Health of refugees and migrants

Regional situation analysis, practices, experiences, lessons learned and ways forward

WHO African Region

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World Health Organization
REGIONAL OFFICE FOR Africa

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ACRONYMS AND ABBREVIATIONS

4Mi	Mixed Migration Monitoring Mechanism Initiative
ACMS	African Centre for Migration & Society
ACT	Artemisinin-based combination therapy
AME	Association Malienne des Expulsées
ART	Antiretroviral Therapy
CAR	Central African Republic
CRRF	Comprehensive Refugee Response Framework
DRC	Democratic Republic of the Congo
EAC	East African Community
ECSA-HC	The East, Central and Southern Africa Health community
ECWC	Eastleigh Community Wellness Centre
EOCs	Emergency Operating Centres
HMIS	Health management information system
HPCSA	Health Professional Council of South Africa
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDP(s)	Internally Displaced Person(s)
ILO	International Labour Organization
maHp	Migration and health project
MDRTB	Multi-drug resistant tuberculosis
mhGAP	WHO Mental Health Gap Action Programme
MHPSS	Mental Health and Psychological Support
MPFA	Migration Policy Framework
PHAMESA	Partnership on Health and Mobility in East and Southern Africa
PHC	Primary Health Care
PoC	Protection of Civilians
PTSD	Posttraumatic stress disorder
ReHoPE	Refugee and Host Population Empowerment
RMMS	Regional Mixed Migration Secretariat
SADC	Southern Africa development community
SAM	Severe Acute Malnutrition
SDG(s)	Sustainable Development Goal(s)
SOPs	Standard Operating Procedures
STA	Settlement Transformative Agenda
TB	Tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNHCR	United Nations High Commission for Refugees
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
UNRWA	United Nations Relief and Works Agency
UPHI	Universal Public Health Insurance
WASH	Water Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization

WHO African region

I. INTRODUCTION

Background

To achieve the vision of the 2030 Sustainable Development Goals – to leave no one behind – it is imperative that the health needs of refugees and migrants be adequately addressed. In its 140th session in January 2017, the Executive Board requested that its Secretariat develop a framework of priorities and guiding principles to promote the health of refugees and migrants[1]. In May 2017, the World Health Assembly (WHA) endorsed resolution 70.15 on 'Promoting the health of refugees and migrants'[2]. The resolution urges Member States to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants. It urges Member States to consider providing the necessary health-related assistance through bilateral and international cooperation to those countries hosting and receiving large populations of refugees and migrants, as well as using the framework of priorities and guiding principles at all levels. In addition, the resolution requests the Director-General to conduct a situation analysis, and identify best practices, experiences and lessons learned in order to contribute to the development of a global action plan for the seventy-second WHA in 2019.

In alignment with resolution WHA70.15, from August 2017 to January 2018, WHO conducted an online call for contributions on evidence-based information, best practices, experiences and lessons learned in addressing the health needs of refugees and migrants. 18 inputs covering practices in 14 Member States in the African region were received from Member States and partners such as the United Nations High Commissioner for Refugees (UNHCR), the International Organization for Migration (IOM) and the International Labour Organization (ILO). This report includes valuable information on the current situation of refugees and migrants, health challenges associated with migration and forced displacement, past and ongoing practices and interventions in promoting the health of refugees and migrants, legal frameworks in place for addressing the health needs of this population, lessons learned, and recommendations for the future.

Scope of the report and evidence synthesis

This report has examined the contributions from WHO regional and country offices, Member States and partners in responding to a global call for contributions, as well as from evidence available on current migration trends, legal frameworks, health challenges and outcomes, policies and public health interventions and good practices to improve the health of refugees and migrants in the African region. The report will contribute to the development of a draft global action plan to promote the health of refugees and migrants to be considered at the Seventy-second WHA. The report also aims to provide information to Member States and partners in the region on current public health interventions and good practices in promoting refugee and migrant health, including access to and outcomes of care. In addition, the report's accompanying document highlights practices in the Region that include efforts to address the health needs of refugees and migrants. The information received from Member States, partners and WHO Country Offices in response to the aforementioned WHO global call for contributions was examined and compiled in the accompanying document – practices in addressing the health of refugees and migrants in the Region of Africa.

[1] EB Decision 140(9) on promoting the health of refugees and migrants

[2] WHA70.15 on promoting the health of refugees and migrants

Methodology and type of evidence

A rapid scoping review of available technical reports, peer-reviewed and grey literature in English, as well as from Member States and partners' contributions to the global call for contributions, was conducted between August 2017 and 20 January 2018.

The synthesis questions

The objective of the review was to address the following questions.

- What are the current migration and displacement trends in the African region?
- What are the relevant global and regional legal frameworks used in the region in addressing the health of refugees and migrants?
- What are the current health challenges and outcomes of refugees and migrants in the region?
- What are the current policies, interventions and practices, experiences and lessons learned within the region? The section on current public health interventions gives examples of interventions and good practices.
- What is the way forward and what recommendations can be identified for addressing refugee and migrant health in the region?

II. CURRENT SITUATION

Migration trends in the region

Migration in the WHO African region is both voluntary and forced, within and outside national borders. In 2017, the WHO African region was home to 1.2 billion people, of which 22 million were international migrants, including 6.3 million refugees *(3)*. The bulk of African migrants move within the continent. More than 80 percent of the migration in Africa occurs within the continent, with intraregional emigration in Sub-Saharan Africa being the largest south-south movement of people in the world *(4).*

Over the last decade, the region has re-emerged as a migration destination. This is linked to the increasing economic opportunities offered in several African countries, as well as a liberalization of economic policies, which has facilitated foreign direct investment. African countries have grown in importance as destination countries for migration mainly from other African countries, but also, increasingly, from China, Europe and elsewhere *(2).* In 2017, the leading destinations for emigration in the region were Cote d'Ivoire (2,197,000 individuals), Nigeria (1,235,000 individuals), South Africa (4,037,000 individuals) and Uganda (1,692,000 individuals).

Since the 1990s, the closure of previously open borders to Europe created a demand for smuggling services and heralded the start of a trans-Mediterranean migration route, which has continued to the present day. Over the 1990s and 2000s, an increasing number of migrants and asylum seekers from Western and other sub-Saharan countries joined this route, also leading to an increasing use of trans-Saharan migration routes through the Algeria, Libya, Mali and Niger *(2)*.

International migration from sub-Saharan Africa to Australia, China, Europe, the Middle East, New Zealand and North America has also increased. In recent years, East and West African countries have increased their outward mobility, mainly towards the Gulf States due to employment opportunities, including an increasing share of women - particularly from Ethiopia - migrating as domestic workers. African migrants are also attracted to fast-growing economies beyond the traditional destinations in Europe, and migration to China has been growing since the year 2000. Initially, this was mostly students who later decided to settle *(2).*

Migration is beneficial for migrants, as well as origin and destination countries. In destination countries, migration replenishes the labour supply and skills, incentivises entrepreneurship and eases strains on pension systems. For origin countries, this contributes to poverty reduction and brings in remittances and diaspora investments *(5).* Remittances play an important role in improving living conditions for households in origin communities. International migrants from the WHO African region have generated US$ 39 billion in remittances that boost the incomes of poor households to not only increase their consumption power, but also to provide funds for education, health and business investments *(6).* However, remittance flows are likely significantly underestimated: only about half of the countries in Africa collect remittance data with any regularity and some major receivers of remittances report no data at all *(7).*

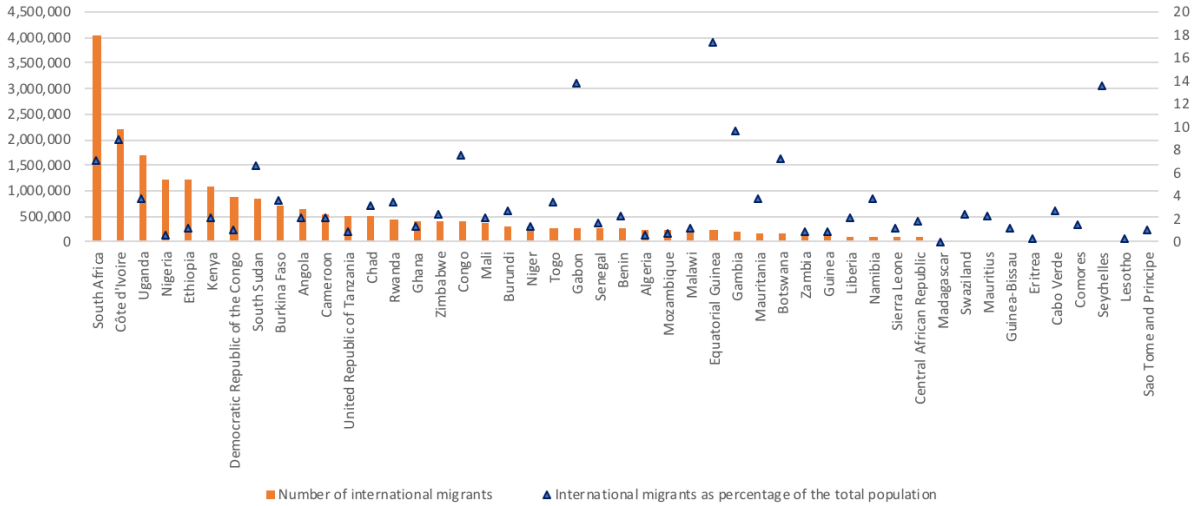

Figure 1: Absolute and relative size of international migrant population in the WHO African region 2017 *(3)*

Forced Displacement

The WHO African region continues to face new and ongoing conflicts. Between 2015 and 2017, the number of refugees in the region has increased, significantly due to conflict in the Central African Republic, the Lake Chad basin crisis and renewed conflict in South Sudan *(2*). By the end of 2016, 14.9 million forcibly displaced people originated from the region, of which 6.4 million were refugees, asylum seekers and stateless persons and 7.4 million were internally displaced. More than half of all refugees and internally displaced people were from Democratic Republic of the Congo, Nigeria and South Sudan.

