International Conference on Refugees & Diabetes
10-12 April 2017 Dead Sea, Jordan

Conference Summary Report

International Conference on Refugees and Diabetes

Together for Refugees with Diabetes

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Dead Sea Declaration and Call to Action on Refugees and Diabetes

Under the patronage of HRH Princess Muna al-Hussein, the International Conference on Refugees and Diabetes, involving more than 75 representatives of the Ministries of Health from Jordan, Lebanon, Palestine and Sudan, bilateral agencies, civil society organizations, academia, the private sector and United Nations organizations, held at the Dead Sea in Jordan between 10 and 12 of April 2017, highlighted the challenge posed by diabetes in the refugee population – a source of suffering for individuals and their families, a great strain on health care systems and economies, and an impediment to the achievement of the Sustainable Development Goals and the pledge to leave no one behind.

The participants adopted the following declaration and urgent call to action.

I. We express grave concern about the growing crisis of diabetes in refugees:

The world is facing a humanitarian crisis. 65.3 million people have been forced out of their homes, and 26.5 million are considered refugees, including 5.2 million Palestine refugees registered with the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). They have been forced to leave their countries, living in fragile, insecure environments with uncertain access not only to health care, but also to livelihoods.

The countries in the Eastern Mediterranean Region of the World Health Organization (WHO) are the epicenter of this crisis. Refugees from Palestine and Syria alone now constitute 10.1 million people. Jordan, Palestine and Lebanon currently host 6.1 million refugees in total. Achieving the Sustainable Development Goals – not only SDG 3.8, universal health coverage for all by 2030, but the entire set of goals – will require a specific focus on the millions of vulnerable refugees worldwide.

According to WHO, the number of people with diabetes has risen from 108 million in 1980 to 422 million in 2014. WHO projects that diabetes will be the seventh leading cause of death by 2030 and notes that diabetes prevalence has been rising more rapidly in middle- and low-income countries.

The global prevalence of diabetes among adults over 18 years of age was 8.5 per cent in 2014. Among refugees, diabetes prevalence is estimated to be at least 50 per cent higher. People with diabetes need access to medicines and care, healthy food, and safe environments for physical activity. They also need information and guidance about how to manage their disease in order to prevent the development of complications.

Refugees and people displaced as a result of conflict have limited access to all of the above, in addition to psychosocial stress; this combination of factors causes suffering, exacerbates the

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1 UNHCR, 2015.
health issues of refugees with diabetes, and precipitates the onset of diabetes in predisposed and at-risk refugees.

Undiagnosed and poorly controlled diabetes may precipitate acute, life-threatening, and late-stage complications such as blindness, amputation, kidney failure, cardiovascular events and early death, inflicting suffering on individuals and their families and straining already-stretched health care resources. Yet diabetes care is not always fully integrated in humanitarian response plans, despite the serious burden it places on refugees and the health systems that serve them, including the host nations.

Whereas the rights of refugees are protected under a series of international frameworks;

And whereas
- The UN Sustainable Development Goals and
- The Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (NCD) specifically address the growing threat posed by NCDs, including diabetes

II. We appreciate that:
National health systems in the Eastern Mediterranean Region and elsewhere worldwide, as well as donor organizations, civil society and the private sector, are providing essential health care and making laudable efforts on behalf of vulnerable refugees every day.

III. We affirm that:

1. Protection from harm and entitlement for service is a prerequisite for effective humanitarian assistance;
2. The inclusion of the health needs of refugees living with diabetes and/or other non-communicable diseases in humanitarian preparedness and responses strategies and plans should be considered;
3. Delivery of structured, uninterrupted access to quality diabetes care with financial protection, to prevent life-threatening and debilitating complications, should be an integral component of public policies and programs directing health services for refugees and displaced populations, without discrimination on the basis of gender, age, religion, nationality, race, or health or legal status;
4. Investment in the prevention of diabetes, its comorbidities and complications by providing structured care may reduce disability, improve quality of life and is cost-effective;

