A, Nimesh R, Gupta M, Thakur JS. Cost effectiveness of mHealth intervention by community health workers for reducing maternal and newborn mortality in rural Uttar Pradesh, India. Cost Effectiveness and Resource Allocation. 2018;16(1):25.

55. Reese Masterson A, Usta J, Gupta J, Ettinger AS. Assessment of reproductive health and violence against women among displaced Syrians in Lebanon. BMC Women's Health. 2014;14(1):25.

56. Refugee Are [10/05/2019]. Available from: http://refugeesare.info/.

57. Refugee Health Network Queensland. Innovative Projects [08/05/2019]. Available from: http://www.refugeehealthnetworkqld.org.au/innovative-projects/.

58. Refugees UHCf. Urban refugee protection in Cairo: the role of communication, information and technology. 2012.

59. Rudd RE. The evolving concept of Health literacy: New directions for health literacy studies. Journal of Communication in Healthcare. 2015;8(1):7-9.

60. Saleh S, Farah A, Dimassi H, El Arnaout N, Constantin J, Osman M, et al. Using Mobile Health to Enhance Outcomes of Noncommunicable Diseases Care in Rural Settings and Refugee Camps: Randomized Controlled Trial. JMIR mHealth and uHealth. 2018;6(7):e137-e.

61. Samari G. Syrian Refugee Women's Health in Lebanon, Turkey, and Jordan and Recommendations for Improved Practice. World medical & health policy. 2017;9(2):255-74.

62. SciDev.net. "Techfugees" : La technologie au service des réfugiés 2017 [22/04/2019]. Available from: https://www.scidev.net/afrique-sub-saharienne/technologie/article-de-fond/techfugees-technologie-refugies.html.

63. Scott Kruse C, Karem P, Shifflett K, Vegi L, Ravi K, Brooks M. Evaluating barriers to adopting telemedicine worldwide: A systematic review. Journal of telemedicine and telecare. 2018;24(1):4-12.

64. Scott RE, Mars M. Telehealth in the developing world: current status and future prospects. Smart Homecare Technology and TeleHealth. 2015;3:25-37.

65. Shifra [10/05/2019]. Available from: https://www.shifra.io/.

66. Simon P, Acker D. La place de la télémédecine dans l'organisation des soins. Ministère de la Santé et des Sports. Direction de l'Hospitalisation et de l'Organisation des Soins 2008.

67. Smith SE, Ludwig JT, Chinchilli VM, Mehta K, Stoute JA. Use of telemedicine to diagnose tinea in Kenyan schoolchildren. Telemedicine and e-Health. 2013;19(3):166-8.

68. Tappis H, Lyles E, Burton A, Jordan Health Access Study T, Lebanon Health Access Study T, Doocy S. Maternal Health Care Utilization Among Syrian Refugees in Lebanon and Jordan. Maternal and child health journal. 2017;21(9):1798-807.

69. TechChange. Refugee health : The potential of mobile health technology 2010 [11/05/2019]. Available from: https://www.techchange.org/2010/11/01/refugee-health-the-potential-of-mobile-health-technology/.

70. The Centre of Global Reproductive Health at Duke. Innovative Ways for Women in Refugee Camps to Find Maternal Health Care 2018 [08/05/2019]. Available from: http://dukecenterforglobalreproductivehealth.org/2018/08/24/innovative-ways-for-women-in-refugee-camps-to-find-maternal-health-care/.

71. The UN Refugee Agency. Forced displacement in 2016: Global trends. 2017.

72. Tiittala P, Tuomisto K, Puumalainen T, Lyytikäinen O, Ollgren J, Snellman O, et al. Public health response to large influx of asylum seekers: implementation and timing of infectious disease screening. BMC Public Health. 2018;18(1):1139.

73. Tsega AH. The Nexus between Migration and Human Security: The Case of Ethiopian Female Migration to Sudan. International Journal of Humanities and Social Sciences. 2016;10(7):2531-7.

74. Tür an Tür. Integreat [https://play.google.com/store/apps/details?id=tuerantuer.app.integreat].

75. UN Refugee Agency. UNHCR Service Guide. 2018.

76. UNFPA. A report on the GBV assessment in conflict affected governorate in Iraq. 2016.

77. UNFPA. Adolescent girls in disaster & conflict : Interventions for improving access to sexual and reproductive health services 2016.

78. UNFPA.. Youth Migrants in the Arab Region: Situation Analysis of Boys and Girls, 2018

79. UNHCR Innovation Services. Using telecommunications to improve clinical healthcare in refugee camps 2019 [08/05/2019]. Available from: https://www.unhcr.org/innovation/using-telecomms-to-improve-clinical-healthcare-in-refugee-camps/.