The crisis in the Lake Chad basin now affects around 17 million people. Population displacement is a result of the ongoing insurgency and its impact on the fragile political and economic structures of countries in the sub-region. While the situation in north-eastern Nigeria is expected to gradually improve, it will take some time until people can safely return to their place of origin *(10).*

The political situation in South Sudan remains volatile and food insecurity further exacerbates the situation, leading to large internal displacement and movements across borders. Half of the South Sudan population has been affected by conflict and a third has been displaced. There are currently 2 million refugees in the sub-region, in addition to the 2 million internally displaced. As a result of the conflict in South Sudan, Uganda has become the largest refugee-hosting country in Africa *(8).*

III. KEY REGIONAL FRAMEWORKS AND LEGAL INSTRUMENTS

Seventy-nine percent of WHO African region Member States are parties to at least one of the various international treaties that comprise the international normative framework on international migration *(11)*: 37 countries (79 percent) are parties of the Convention relating to the status of Refugees (1951); 38 (80 percent) to the Protocol relating to the status of Refugees (1967); 25 (53 percent) to the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990); 41 (87 percent) to the Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children (2000); and 40 (85 percent) to the Protocol against the Smuggling of Migrants by Land, Sea and Air (2009).

The African Union approach to migration is articulated in policy documents such as: The Common Position on Migration and Development (African Common Position) *(12)* and the Migration Policy Framework (MPFA) *(13),* both adopted by the Executive Council of the AU in 2006. The revised MPFA aims to assist Member States and Regional Economic Communities in the development of their own national and regional migration policies. It provides policy guidelines in nine thematic areas, namely: Labour Migration; Border Management; Irregular Migration; Forced Displacement; Human Rights of Migrants; Internal Migration; Migration Data Management; Migration and Development; and Inter-State cooperation and partnerships *(14).*

The right to health of migrants in the African region

The commitment from African governments and states to protect the migrants' human rights, including the right to health, has been stressed in several instances. The African Charter on Human and People's rights *(15),* ratified by most of the member states of the region, prohibits discrimination and states that every individual has the right to enjoy the best attainable state of physical and mental health. The African Common Position states that management of migration should not jeopardize the human rights of refugees and should adhere to the principle of non-discrimination *(12).* The joint Africa-EU declaration on migration and development (Tripoli 2006) recognizes that effective protection of the rights of migrants is one of the major components of managing migration, and states that the management of irregular migration should not compromise human rights *(16).* In 2008, the Declaration Africa and Migration: challenges, problems and solutions, reaffirmed that states shall guarantee to all persons found on their territory, without any kind of distinction, the rights stated in international instruments. It also called on host countries to ensure that migrants are given the same treatment as citizens with respect to access to social services (education and health) *(17).*

Specifically related to health, several declarations and frameworks for action have been agreed upon and endorsed by African governments and states that specifically mention the need to promote human rights, reduce marginalization and give special attention to migrants, mobile populations, refugees and internally displaced persons in national and regional policies *(18).* These include: the Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases (2001) *(19)*; the Abuja call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria (2006) *(20)*, and the Abuja Declaration on HIV/AIDS, Tuberculosis and Malaria: Toward the Elimination of HIV/AIDS, Tuberculosis and Malaria in Africa by 2030 (2013) *(21)*. Sub-regional frameworks are also in place, including provisions to ensure access to health for displaced and migrant populations such as: Southern Africa Development Community (SADC) draft policy framework on Population Mobility and Communicable Diseases, (2009) *(22)*; the SADC Declaration and Code of Conduct on TB in the mining sector (2012) *(23)* and the East Africa Community (EAC) Regional Integrated Multi-Sectoral Strategic Plan for HIV and AIDS 2008-2012 (2007) *(24)*.

IV. HEALTH CHALLENGES AND OUTCOMES ASSOCIATED WITH MIGRATION AND DISPLACEMENT

Access to health services and social determinants of health

Access to health care still represents a challenge among local populations in the WHO African region, which scored 44 in the Universal Health Coverage (UHC) service index - the lowest of all WHO regions - and where an estimated 10.8 to 56.8 million people incurred out-of-pocket payments that led to catastrophic health expenditures in 2017 *(25).* Although Africa has seen a rapid improvement in coverage of key health services, such as coverage of insecticide-treated bed nets for children, antenatal care and skilled birth attendance, disparities remain among and within countries and coverage gaps remain large for many critical services. The region is facing challenges to reach the 2030 Sustainable Development Goal (SDG) basic essential health services objective of 80 percent population coverage *(26).*

Migrants may be less likely than other populations to access or fully benefit from their host country's healthcare system *(27).* Even in countries where the legislation explicitly confirms a range of rights regardless of legal status, including access to free basic healthcare, these rights are not always sustained. Research has shown that challenges faced by migrants when trying to access to healthcare services include language barriers, denial of access on the basis of lack of documentation, and negative healthcare provider attitudes *(28).*

Along the migration route in the region, refugees and migrants face various health risks. Long and overcrowded travel in the back of container trucks poses serious health risks to migrants, with reported cases of migrant deaths due to suffocation *(29).* In addition, refugees and migrants routinely cross forests and deserts in order to enter various countries through unofficial borders. These unregulated routes are extremely dangerous because of the nature of the journey and the lack of access to health services, water, food and shelter along the way *(30).* Between January and June 2016, the IOM had recorded 471 deaths and disappearances in Africa, many due to exposure, hunger or dehydration in the Sahara Desert *(31).*

Refugee and migrant health workforce, migrant workers' health

In 2016, 11,099 doctors and 16,548 nurses and midwives trained in sub-Saharan Africa were working in OECD countries *(32).* As a result, the emigration of African-trained health professionals has reduced the workforce density in most sub-Saharan African countries below the threshold that is essential to achieving health-related SDG. In some countries in the African region, the needs-based shortage is actually forecasted to worsen by 45 percent between 2013 and 2030 (30). South to south migration of healthcare workers has also increased; many high-skilled sub-Saharan female nurses and doctors chose to migrate to southern African countries *(33).*

In emergency situations, health personnel flee insecurity and conflict together with the general population, or in some cases, due to direct attacks on healthcare services/medical facilities, leaving the country of origin with a shortage of trained healthcare workers *(34).*

Care workers, many of whom are migrant women, make a large contribution to global public health, but are exposed to many health risks themselves while experiencing few labour market and health protections. Although the African Union provides some general protection and has shown efforts to ensure the right to health for female care workers, there is significant room for improvement *(35).*

Many migrants, particularly those who are low or semi-skilled, work in some of the riskiest industries in their destination locations, including agriculture, construction and mining, which have high rates of fatality in African countries *(36).* In addition, migrants in those industries are highly exposed to injuries, infectious diseases, chemicals, and environmental pollutants with their associated risks *(37).*

Emergency and humanitarian health assistance

More than 2.3 million people remain displaced from the affected areas across the four Lake Chad basin countries. Most of the displaced families are sheltered by communities that count among the world's' poorest and most vulnerable, where food insecurity and malnutrition have reached critical levels *(38).* Insecurity in the area continues to be a risk to civilians, challenging protection efforts, and raising concerns about shelter, access to healthcare services and to water and sanitation for displaced populations. Populations in the Lake Chad basin remain highly dependent on emergency food assistance (10). In most conflict-affected areas, malnutrition rates have surpassed the emergency threshold. Across the Lake Chad basin, more than 500,000 children are severely acutely malnourished, of whom 75,000 could die without urgent assistance *(38).*

One in four Central African Republicans is either internally displaced or a refugee *(9).* 600,000 people remain displaced internally and 530,000 are living as refugees in neighbouring countries. Less than half of the children are fully immunised and an estimated 1.8 million people have no access to safe water. In settlements for the internally displaced, overcrowded conditions and poor access to water and sanitation increases the risk of diseases such as respiratory infections, diarrhoea, cholera, and hepatitis E *(39).*