2 Main international frameworks in this regard:
- The UN Convention Relating to the Status of Refugees developed in 1951, also known as the 1951 Refugee Convention;
- The 1967 Protocol Relating to the Status of Refugees;
- The 1974 United Nations Declaration on the Protection of Women and Children in Emergency and Armed Conflict;
- The New York Declaration for Refugees and Migrants adapted by the UN General Assembly at its seventieth session, on 19 September 2016;
- The World Health Assembly resolution (WHA61.17) on the health of migrants;
- The Outcome document of the High-level Meeting on Refugee and Migrant Health, Rome, Italy, November 2015.
5. Although evidence-based best practices in diabetes care for refugees exist, more research is needed, and should be used as a platform for improving prevention, treatment and care for refugees worldwide;

6. Inter-sectoral, inter-country and inter-agency coordination and collaboration mechanisms working towards improving the health of refugees with diabetes and other related comorbidities should be pursued;

7. Social, economic and environmental factors that are amplifying the numbers of refugees affected by diabetes, related comorbidities and late complications need to be addressed urgently;

8. Focusing on diabetes is likely to improve health system capacity to manage other related NCDs and comorbidities, as chronic disease management and care has many commonalities across disease areas; and

9. Sustainable financing to fulfill these obligations should be secured.

IV. We commit ourselves to addressing the prevention and care of diabetes in refugee populations by working to:

1. Strengthen health systems to provide universal access to essential health services, including diabetes care to refugees and displaced populations in need;

2. Ensure that diabetes care is part of health system response plans for emergencies and refugee situations, with the mechanisms required to deliver diagnostics, medicines, and referral services to refugees, including for uninterrupted diabetes care;

3. Promote refugee and migrant-sensitive health services that are culturally, linguistically, age, gender and context appropriate;

4. Continue advocating for adequate and sustainable financing mechanisms for providing health care to refugees, including effective diabetes care delivery;

5. Emphasize and promote partnerships and inter-sectoral/multisectoral coordination mechanisms among governmental and non-governmental agencies to deliver health care to refugees, including diabetes care;

6. Establish and implement standards, guidelines and procedures as well as proper task-based training for available health care providers to deliver effective diabetes care to refugees;

7. Ensure proper mechanisms for data collection, to document, monitor, evaluate and continuously improve care for refugees with diabetes while respecting patient privacy; and

8. Conduct operational research to improve prevention and diabetes care for refugees, including cost-effectiveness studies, and share better practices.

V. We call upon our partners and other stakeholders to:

1. Include diabetes care in all humanitarian responses, both during the acute phase and protracted phase of an emergency;

2. Establish supporting mechanisms including an essential package for diabetes and other common non-communicable diseases in emergency kits; and

3. Strengthen health systems to provide care for common non-communicable diseases at the primary care level.

Through this declaration, we hope to inspire ourselves and our partners to live up to the responsibility and capacity of each organization to address the crisis of diabetes in refugee populations worldwide.
المؤتمر الدولي حول اللاجئين ومرض السكري
البحر الميت، الأردن
10 إلى 12 نيسان/ إبريل 2017
إعلان البحر الميت ودعوة للعمل بشأن اللاجئين والسكري

تحت رعاية صاحبة السمو الملكي الأميرة منى الحسين المعظمة، عقد المؤتمر الدولي حول اللاجئين ومرض السكري - الشديدة ضغطاً - الذي يشكل مرض السكري لللاجئین، وهو مصدر لمعاناة الأفراد، ويشكل صعوبةً شديدةً على نظام الرعاية الصحية والاقتصاديات، ويقف كعقبة تحول دون تحقيق أهداف التنمية المستدامة والتعهد بعده. ترك أحد في الوراء.

وقد تبنى المشاركون الإعلان التالي والدعوة العاجلة إلى العمل.

أولاً: نعرب عن قلقنا البالغ إزاء التصاعد المستمر في أزمة مرض السكري لدى اللاجئين:

إن العالم يواجه حالياً أزمة إنسانية. حيث أجري 65.3 مليون شخص على ترك منازلهم، و 26.5 مليون يعتبرون لاجئين، بنم فيهم 5.2 مليون لاجئ فلسطيني مسجل لدى وكالة الأمم المتحدة لغذاء وتشغيل اللاجئين الفلسطينيين في الشرق الأدنى (الأونروا). وقد دفع كل هؤلاء إلى مغادرة بلدانهم بالقوة، ويعيشون في بيئات هشة وغير آمنة، مع قدرتهم غير المؤكدة، ليس فقط على الحصول على الرعاية الصحية، بل وعلى العيش على سبل العيش أيضاً.