80. UNHCR. Connecting refugees : How internet and mobile connectivity can improve refugee well-being and transform humanitarian action. 2016.

81. UNHCR. Egypt Regional Refugee & Resilience Plan 2017-2018. 3RP, 2017.

82. UNHCR. Fact sheet Morocco 2019 [22/04/2019]. Available from: http://reporting.unhcr.org/sites/default/files/UNHCR%20Morocco%20Fact%20Sheet%20-%20February%202019.pdf.

83. UNHCR. Sexual and Gender-based Violence Prevention and Response In Refugee Situations in the Middle East and North Africa. 2015.

84. UNHCR. UNHCR uses drones to help displaced populations in Africa 2016 [12/05/2019]. Available from: https://www.unhcr.org/news/latest/2016/11/582dc6d24/unhcr-uses-drones-help-displaced-populations-africa.html.

85. van den Ameele S, Keygnaert I, Rachidi A, Roelens K, Temmerman M. The role of the healthcare sector in the prevention of sexual violence against sub-Saharan transmigrants in Morocco: a study of knowledge, attitudes and practices of healthcare workers. BMC health services research. 2013;13:77.

86. Walji M. Bringing telehealth to humanitarian settings. CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne. 2015;187(4):E123-E4.

87. Were MC, Emenyonu N, Achieng M, Shen C, Ssali J, Masaba JP, et al. Evaluating a scalable model for implementing electronic health records in resource-limited settings. Journal of the American Medical Informatics Association. 2010;17(3):237-44.

88. White A, Thomas DS, Ezeanochie N, Bull S. Health Worker mHealth Utilization: A Systematic Review. Computers, informatics, nursing : CIN. 2016;34(5):206-13.

89. WHO Eastern Mediterranean Region. Health of refugees and migrants: Practices in addressing the health needs of refugees and migrants. 2018.

90. WHO European Region. Strategy and action plan for refugee and migrant health in the WHO European Region. 2016.

91. WHO. What is a migrant? How definitions affect access to health care 2017 [22/04/2019]. Available from: http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2017/03/what-is-a-migrant-how-definitions-affect-access-to-health-care.

92. World Bank. Measuring and Monitoring in FCV Environments: Using New Methods and Technologies 2015. Available from: https://fcvindicators.worldbank.org/content/pilot-toolkit-measuring-and-monitoring-fcv-environments.

93. World Healh organization. mHealth : Use of appropriate digital technologies for public health. 2018.

94. World Healh organization. mHealth: New horizons for health through mobile technologies. 2011.

95. Youth4Peace. Inter-Agency Working Group on Youth & Peacebuilding [22/04/2019]. Available from: https://www.youth4peace.info/About_WGYPB.

96. Zanzu Portal [10/05/2019]. Available from: https://www.zanzu.de/d

ANNEX:

Summary "Analysis Framework/Matrix" of Desk Review

Axis	Dimension/ Sub-Dimension	Comments					
		Jordan	Lebanon	Iraq	Egypt	Morocco	Sudan
1. Information	Law and services	Not Treated	Not Treated	Not Treated		Not Treated	Not Treated
	Literacy of health services			Not Treated		Not Treated	Not Treated
	Literacy on SRH issues			Not Treated	Not Treated		Not Treated
2. Access to Health services	Availability of a sufficient number of human resources					Not Treated	Not Treated
	Availability of trained human resources					Not Treated	Not Treated
	Government financial resources			Not Treated		Not Treated	Not Treated
	Costs & financial support (migrants)						
	Geographic & logistic barriers			Not Treated	Not Treated	Not Treated	Not Treated
	Legislation (rights to/ for services)	Not Treated		Not Treated	Not Treated		
	Social/ psycho-social support		Not Treated				
	Access to supplies & drugs	Not Treated	Not Treated	Not Treated	Not Treated	Not Treated	Not Treated
	Cultural & religious barriers	Not Treated	Not Treated	Not Treated	Not Treated	Not Treated	Not Treated
	Linguistic barriers	Not Treated	Not Treated	Not Treated	Not Treated	Not Treated	Not Treated
3. Adequacy/ Perception of Health services	Specialized services						Not Treated
	Proper medical care & advice			Not Treated	Not Treated		Not Treated
	Communication			Not Treated		Not Treated	Not Treated
	Gender sensitivity concerns			Not Treated	Not Treated	Not Treated	Not Treated
	Stigma & judgement/ discrimination			Not Treated		Not Treated	Not Treated
	Facilities for the reception and care of GBV survivors				Not Treated		
	Prevention measures & protection against GBV						

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