More than 40,000 Malians remain internally displaced and 134,079 are still refugees in neighbouring countries. Several communities affected by the conflict still struggle to access food, water and healthcare *(40).* The health system is fragile and relies primarily on humanitarian actors (for staff salaries, operations and equipment) *(41).* Lack of access to essential services and limited state presence and capacity in the north are driving humanitarian needs. In 2018, an estimated 907,000 people will need access to safe water and 165,000 children will be at risk of severe acute malnutrition (SAM) *(42).*

Disease burden

In our increasingly interconnected world, new communicable diseases are emerging at an unprecedented rate, often with the ability to cross borders rapidly and spread *(43).* Population mobility may hinder effective outbreak control and increases the risk of disease spreading across international borders, as seen during the Ebola West Africa outbreak. First, cross border contact tracing is difficult, as populations readily cross porous borders but responders do not. Second, as long as one country experiences intense transmission, other countries remain at risk *(44).*

In 2017, insecurity and conflict in the region led to mass displacement in the Central African Republic (CAR), the Democratic Republic of the Congo (DRC), Nigeria and South Sudan. Several outbreaks of cholera and measles mainly affected areas with high numbers of refugee and internally displaced populations (IDPs) and imported cases of polio were reported in Cameroon from Nigeria *(45).*

Communicable diseases

Malaria

Seasonal migrant workers moving from low malaria endemic areas to higher malaria endemic areas are susceptible to malaria infections and may have significant barriers to the use of malaria prevention and control measures, risking bringing malaria back to their home communities *(46).* Human population movements from higher transmission areas also risks reintroduction and resurgence in malaria-free receptive areas and has undermined elimination efforts *(47).* For example, in the northern South Africa province of Mpumalanga from 2001 to 2008, almost half of the cases of malaria were acquired in a neighbouring country *(48).* Strategic control and elimination plans will therefore need to include information on human population movements and likely parasite movement volumes and routes *(49).*

Tuberculosis

Tuberculosis (TB) is a significant public health problem in the WHO African region. In 2016, 25 percent of the estimated new cases occurred in the region, with a case fatality rate of more than 20 percent *(50).* Forced displacement often results in relocation to camps where risk factors such as overcrowding, malnutrition and poor health-seeking behaviours make affected populations more vulnerable to TB *(54).* The challenge is also critical in the mining industry. The incidence of TB among the South African mining workforce is 10 times the WHO threshold for a health emergency and is four to seven times higher than in the general population. Every year, half a million men travel from across the Southern Africa region to work in South Africa's mines and in doing so, are at high risk of contracting TB *(51).*

Continuity of care is a challenge in mobile populations. The movement of mineworkers across provincial and national borders and a poor cross-border health referral system fuel infection rates negatively, affect adherence to TB treatment, and contribute to the incidence of drug resistant strains and spread of the disease *(52).* Cross-border Zimbabweans living in Botswana and South Africa experience several challenges to access health services, as irregular migrants often avoid public health facilities in host countries due to fear of deportation, the long distances to health facilities, the negative attitudes of health workers, the cost of travel, and a lack of time, as well as a poor understanding of the disease *(53).*

Imprisonment and detention increases exposure to TB, and in some cases, multi-drug resistant tuberculosis (MDRTB). A study in Zambia found cases of MDRTB in prisons, so migrants who are imprisoned in Zambia, exposed to tuberculosis or MDR-TB, and later released, could spread TB and/or MDR-TB during their journey, posing a significant regional risk *(29).*

HIV/AIDS

Migration may increase vulnerability to HIV and has been identified in certain regions in sub-Saharan Africa as an independent risk factor for HIV among men *(55).* Migration was also identified as an independent risk factor for HIV infection for women; female migrants were found to be 1.6 times more likely to be HIV-positive than non-migrants in certain cities in South Africa *(56).*

Conflicts and instability are forcing many people to leave their homes and to move into camps, where health facilities are limited. In addition, many health facilities have been destroyed, made inaccessible and/or become unstaffed during crisis situations. In these circumstances, many people on antiretroviral therapy (ART) are unable to continue their treatment. For instance, in the DRC, a third of people were unable to continue their ART (*57).*

Different groups of migrants are at increased risk for HIV infection. Studies of sex workers and their truck driver clients along a South African trucking route found that up to 56 percent of both were HIV-positive *(58*). The mining sector is one industry in which migrants are shown to have an increased risk of acquiring HIV. Migrant miners between Lesotho, South Africa and Swaziland aged 30 – 44 are 15 percent more likely to be HIV-positive and having a migrant miner as a partner increases a woman's probability of becoming HIV-positive by 8 percent *(59).* Foreign workers in commercial farms in Southern Africa were found to be particularly vulnerable to HIV infections. Due to insecure legal status, high mobility and short stays on farms, they have limited access to health services or be reached by HIV/AIDS information campaigns. Significantly higher rates of HIV have been found among workers in the fishing industry in various parts of the world, particularly in western Africa *(60).*

Conversely, HIV prevalence rates are frequently lower in refugee camps than in the surrounding populations. UNHCR and its partners measured HIV prevalence among pregnant women in more than twenty camps housing around 800,000 refugees in Kenya, Rwanda, Sudan, and Tanzania, and found that the refugee populations in three of the four countries had significantly lower HIV

prevalence rates than the surrounding host communities. In the fourth, the refugees and host community had comparable rates *(61).*

Non-communicable diseases

Refugees and forced migrants often face war, persecution and extreme hardship, showing prevalence estimates of 15.4 percent for posttraumatic stress disorder (PTSD) and 17.3 percent for depression *(62).* Migrants in precarious situations such as living in poor housing conditions, unemployment, poverty and cultural dislocation can cause or exacerbate mental health problems *(63).* One of the challenges in responding to the mental health needs for refugee and migrant population is the scarcity of resources. The majority of African refugees and migrants remain in the region where the ratio of psychiatrists to population is less than 1:100,000 *(64).*

Child, adolescent and women's health

In 2017, the WHO African region was home to 6.35 million migrant children. Data about the long-term impacts of voluntary migration on health for child migrants in Africa is extremely limited. However, the catastrophic impact of conflict and forced displacement for children is evident. In addition to the direct threat of violence, children forcibly displaced face inadequate access to water and sanitation, outbreaks of disease, limited access to appropriate nutrition, incomplete vaccinations, and long-term psychological trauma *(65).*

Children in Sub-Saharan Africa are particularly at risk of trafficking, representing 64 percent of all victims of trafficking in the region *(66).* Children subjected to trafficking are exposed to physical, sexual and psychological violence, which often results in acute and long-term health consequences *(67).* With limited regular migration opportunities, there is evidence of children on their own increasingly using irregular and dangerous routes within Africa, where they are more vulnerable to trafficking and exploitation than those travelling in groups *(68).*

One of the most dangerous migration pathways in Africa is the Central Mediterranean Route to Northern Africa and onward to Europe. Although the experiences of ill-treatment and detention of migrant children are reported from Libya *(69),* detention is common in various countries along the migratory path in Africa *(70).* The impact of detention in children is particularly worrying, as the consequences for their cognitive and emotional development may be lifelong *(71).*

Child marriage is one reason for girls to migrate. These girls are disadvantaged in many ways: They have lower levels of education, less access to information and a higher risk of maternal mortality *(72).* Migrant women meet numerous obstacles to access maternal and child services, including financial difficulties, language constraints, and lack of trust in available services due to health care workers' attitudes and quality of services *(73).* Irregular migrants and female sex workers are often overlooked in regard to health promotion activities, leading to maternal mortality and low vaccination coverage for children of migrant women *(74).*

Conflict-induced or forced migration increases women's vulnerability to sexual violence. In conflict, many women must flee without the added safeguard of male relatives or community members. Unaccompanied girls are likely among the most vulnerable to sexual exploitation. Camps for the internally displaced or refugees may offer limited protection, as women are also at risk of rape in or near camps for IDPs or refugees *(75).*

V. CURRENT PUBLIC HEALTH INTERVENTIONS AND PRACTICES

1. Promoting right to health, and mainstreaming refugee and migrant health in the global, regional and national policies, planning and implementation

Increasingly, governments and states in the region are including non-discrimination provisions in their national legal and policy frameworks, providing a base for refugees and migrants to assert their rights to access health services that are available to citizens of their countries of residence. For instance, Algeria, Ghana, Mauritius, Nigeria and Uganda, among others, do not distinguish between nationals and non-nationals for the purpose of access and enjoyment of fundamental rights. Regionally, the Khartoum process, a platform for political cooperation amongst the countries along the migration route between the Horn of Africa and Europe, launched the Addressing mixed migration flows on East Africa project to set up safe and rights-respectful centres for migrants, strengthening the response capacity of national authorities in addressing the needs of migrants in Eastern Africa.