إن بلدان إقليم شرق المتوسط، التابعة لمكتب منظمة الصحة العالمية في هذا الإقليم، تشكل مركز هذه الأزمة.

ويشكل اللاجئون الفلسطينيون والسوريون وحدهم الآن حوالي 10.1 مليون شخص. كما يستضيف كل من الأردن وفلسطين ولبنان حاليًا 6.1 مليون لاجئ في المجم. وقد اتخذوا إجراءات لتحسين النمط الصحي للمستقبل. ليس فقط الأهداف الصحية للمستقبل، بل تحقيق أهداف التنمية المستدامة - ليس من أجل الهدف الإنمائي للتنمية المستدامة رقم 3.8 أي التغذية الصحية الشاملة للجميع بحلول عام 2030، بل لجميع الأهداف بأكملها - تركز خصوصاً على مواجهة اللاجئين الضغوط في جميع أنحاء العالم.
وبوفقاً لمنظمة الصحة العالمية، فقد ارتفع عدد المصابين بمرض السكري من 108 مليون في عام 1980 إلى 422 مليون في عام 2014. وتشير تنبؤات منظمة الصحة العالمية إلى أن مرض السكري سيكون السبب الرئيسي السابق للوفاة بحلول عام 2030، وتركز على أن انتشار مرض السكري أخذ في الارتفاع بسرعة أكبر بين السكان في البلدان متوسطة ومنخفضة الدخل.

وكان معدل الانتشار العالمي لمرض السكري بين البالغين الذين تزيد أعمارهم عن 18 عاماً حوالي 8.5 في المائة في عام 2014. وبين اللاجئين، يقدر بأن معدل انتشار مرض السكري أعلى بحوالي 50 في المائة من ذلك على الأقل. ويحتاج الأشخاص المصابون بمرض السكري إلى الحصول على الأدوية والرعاية الصحية والغذاء الصحي والبيئات الآمنة للنشاط البدني. كما أنهم بحاجة إلى معلومات وتوجيهات حول كيفية إدارة مرضهم من أجل منع ظهور وتطور مضاعفهم.

ويعاني اللاجئون والأشخاص المشردون نتيجة للنزاعات من ضعف إمكانية الوصول إلى كل ما سيق بالإضافة إلى تعرضهم إلى الإجهاد النفسي الاجتماعي؛ وهذا الجمع بين عوامل متعددة يسبب المعايير الشديدة لهم، ويزيد من تفاقم القضايا الصحية للأفراد المصابين بمرض السكري، ويعجل من تطور مرض السكري لدى اللاجئين الذين لديهم الاستعداد للإصابة به، وأولئك المعترضين على الإصابة به.

قد يؤدي مرض السكري غير المشخص وسوء السيطرة عليه إلى تجلب المضاعفات الحادة والمهدة للحياة، إضافة إلى مواجهة المضاعفات المتأنئة لمرض السكري مثل العقم ويت الأطراف والفشل الكلوي والأمراض القلبية الوعائية والوفيات المبكرة، ما يسبب المعاناة للآخرين، ويجعل مرحلة الرعاية الصحية المجيدة أصلاً.

ومع ذلك، فإن رعاية مرض السكري ليست دائمًا متممة تمامًا في خطط الاستجابة الإنسانية، على الرغم من العتب الخطر الذي تفرضه على اللاجئين وعلى النظم الصحية التي تخدمهم، بما في ذلك شعوب الدول المضيفة.

وحيث أن حقوق اللاجئين محمية بموجب سلسلة من الات دولية 3;

وقال:

أهداف الأمم المتحدة للتنمية المستدامة; و

الإعلان السياسي الصادر عن الاجتماع الرفيع المستوى للجمعية العامة بشأن الوقاية من الأمراض غير السارية ومكافحتها.