Kenya: Health in the National Migration Policy, Kenya

Context: Kenya experiences both forced internal displacement (as a result of conflict, natural disasters, climate change and environmental degradation) and voluntary migration of people looking for better opportunities elsewhere in the country. Kenya is also a regional hub for migration as an origin, transit, and destination country and is home to one of the largest refugee populations and some of the oldest refugee camps in Africa *(76).* Migrant and mobile populations face many barriers in accessing essential healthcare services, especially irregular migrants who may choose to avoid accessing public services due to distrust and fear of deportation, therefore missing out on important promotive health measures such as immunization, pregnancy care and safe childbirth. Lack of migrant-inclusive health policies also discourages patients' attendance *(74).*

Practice: The Ministry of Public Health and Sanitation, in partnership with WHO and IOM, hosted a National Consultation on migration and health in 2011. The national consultation aimed to reach a common consensus on achieving quality and equitable health services for migrants and mobile populations in Kenya and serve as a platform to materialize the WHA resolution 61.17 on the Health of Migrants. Participants, who included various ministries, non-governmental organizations (NGOs), academics, migrant representatives, and embassies, agreed in a set of recommendations on policy, programmatic issues, and partnerships *(77).* Following the national consultation, the Ministry of Public Health commissioned an analysis of migration and health in Kenya to provide an overview of the issue, aiming to stimulate discussion and lead to action from the government to ensure migrants enjoy equitable access to health services.

Results: In 2017, the National Coordination Mechanism on Migration submitted a draft policy for validation, which covers various migration issues, including migration and health, providing a comprehensive normative framework that will guide migration management, with the main goal to enhance socio-economic development and security in the country while considering achieving the Sustainable Development Goals *(78).*

2. Promoting and implementing refugee and migrant-sensitive health policies; legal and social protection; and interventions to provide equitable, affordable, and acceptable access to essential health services for refugees and migrants

Migrants' accessibility to and appropriate utilization of health services are often compromised by lack of familiarity with enrolment processes and entry points, financial and structural barriers to

receiving care, and discouraging or discriminatory treatment by staff. Migrant-sensitive health systems and programmes aim to consciously and systematically incorporate the needs of migrants into all aspects of health services' financing, policy, planning, implementation, and evaluation through a broad range of measures, from single-site interventions to comprehensive national policies.

In Algeria, the 2017 health law draft states that all people in difficulty (as refugees and migrants) are entitled to health protection at the expense of the state. Several countries' refugees, such as Uganda, Liberia, Angola or Ghana, are entitled to equal access to all national health facilities as nationals. In Mauritius, the government ensures that employers finance health insurance schemes for migrant workers. Mali has implemented measures aimed at the economic reintegration of returnees, such as the creation of an information desk and an agreement with two banks.

Cabo Verde: Equality and integration policies

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

Practice: The General Immigration Department undertook initiatives, including conferences on migration, to sensitize the local population and migrants to the importance of migration and mutual respect. Regular training plans for both public care services and the national police are also organized to ensure that migrants receive equal access to public services and an improved access to the enforcement of their rights. The National Immigration Strategy (Resolution No. 2/2012) is based on the principle of non-discrimination and includes measures aimed at integration and inclusion of migrant workers in society *(79)*.

Kenya: Access to primary health care for refugees and migrants and financial protection for urban refugees

Context: Nairobi is home to thousands of migrants. Eastleigh, a large trading district in the city, hosts many of the urban refugees, as well as a large number of irregular migrants. Living conditions are difficult, with the population living in overcrowded, dark and poorly ventilated apartment blocks. The majority of migrants are living with irregular migration status, which deprive them of access to basic health services.

Practice: The Eastleigh Community Wellness Centre (ECWC)[3] offers migrant health services to both migrants and host communities. Initially, the centre offered free TB treatment but has expanded its scope and currently offers free primary healthcare (PHC) services, including comprehensive TB and HIV services, sexual and reproductive health services, maternal and child health services, nutrition services, and health promotion through a community approach, as well as interpretation services.

The National Hospital Insurance Fund[4] provides unrestricted secondary and tertiary healthcare to subscribers. Subscribers also enjoy out-patient care in health facilities they select during the registration (subscribers have the possibility of changing facilities over the course of the year). UNHCR is conducting a sensitization campaign among urban refugees to ensure refugees register using any of the recognized documents. In refugee hosting areas, UNHCR works with county authorities to ensure harmonized and integrated health care under the leadership of the county authorities.

[3] Information collected from IOM submission
[4] Information collected from UNHCR submission

Results: The clinic serves a catchment population of 300,000 people, with monthly attendance of 2,500 patients, half of them migrants. In the period of 2014-2016, the clinic served more than 100,000 clients. More than 8,000 people received HIV counselling and testing and almost 5,000 people were screened for TB. Half of the children attending the welfare clinic were migrants.

8,771 families have been registered to the National Hospital Insurance Fund.

Lessons learned: The ECWC health service delivery demonstrates how to address the provision of migrant-sensitive healthcare in urban areas, applying an integrated and inclusive approach to ensure equal access to care for both migrants and the host population. In refugee hosting areas, integration of healthcare provisions for refugees works well in areas of shared infrastructure (e.g. antiretroviral (ARV), TB, malaria drugs, vaccines and use of training

3. Addressing the social determinants of health

The right to an adequate standard of living and access to social security, including social insurance, is reflected in the internationally agreed normative framework. The Declaration of Human Rights affirms that every member of society has the right to a standard of living to safeguard well-being for themselves and their family, as well as the right to security in circumstances beyond his control. States Parties to the International Covenant on Economic, Social and Cultural Rights recognize the right to social security and commit to take appropriate steps to ensure the realization of this right; the convention Relating to the Status of Refugees states the right to housing, public relief and social security for refugees. The Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children affirms that States Party shall take into account the special needs of children, including appropriate housing, education and care. Despite strong political commitment in scaling up action on social determinants of health and improving health equity, some challenges and gaps remain.

Governments, UN agencies and development and humanitarian partners are providing life-saving assistance throughout the migration path in the WHO African region, aiming to improve social determinants of health. For instance, in Algeria, the state is setting up a pilot centre in Tizi Ouzou to provide shelter, water, sanitation, and food to irregular migrants. In Mauritius, the migrant workers unit of the ministry of employment verifies contracts and conditions of workplaces and shelter for migrants. In 2013, under the Health in All policies initiative, eleven countries in the region had a national intersectoral plan to address social determinants of health. Ethiopia, Guinea-Bissau, Lesotho and Uganda developed a plan with the involvement of all ministries, although only Botswana made funding available in the budget *(80).*

Ethiopia: Enhancing capacity to address social determinants of health for refugees and host population

Context: More than 850,000 refugees are hosted in Ethiopia in 25 camps across five regional states, mainly from Eritrea, Somalia and South Sudan.[5] Many of the border regions receiving refugees face the challenges of poor infrastructure, high levels of poverty, adverse environmental conditions, low capacity and poor development indicators. The unit cost of water provided in the camps is relatively high and the achievement of international minimum standards varies from one location to another. Where the standards have been met is usually with the support of humanitarian financing. The

[5] UNHCR global trends

government[6], donors and humanitarian and development actors have put forward new models for sustainable water provision to benefit refugees and host communities alike.

Practice: The Administration for Refugees and Returnees Affairs, UNHCR, the United Nations Children's Fund (UNICEF) and the Regional Water Bureau agreed on building a water system spanning two refugee camps and two towns through a pipe network covering 100 km. This large infrastructure development, the Itang integrated water project, has been functional since 2016 and is currently being extended to one additional site *(81).*

Results: The Itang integrated water system will provide water to 250,000 people (75 percent or more are refugee beneficiaries).

Lessons learned: Ethiopia's willingness to include refugees in the national water system makes it stand apart from the more traditional humanitarian responses. This experience is likely to shape future water programming in other refugee camp settings.

South Africa: Empowerment of refugees and migrants in Johannesburg

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

Practice: Mpilonhle-Mpilonde (quality life-long life). Initially the intervention was designed to prevent HIV infection in refugees and migrants and to improve access to HIV-related health services. Quality of life clubs are community health clubs, which were a central vehicle for driving change in the communities. In a series of structured learning sessions facilitated by a trained expert facilitator, community participants identify challenging and problematic aspects of their environment and collectively formulate responses to bring about change. Similar clubs have been implemented in rural settings in Sierra Leone and Zimbabwe as a long-term strategy to enhance people's control over social determinants of health *(82).*

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

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

[6] The institutional responsibility for the implementation of policies relating to refugees and returnees lies with the Administration for Refugee and Returnee Affairs (ARRA).

4. Enhancing health monitoring and health information systems

To effectively respond to their needs, assessing and analysing trends in refugees' and migrants' health are essential. There is a need to disaggregate health information by relevant categories, conduct research, and identify, collate and facilitate the exchange of experiences and lessons learned, as well as generate a repository on relevant experience.

The Southern Africa migration and health project (maHp) aims, through research and public engagement projects, to generate and communicate knowledge in order to improve responses to migration in the Southern African development community *(83).* In 2014, the Regional Mixed Migration Secretariat (RMMS) created the Mixed Migration Monitoring Mechanism Initiative (4Mi) to collect and analyse data on mixed migration flows in strategic migration hubs in Northern, Eastern, and Southern Africa, Southern and Eastern Europe, and the Middle East. As an attempt to address the need for better data through a network of locally recruited monitors in migration hubs, 4Mi produces graphics, analysis and infographics based on the accumulated data collection *(84).* Human mobility can amplify the spread of communicable diseases. A collaborative agreement between African governments, U.S. Centres for Disease Control, and IOM is in place to build the capacities of thirteen African States to better prevent, detect and respond to disease outbreaks and other health threats with a special focus on international borders and crossings, travel routes and congregation points *(85).* People have gone missing along mixed migration routes, so in order to better understand the scope of the problem, UNHCR and IOM monitor migratory movements along different routes, including the people who have died or gone missing "en route".

East Africa: Assessing and analysing migrants' health needs

Context: Migrants and other populations associated with major transport hubs often face increased vulnerability to infectious diseases and ill health due to conditions surrounding the migration process. While barriers are similar to those of other underserved populations, migrants face the additional burden of having to search for health care options while on the move. In 2013, under the umbrella of the East African Community (EAC), a regional task force on integrated health and HIV and AIDS programming along transport corridors in East Africa was established. A mapping of health services along major transportation corridors was conducted to inform the strategy *(86).*

Practice: Data on the mapping of health services along major transport corridors in East Africa was gathered from the five EAC partner states, namely Burundi, Kenya, Rwanda, Tanzania and Uganda. Information was collected through a records review and a quantitative survey of health workers, as well as from facilities that provided health services for key populations at selected hotspots along different transport corridors. The survey targeted all functional public, private and civil society organization-supported health facilities. Overall, a total of 341 health facilities were surveyed.

Results/findings: From the 341 health facilities surveyed, the majority of them were government owned in Burundi, Rwanda and Tanzania, whereas in Kenya and Uganda, the majority of the facilities were privately owned, providing PHC. Several health facilities partnered with civil society organizations (from 46 percent in Uganda to 79 percent in Rwanda). Key population groups represented 16 percent of the total adult facility caseload per month. Health services needs for key and vulnerable populations included infectious diseases, STI screening and treatment (including HIV counselling and testing) and accidents. Almost all facilities utilized a Health Management Information System and most collected information on key and vulnerable populations. Nurses and nursing aides comprised more than two-thirds of the professionals, while doctors were mainly found in hospitals. Provision of HIV and TB treatment was low, as only 40 percent of facilities reported providing HIV treatment services and only 31 percent of the facilities offered TB treatment.

Lessons learned: The study showed that segregating data and including information on migration status in the health management information system (HMIS) and analysing them is important to

identify migrants' health needs as well as gaps in health service delivery for the migrant population. The study also revealed that one of the major reported barriers to accessing health services was the lack of client-friendly, migrant-sensitive services.

West Africa: Addressing health security and preparedness

Context: Human mobility can amplify the spread of communicable diseases and the impact of public health events. SARS, H1N1, and H5N1 global epidemics have highlighted this fact. In 2005, WHO outlined the core capacities to be put in place to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate to the threat and which avoid unnecessary interference with international traffic and trade. The Ebola crisis of 2014-2015 in West Africa was the most recent reminder of the work still to be done in realizing these capacities. To contribute to close the gaps, in 2015 IOM and US Centres for Disease Control and Prevention entered into a cooperative project to better prevent, detect and respond to disease outbreaks and other health threats.

Practice: Framed by the global health security agenda, the project addresses four of its 11 action packages: Surveillance, emergency operation centres, public health and law enforcement, and medical countermeasures in Ghana, Guinea-Bissau, Guinea, Liberia, Mauritania, Mozambique, Senegal and Sierra Leone. The project is grounded in IOM's Health, border and mobility management framework, which provides a platform to develop country-specific and multi-country interventions by focusing on border crossings, travel routes and congregation points where travellers interact with each other and with the surrounding communities.

Results: Shared cross-border information on health through regional meetings, and cross-border coordination groups between Guinea and Sierra Leone; strengthened surveillance through community-based surveillance in Guinea and Sierra Leone, using the community health workers in responding to the most recent measles outbreak in Guinea (2017); reinforced emergency response capacity through operationalization of public health emergency operations centres (EOCs) in Guinea, and technical contributions to developing and revising public health emergency response plans (PHERPs) in Ghana, Senegal and Sierra Leone; and developed the capacity of points of entry through capacity assessments, logistical and procurement support, trainings on health screening and case management, and development of standard operating procedures (SOPs).

Lessons learned and ways forward: This project and best practices highlight the benefits of strategically allocating resources towards building strong partnerships to improve the ability of countries' programs to detect and respond to events of public health concern. The Ebola epidemic highlighted the importance of such partnerships to move beyond the epidemic and to build otherwise lacking capacities before the epidemic, including at the EOCs, stronger laboratories and surveillance systems, as well as improved public awareness of the threats posed by infectious diseases. In learning from the achievements made in each affected country, relevant stakeholders should capitalize on the positive outcomes achieved to date and invest more efforts to strengthen the health systems of target countries to sustain activities and outcomes beyond the lifetime of the project.

5. Providing Universal Health Coverage and equitable access to quality essential health services, financial support and protection, and access to safe, effective, affordable essential medicines and vaccines for refugees and migrants

Achieving UHC and meeting the SDGs target 3.8 requires ensuring that refugees and migrants benefit fully from social protection mechanisms, developing sustainable financial mechanisms, and strengthening health systems' resilience and capacity.

Forty-nine African countries have signed the Addis Declaration on Immunization to ensure that everyone in Africa - regardless of who they are and where they live - receive the benefits of full immunization *(87).* The essential health needs of refugees and internally displaced populations living in recognized settlements in all Africa countries are usually covered by the state with the support of UN agencies and their partners.

Mali: Improving access to basic services, including mental health to forced return migrants

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

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

Results and lessons learned: The project achieved positive results in providing immediate assistance to forced returnees. The setting up of a referral system faced difficulties due to a shortage of suitably qualified staff within the national health system. Strengthening of the health system, including the training and retention of mental health professionals, is necessary to integrate mental health care *(88).*

Support for refugee doctors in South Africa

Context: South Africa has a long history of providing asylum. In 2015, the country accepted 120,000 refugees, some of whom were doctors. Africa Health Placements[7] (AHP) is an NGO that was established in 2005 with the mission to help plan for, find and retain the health workforce needed to provide access in rural and underserved communities. A major component of AHP's work has been recruiting foreign-qualified doctors to take up vacant posts in rural government hospitals in South Africa, usually for a one-year period.

Practices: AHP supports refugee doctors in their applications for professional registration and employment through active partnership with the national department of health and the Health Professional Council of South Africa (HPCSA). AHP provides support to refugee doctors by helping them to complete their application forms to the Foreign Workforce Management Directorate at the

[7] http://www.who.int/workforcealliance/brain-drain-brain-gain/17-304-south-africa-case-studies2017-09-26-justified.pdf

national Department of Health for permission to seek employment, as well as to the HPCSA for professional registration. AHP checks that the forms are compliant with the regulations and helps to submit them on behalf of the refugee doctor and follows up on progress. Once these applications have been approved, AHP helps the refugee doctors find jobs by matching them with available posts in the public sector. Refugee doctors are only allowed to work in the public-sector facilities and must work at least one year in an underserved community.

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

Lessons learned: AHP believes that supporting refugee doctors' work in the health system in South Africa brings considerable benefits to both the country and to the refugee. Staying longer enables these doctors to adapt more to the local practice and culture, and to be available to take on important clinical leadership roles in the facilities where they work. For the refugee, the ability to take up posts in the health system brings the obvious benefits of being able to work, support their families and continue in their careers. The process for obtaining professional registration and a job offer is also a difficult one that can be slow and expensive to complete. There may therefore be opportunities to streamline the process further, for example by providing more regular opportunities for candidates to undertake the HPCSA examinations or by offering bridging programmes (such as in language skills or medical practice) to help refugees reach the required standards more quickly.

It is essential that due processes are followed to prevent active recruitment from critical shortage countries and to ensure the professional competency of all doctors. If these are in place, the experience of South Africa demonstrates that enabling and supporting refugees with medical qualifications to practice as doctors can provide mutual benefits for both refugees and the host country.

6. Providing humanitarian assistance and long term public health interventions to reduce mortality and morbidity among refugees and migrants, including addressing communicable and non-communicable diseases

In the WHO African region, new and ongoing conflicts continue to generate population displacement. Protracted situations prevent millions of refugees and IDPs from returning home. Rapid and effective emergency humanitarian responses are as essential to saving lives and relieving suffering as it is ensuring sustainability of the response and enhance local capacity to address public health issues.

Rapid responses to outbreaks include, when possible, immunizations campaigns. WHO has supported governments in implementing reactive oral cholera vaccination campaigns in Cameroon, Malawi, South Sudan and the United Republic of Tanzania. Preventative intervention in a humanitarian crisis such as mass displacement is also important; to reduce mortality and morbidity due to malaria in displaced populations, WHO conducted a mass drug administration with Artemisinin-based combination therapy (ACT) for children under five years of age *(91)* in Nigeria. Outside humanitarian crises, population movements also have an impact on malaria transmission. Mass testing and treatment for malaria in low transmission areas with a large percentage of returning migrant workers in Ethiopia and Zambia have been done as a malaria control strategy (*89, 90).*

In Mali, the health cluster led by WHO was established in March 2012 and reinforced to ensure key functions are supported for public health, including data and information management to reduce mortality and morbidity, and the quick restoration of provision of care. In addition, WHO established an emergency coordination unit at WHO Country Office to increase effectiveness. Since then, the WHO has deployed sixteen humanitarian interventions. WHO physicians provided 79,476 curative consultations, assisted 2,702 deliveries, conducted 2,652 surgical interventions (including 548 caesarean sections), attended 99 war-wounded and supported the hospitalization of 9,613 patients.[8]

To comprehensively respond to the needs of refugees to have a link between humanitarian assistance and development, Ethiopia, Kenya, Tanzania, Uganda and Zambia are rolling out the Comprehensive Refugee Response Framework in collaboration with UNHCR in the WHO African region. The government of Zambia collaborated with the IOM, UNHCR and UNICEF to develop a national referral mechanism and associated guidelines to effectively identify vulnerable migrants and refer them to appropriate authorities and services *(92).*

Uganda: A progressive approach to refugee management

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

Practices: In 1999, the Office of the Prime Minister and UNHCR formalized the integration of service delivery systems for refugee and local populations in order to promote peaceful coexistence and fairness between refugee and host populations. The 2006 Refugee Act, as well as the 2010 Refugee Regulations, have further strengthened migrants and refugees' rights within the country. Uganda's refugee law is one of the most progressive in the world. The government maintains an inclusive approach, granting refugees freedom of movement, a plot of land, the right to seek employment and engage in business, and access public services such as education and health on par with nationals *(93).*

Despite the challenges generated by the recent influx from South Sudan, refugee families receive plots of land. Uganda has integrated refugees into national development plans through the Settlement Transformative Agenda (STA), which supports the objectives of refugee self-reliance through development interventions to ease pressure on the host county and communities *(94).*

Building on these existing approaches, the Office of the Prime Minister and the UNHCR officially launched the Comprehensive Refugee Response Framework (CRRF), addressing four mutually-reinforcing themes: admission and rights; emergency response and ongoing needs; resilience and self-reliance of refugees; and expansion of solutions through resettlement and alternative pathways, such as scholarships and work placements abroad. Through the implementation of the CRRF, Uganda seeks to accelerate the implementation of the government's Refugee and Host Population Empowerment (ReHoPE) strategy, which provides a national framework for integrated and holistic support to refugees and host populations.

In October 2017, Uganda's government led a high-level, multi-stakeholder steering group, bringing together humanitarian and development actors, local authorities, refugees and the private sector to engage with the roll out of the CRRF.

Results and lessons learned: Integrated comprehensive health care packages are provided in the facilities for host and refugee populations in 87 health facilities supported by UNHCR across the

[8] For further detail see WHO submission in the compendium

country, 72 percent of the total number of primary health care consultations are made to the refugee population *(95).* The refugee response is chronically underfunded. Uganda remains a low-income country with scarce resources and even though the approach has been proven to establish peaceful coexistence between host population and refugees, it requires support from the international community and further investments to fully realize this exemplary model.

Nigeria: Improved access to mental health services through outreach to primary healthcare facilities and support to referral system

CONTEXT: In emergency settings, the rate of common mental disorders can double — often from 10 percent to 20 percent[9]. Over the last nine years, the Boko Haram insurgency in north-eastern Nigeria has caused a humanitarian emergency, with an estimated 7.7 million people in need of support, including health services. The insurgency has created a situation that has led to a significant displacement of people, thereby resulting in significant psychological suffering of the affected population. In addition to the impact of the displacement and the weakened health delivery system on the health, gross atrocities such as abduction, suicide bombings and killings are expected to have a negative effect on mental health.

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

Results: A total of 64 PHC health workers were trained for five days on mhGAP. Nine mental health specialists from the Neuropsychiatry hospital conducted 241 outreach sessions on mental health at selected PHCs. During these outreach sessions, a total of 3,320 patients with mental health problems were treated over a four-month period. Out of these, 253 were referred for better care and 27 were treated as inpatients.

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

7. Protecting and improving the health and well-being of women, children and adolescents living in refugee and migrant settings

Women and children are particularly vulnerable during displacement. Forced displacement and irregular migration particularly increases exposure to violence, including sexual and gender-based violence and exploitation. Mass population movements, lack of drinking water, inadequate shelter and sanitation, as well as limited access to health services increase the risks of refugees and migrants acquiring communicable diseases. These risks are amplified in the case of children without full immunization. Providing appropriate health care, nutrition and decent living conditions and addressing the education and social protection needs of children and adolescents is critical to ensure their health and well-being.

In Borno State, Nigeria, WHO, in collaboration with health sector partners, has conducted multiple immunization campaigns against polio, measles and meningitis, established an early warning and response system in 158 sites, supported 35 mobile teams in the least accessible locations in 25 Local Government Areas, and assessed the functionality of 749 health facilities *(96)*. In South Africa, unaccompanied migrant children are assigned a social worker. In Mbera camp, Mauritania, UNHCR is

[9] http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf?ua=1

reinforcing the community protection network, training its members on core child protection principles and addressing specific issues such as education, health, early marriage, as well as targeting outreach activities to men and boys to address harmful practices. In Rwandan refugee camps, IFRC is running the 'Mobile Solar Kiosk' project to help migrants in camps charge their phones, increasing access to communication material. Save the Children has helped set up bilateral coordination working groups, which consist of government and non-governmental actors from both sides of the borders between Mozambique, South Africa and Zimbabwe. One of the tasks for the groups has been to work to improve protocols and guidelines for family tracing and reunification and for the provision of psychosocial support, both for children in shelters and for those who have recently returned to their families.

Ethiopia: Preventing human trafficking and exploitation

Context: Ethiopia has a large number of migrants leaving for positions as domestic workers in the Middle East and Gulf States. Approximately 180,000 women depart each year and an estimated 60 - 70 percent of those are undocumented. Exploitation, neglect and physical and sexual assault against Ethiopian domestic workers is common given the legal status of the migrant and weak labour laws. In response, the Ethiopian government has implemented policies and conducts awareness-raising campaigns in an effort to reduce the vulnerability of migrants and reduce risky migration.

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

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

Lessons learned: Coordination and collaboration with government officials at all levels improves outcomes for overseas workers. Local community members are best placed to identify and execute local solutions. Exchange with other countries is very valuable. In 2016, the Freedom Fund sponsored a trip for Ethiopian government officials to go to Philippines to exchange experiences. Following the Philippines trip, they produced a report including suggestions to adapt Ethiopia's migration policy to promote more effective migration practises and develop services provided to migrants and their families. Pursue further research on communities' attitudes on migrations and evaluate partners. Establish a national migration platform to bring together government officials and civil society organisations.

South Sudan: Enhancing the psychosocial well-being of internally displaced persons and conflict-affected populations

Context: In December 2013, fighting erupted in South Sudan. Within a week, 35,000 people sought refuge inside the United Nations Mission in South Sudan (UNMISS) peacekeeping bases. Three years later, more than 200,000 IDPs continue to shelter inside these so-called Protection of Civilians (PoC) sites within UNMISS bases. The declining living conditions, breakdown of social structures, and rising levels of violence among and between communities have significantly exacerbated tensions inside the PoC *(97).*

Practice: Mainstreaming the mental health and psychological support (MHPSS) approach and developing the capacity of humanitarian actors sent as first responders in the provision of psychosocial first aid. Provision for training in basic life skills, establishing a network of support groups, ongoing provision of psychological interventions as needed, and contributing to community rebuilding activities. Specific activities offer included: counselling and home visits; support groups for mothers, widows, teenage mothers, men, youth, children, and people with special needs; recreational learning and cultural activities; capacity building activities, such as training on psychological first aid; MHPSS 101; counselling skills; and reporting and caring for gender-based violence survivors.

Results: Creation of psychosocial support teams composed of 73 IDPs trained on the provision of psychosocial support, which provided services to more than 10,000 individuals. In addition, the PSS mobile teams organized several awareness campaigns on MHPSS and conduct regular home visits.

Lessons learned and way forward: Mental health and psychological support services have helped to address high levels of distress, strengthen positive coping mechanisms, and contribute to effective referral and protective mechanisms. Many of the trainees expressed the need for refresher training. In the future, the project will also target host communities to create a more balanced response to the conflict affected population.

8. Promoting continuity of care for refugees and migrants, in particular for persons with disabilities, people living with HIV/AIDS, tuberculosis, malaria, mental health and other chronic health conditions, as well as those with physical trauma and injury

Forced displacement and migration may have a negative impact on the continuation of care for chronic conditions. It is important that health promotion, including dissemination of information on availability of services, be made readily available among refugee and displaced populations.

The East, Central and Southern Africa Health community adopted a strategic framework for cross-border and regional programming in tuberculosis prevention and control for the ECSA-HC region (2015-2020) *(98).* The World Bank supports ministers of health and minerals and mining companies in Lesotho, Mozambique, South Africa and Swaziland to mobilize resources and stakeholders and additional resources from the global fund for scaling up effective interventions *(99).* In 2010, Namibia lifted its travel restrictions against people living with HIV and in 2014, the Union of the Comoros enacted a law promoting the absence of restrictions to entrance, stay and residence based on HIV status, stipulating the prohibition of mandatory HIV testing as condition for employment and guaranteeing access to treatment for migrants living with HIV.

Southern Africa community: Providing health and HIV care across borders

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

Practices: The ILO transport corridor initiative targets cross-border mobile migrant workers and their families in Malawi, Mozambique, South Africa and Zimbabwe. In collaboration with cross-border institutions, companies and small or informal traders, and communities regularly interacting

with migrant workers in transportation and commerce, the ILO transport corridor initiative aims at improving key access to health services and HIV prevention mechanisms in transport corridors in Southern Africa. The initiative has trained peer educators, notably executives of 128 "cross-border institutions" (for instance customs agencies and other regulatory bodies) and of 76 transport companies in the implementation of HIV and AIDS programmes and for the regular distribution of condoms. At the Ressano-Garcia border between Mozambique and South Africa, the project reached out to informal communities operating along the railways. An agreement was signed between ASSOTSI, an informal sector association, and customs authorities to ensure that informal workers are not excluded from access to HIV services at border areas. In Zimbabwe, the ILO facilitated the mobilization of leaders

Outcomes: More than 42,000 transport workers, including long-distance truck drivers, are estimated to have benefited from the transport corridor initiative. The approach has taken into account local conditions and opportunities. In Zimbabwe, for example, leaders from small business and informal sector associations have established a saving and credit cooperative at one of the country's key border posts.

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

9. Promoting workers' health, including occupational health safety in work places where refugees and migrant workers are employed, in order to prevent work injuries and fatal accidents

Accurate occupational health-related information is scarce in Africa. Even the most comprehensive notification systems in the region do not cover small scale or informal sector production. Surveys in the informal sector have shown occupational injury and mortality rates similar to those on the formal sector, and higher rates of occupational illness. Informal sector workers are exposed to poor work organization, poor access to clean water and sanitation, and hazardous exposure to dusts and chemicals. Risk management and control measures need to be put in place in the formal and informal sector to improve health safety.

The Southern Africa development community (SADC) has published its policy framework for population mobility and communicable diseases in the SADC region, which provide guidance on the protection of the health of cross-border mobile people and the control of communicable diseases across borders in the region. In Mauritius, the migrant worker unit of the Ministry of Health verifies contracts and inspects migrant workplaces. In Seychelles, the Ministry of Immigration and Employment has in place an enforcement unit to investigate and act on cases of abuse or ill-treatment of migrants. In Cameroon, IOM started the implementation of a project on the protection of domestic workers (most of whom are women and girls) in order to strengthen the government's capacity to protect domestic workers' labour rights and fight trafficking for domestic servitude *(91).* Domesticare provides insurance to privately employed South African domestic workers, ensuring access to occupational and primary healthcare, providing medicines, x-rays and blood testing, as well as consultations with general practitioners.

Region: Strengthening labour inspection

Context: Labour inspection and implementing labour inspectorates are a key means of monitoring, upholding and enforcing labour standards, notably regarding occupational safety and health, at workplaces. Labour inspection can be an especially effective means of extending occupational safety

and health protection and establishing decent working conditions for migrant workers. Spurred by the ILO-AIDS programme work and the ILO HIV and AIDS Recommendation, 2010 (No. 200), addressing HIV and AIDS has increasingly become an important component of labour inspection and in training of labour inspectors. To support implementation of HIV and AIDS recommendation, 2010 (No. 200) and to specifically enhance the knowledge, roles and engagement of labour inspectorates regarding HIV and AIDS workplace awareness and prevention, ILO and the ILO international training centre (ITC) in Turin developed HIV and AIDS components for the training programs and modular training manuals. The support also targeted labour inspectors in countries in Africa, the Caribbean, Eurasia, and Latin America for HIV-focused training and national strategies to advocate for and implement HIV and AIDS legislation and workplace responses.

Practices: In Mozambique, occupational safety and health inspectors have been targeted for training. In Ghana, incorporating HIV training into the work of labour inspectors has been held. In Ethiopia, the Ministry of Labour has developed a checklist to guide inspections targeting HIV and AIDS. In Senegal, the Labour Inspectorate also developed a methodological guide to harmonise intervention methods and practices of inspectors at the workplace. In Namibia, the Directorate of Labour Services completed specific inspections focusing on HIV-related discrimination in the workplace. In Kenya, the Ministry of Labour Strategic Plan calls for a reduced workload and provision of sick leave for affected workers. Labour inspectors are also called upon to train workers and employers regarding their rights and obligations in relation to HIV and AIDS *(101).*

10. Promoting gender equality and empowering refugee and migrant women and girls

Women represent almost half of the refugee and migrant population in the region. In unstable contexts and insecure routes, refugee and displaced women and girls are particularly vulnerable to sexual violence or exploitation. Migrant women are often concentrated in occupations that may not receive legal protection under labour laws, such as employment as domestic workers. Namibia has reported on provisions of their penal codes that address violence against all women, including migrant workers and the adoption of national policies and strategies to combat violence against women and children that respond to migrant women. In South Africa in 2013, Community Media for Development worked with 20 refugees, migrants, and South Africans to develop three mini-dramas and related discussion guides. The drama, Change the Story: migrants and refugees speak against gender-based violence, was played to help promote awareness, encourage dialogue, and urge migrants and refugees in South Africa to seek protection *(102).*

Ethiopia: Preventing sexual exploitation and abuse

Context: Young women who have relocated to urban areas and slums in Ethiopia are at risk of coerced sex, sex work, and exploitative labour. There are few programmes seeking to address social exclusion and HIV vulnerabilities among the most marginalized girls, including migrant girls. The Biruh Tesfa ("Bright Future") project reaches out-of-school adolescent girls in urban slums in 18 cities in Ethiopia, and two-thirds of the girls who enrolled were migrants *(103).* From 2006 to 2014, the Biruh Tesfa project addressed vulnerabilities of young women in urban areas and slums. A main activity of Biruh Tesfa was mentoring out-of-school girls and young adults ages 7-24 on topics such as HIV and AIDS, reproductive health, and violence and coercion. The mentorship program empowered young women by identifying, training and hiring female community leaders as mentors and by creating 'safe spaces'.

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

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

11. Improving communication and countering xenophobia to dispel fears and misperceptions among refugee, migrant and host populations on the health impacts of migration and displacement

Xenophobia threatens the lives and livelihoods of refugees and migrants. Xenophobic attacks have occurred in all parts of the region, affecting, among others, Zimbabweans in South Africa, Somalis and people from the Democratic Republic of the Congo in Kenya *(106).*

South Africa: Tracking xenophobic threats and attacks

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

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

12. Enhancing partnerships, inter-sectorial, intercountry and interagency coordination and collaboration, and enhancing better coordination between humanitarian and development health actors

Migration in Africa is comprised of a diversity of people, labour migrants, families of migrants, refugees, irregular migrants and trafficked persons. Managing large movements of refugees and migrants in a humane, sensitive, compassionate, and people-centred manner is a shared responsibility. This implies the need to strengthen existing partnerships and foster new ways of working among states, international organizations, the private sector and civil society to achieve synergies and efficiency.

The Nairobi City Council's Health Department, together with IOM, established the Eastleigh Community Health Centre in 2002. This is an example of effective collaboration between a (local) government department and a third party for the purpose of integrating migrants into the healthcare system. The centre serves a catchment population of more than 300,000 people, with a monthly attendance close to 2,500 patients, half of whom are refugees and migrants.

The Ripfumelo Project combines three of the WHA pillars – monitoring, health services, and partnerships – to achieve an overall objective of reducing HIV and TB vulnerability amongst migrants and mobile populations, and local populations in selected geographical areas in South Africa. The project targets approximately 20,000 seasonal, temporary, and permanent farm workers (whether South African or foreign, documented or undocumented), on about 120 commercial farms *(107).* An international group of researchers has also been formed to examine healthcare and population mobility in Southern Africa.

East and Southern Africa: Enhancing partnerships

Context: East and Southern Africa experience high levels of population mobility, and the largest HIV and TB epidemics in the world makes migrant health a critical issue in the Rregion. However, existing interventions often fail to consider the impact of the conditions surrounding the migration process, which exposes migrants and host populations to various risks that make them vulnerable to ill health. The global policy context has evolved in recent years into a more public health-based approach, which is centred on the health of migrants as a response to global health challenges, as the PHAMESA program responds to the 61st 2008 World Health Assembly (WHA) Resolution 61.17 on health of migrants *(94).* From the previous two programs focused on HIV and TB in Southern Africa, PHAMESA has evolved in scope, scale and structure. The overall objective of the program is to contribute to the improved standards of physical, mental and social wellbeing of migrants and the migration-affected population.

Practice: Partnership on Health and Mobility in East and Southern Africa (PHAMESA). Since 2003, IOM has implemented regional programs addressing health vulnerabilities of migrants and migrant-affected communities in East and Southern Africa. The initiative fosters partnerships among governments, UN agencies, private sector and civil society; and monitors migrant health through assessments on needs, vulnerabilities and gaps on services for migrant population. It supports the provision of health services in health structures; provides capacity building of implementing partners, including state employees such as police, health and social services staff, informing them about migration and health, with an important focus on gender. This also delivers training to community health workers on social behaviour change communication.

Lessons learned: The programme is managed by objectives and interventions and does not articulate overall programme results, making it difficult to monitor and manage results. PHAMESA has evolved as a regional program but is anchored in a centralized management structure linked with one country office, which limits the level of collective ownership and accountability. According

to a program evaluation, the greatest added value of PHAMESA involves increasing visibility, increasing the partnership around resources and expertise, and facilitating policy formulation and implementation at national and regional levels *(108).*

VI. LESSONS LEARNED, WAYS FORWARD AND RECOMMENDATIONS

Recommendations

1. Provision of sensitive reception and accommodation spaces for refugees and migrants. The assistance should also take into consideration their special gender- and age-specific needs in terms of adequate health care, education, shelter, and protection from human rights violations.

2. Increase refugee and migrant recognition and access to basic services through the inclusion of refugees and migrants in the host countries' internal identification and documentation systems. Develop mechanisms to better understand the health status and needs of refugees and migrants in the origin, transit and destination countries.

3. Address social determinants of health and improve access to quality health services for refugees and migrants:

    a) Deploy targeted health services designed for refugees and migrants and innovative financing.

    b) Invest in improving access to water, sanitation and appropriate shelter and nutrition.

    c) Ensure disease surveillance and rapid response mechanism to deal with outbreaks

    d) Promote cross-border interventions and foster interactions between partners involved in the provision of health services in different countries to ensure continuation of care for mobile populations.

4. Address the negative media narrative, xenophobia and criminalization of migrants. Build the capacity of judicial and law enforcement officials, including developing trainings programs on human rights and protection of migrants.

5. Enhance partnerships between Member States, UN agencies, non-governmental organizations, civil society and private sector. Document experiences and practices to develop lessons learned and best practices in order to share them with Member States in the region.

VI. STRENGTHS AND LIMITATIONS OF THE REPORT

Owing to the limitations of the available evidence, the results of this report should be interpreted with the following limitations.

- Studies assessing refugee and migrant health used inconsistent terminology and methodologies for assessing refugee and migrant health. There is a lack of a shared definition of migrants at the international level and it was challenging to stratifying data by migrant legal status (with and without documentation, and refugees).

- Although migration and forced displacement are increasing, there are a limited number of studies in the region; most of these were carried out in western countries, and none used clinical or social outcome measures for evaluating the impacts of defined practices.

- There is also relatively little information about the health status of, and health policies for, refugees and migrants, in particular irregular migrants. Moreover, the information available also often does not distinguish between documented and irregular migrants.

- Since the implementation of policies takes place at local level with the involvement of different actors and ministries (e.g. health, labour, foreign affairs, NGOs), it was not possible to ensure that all existing information had been collected, or to claim the completeness of the report.

- The findings may also highlight the lack of available research in the region on the subject. Although there has been some success in addressing refugee and migrant health, more research is needed to support development of good practice in this area.

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Annex 1: International Migrants in the WHO African Region

African Region Countries								
Major area, region or country of destination	Number of international migrants (thousands)		International migrants as percentage of total population		Females among international migrants (percentage)		Median age of international migrants (years)	
	2000	2017	2000	2017	2000	2017	2000	2017
Algeria	250	249	0.8	0.6	45.2	47.2	34.8	39.6
Angola	46	638	0.3	2.1	49.3	51.8	27.4	21.9
Benin	134	253	1.9	2.3	46.4	43.9	23.6	31.1
Botswana	57	166	3.3	7.3	42.4	45.3	30	34.1
Burkina Faso	520	709	4.5	3.7	51.8	52.4	16.7	31
Burundi	126	300	2	2.8	51.4	50.7	51.4	50.7
Cabo Verde	11	15	2.5	2.8	47.8	49.4	30.5	38.3
Cameroon	228	540	1.5	2.2	45.4	50.6	33.5	28.9
Central African Republic	124	89	3.3	1.9	46.9	47	27.9	32
Chad	105	490	1.3	3.3	46.1	53.9	22.5	25.9
Comores	14	13	2.5	1.5	52.8	51.6	31.9	36.7
Congo	305	399	9.5	7.6	49.9	45.2	28.5	31.9
Côte d'Ivoire	1994	2197	12	9	44.6	44.6	29.1	36.2
Democratic Republic of the Congo	744	879	1.6	1.1	51	51.3	23.9	28
Equatorial Guinea	5	222	0.7	17.5	47	22.9	32.4	33.8
Eritrea	13	16	0.4	0.3	47.1	44.6	30.1	31.2
Ethiopia	611	1227	0.9	1.2	47.3	49.1	29.4	22.1
Gabon	196	280	15.9	13.8	42.9	42.9	28.2	32
Gambia	183	205	14.8	9.8	46.8	47.3	25	30.8
Ghana	192	418	1	1.4	49.2	49.1	17.9	28
Guinea	560	123	6.4	1	50.2	41.1	21.2	27.6
Guinea-Bissau	20	23	1.6	1.3	50.3	51.5	21.2	25.6
Kenya	699	1079	2.2	2.2	50.1	50.1	20	24.6
Lesotho	6	7	0.3	0.3	45.9	45.9	26.7	37.3
Liberia	152	99	5.3	2.1	45.9	43	23.5	29.6
Namibia	134	95	7.1	3.8	46.1	46.1	29.6	35.2
Niger	122	296	1.1	1.4	52.4	52.6	22.5	25.2
Nigeria	488	1235	0.4	0.6	44.6	45.1	20.2	18.9
Madagascar	24	34	0.1	0.1	43.6	43	41.1	42.5
Malawi	233	237	2	1.3	52.1	52.4	31.5	34.5
Mali	189	384	1.7	2.1	48.4	48.8	18.6	26.9
Mauritania	57	168	2.1	3.8	45.7	43.5	26	25
Mauritius	16	29	1.3	2.3	63.3	44.6	28.8	39
Mozambique	196	247	1.1	0.8	47.3	51.1	24.6	30
Rwanda	347	443	4.3	3.6	49.4	50.2	29	29.2
Sao Tome and Principe	4	2	3.1	1.1	49.3	50	43.4	44.1
Senegal	232	266	2.3	1.7	47.6	46.9	27.9	29.1
Seychelles	7	13	8.1	13.6	41.6	30	33.4	37.8
Sierra Leone	98	95	2.2	1.3	44.4	45.2	23.5	28.6
South Africa	1002	4037	2.2	7.1	40.1	44.4	36.4	33.7
South Sudan	0	845	0	6.7	0	48.9	0	29.4
Swaziland	23	33	2.2	2.4	42.9	48.2	31.8	36.4
Togo	138	284	2.8	3.6	49.9	49.7	21.3	23.1
Uganda	635	1692	2.6	3.9	50.5	53.1	29.2	30.5
United Republic of Tanzania	928	493	2.7	0.9	49.3	50.1	31.2	34.3
Zambia	321	157	3	0.9	49.1	49.5	27	33.9
Zimbabwe	410	404	3.4	2.4	43	43.1	33.6	38.3
African Region Countries	**12899**	**22125**	**1.9**	**2.1**	**47.2**	**47.7**	**27.6**	**31.8**

Source: United Nations, Department of Economic and Social Affairs. Population Division (2017). Trends in International Migrant Stock.; United Nations, Department of Economic and Social Affairs (2017). International Migration Report 2017.

Annex 2: Contributions from Member States and Partners

Country	Contributor (number of submissions)	Type
Algeria	Ministry of Health	Member State
Botswana	ILO	Partner
Ethiopia	Federal Ministry of Health, UNHCR	Member State, UNHCR
Ghana	IOM	Partner
Kenya	IOM, UNHCR (NHIF)	Partner
Liberia	Ministry of Health	Member State
Mauritania	UNHCR	Partner
Mauritius	IOM	Partner
Sierra Leone	IOM	Partner
South Africa	ILO (2), Human Rights Council	Partner
South Sudan	IOM	Partner
Tanzania	UNHCR	Partner
Uganda	UNHCR	Partner
Zambia	UNHCR	Partner