3 Main international frameworks in this regard:
- The UN Convention Relating to the Status of Refugees developed in 1951, also known as the 1951 Refugee Convention;
- The 1967 Protocol Relating to the Status of Refugees;
- The 1974 United Nations Declaration on the Protection of Women and Children in Emergency and Armed Conflict;
- The New York Declaration for Refugees and Migrants adapted by the UN General Assembly at its seventieth session, on 19 September 2016;
- The World Health Assembly resolution (WHA61.17) on the health of migrants;
- The Outcome document of the High-level Meeting on Refugee and Migrant Health, Rome, Italy, November 2015.
يعالج بالتحديد التهديد المتزايد الذي تشكله الأمراض غير السارية، بما في ذلك مرض السكري.

ثانياً: ننظر بالتقدير إلى:

تقديم النظم الصحية الوطنية في إقليم شرق المتوسط وغيره من أنحاء العالم، فضلاً عن المنظمات المانحة والمجتمع المدني والقطاع الخاص، لخدمات الرعاية الصحية الأساسية وبدل الجهد الجدير بالثناء لصالح اللاجئين الضعفاء بشكل مستمر وفي كل يوم.

ثالثاً: نؤكد على أن:

الحماية من الأذى واستحقاق الخدمة شرط مسبق للمساعدة الإنسانية الفعالة؛

10. ينبغي الأخذ بعين الاعتبار إدراج الاحتياجات الصحية للأجئين الذين يعيشون مع مرض السكري أو الأمراض المزمنة غير المعدية الأخرى ضمن الاستعدادات الإنسانية واستراتيجيات الاستجابة والخطط المتعلقة بذلك.

11. ينبغي أن يكون إيصال خدمات الرعاية الصحية على نحو منتظم ودون انقطاع، مع توفير إمكانية الوصول إلى الرعاية ذات الجودة لمرض السكري مع الحماية المالية، من أجل منع المضاعفات المهينة للحياة والمدمجة، جزء لا يتجزأ من السياسات والبرامج العامة التوجه نحو الخدمات الصحية للأجئين والأشخاص المشردين دون تمييز على أساس النوع الاجتماعي، أو العمر، أو الدين، أو الجنسية، أو العرق، أو الوضع الصحي أو القانوني؛

12. الاستمرار في الوقاية من مرض السكري والاعتلالات المشتركة معه ومضافاته من خلال توفير الرعاية الصحية المنظمة، والذي قد يقلل من احتمالات الإصابة بالإعاقة وتحسين نوعية الحياة في حالة فعالاً من حيث الكلفة المالية.

13. وعلى الرغم من وجود ممارسات فضلى ومستندة على الأدلة في مجال رعاية مرضى السكري من اللاجئين، فإنه يلزم إجراء المزيد من البحوث، والتي ينبغي أن تستخدم كمنصة لتحسين عمليات الوقاية والعلاج والرعاية للأجئين في جميع أنحاء العالم.

14. ينبغي متابعة آليات التنسيق والتعاون بين القطاعات المختلفة، وبين البلدان وبين الوكالات التي تعمل على تحسين صحة اللاجئين المصابين بمرض السكري وغيره من الأمراض المصاحبة ذات الصلة.

15. هناك حاجة ملحة إلى التصدي العاجل للعوامل الاجتماعية والاقتصادية والبيئية التي تضخم أعداد اللاجئين المتضررين من مرض السكري، والأمراض المصاحبة ذات الصلة والمضاعفات المتلاحقة له.

16. من المرجح أن يؤدي التركيز على مرض السكري إلى تحسين قدرة النظم الصحية على إدارة الأمراض غير السارية والأمراض المصاحبة الأخرى ذات الصلة، نظرًا إلى أن إدارة الأمراض المزمنة ورعاية المصابين بها لها أوجه مشتركة عدة ضمن المجالات المختلفة للأمراض؛ و
18. ينبغي تأمين التمويل المستدام للفوائد بهذه الاتفاقات.

رابعاً: نلتزم بمعالجة عملية الوقاية من مرض السكري ورعايته في صفوف اللاجئين من خلال العمل على:

1. تعزيز النظام الصحي لتقديم الوعي الشامل للجميع إلى الخدمات الصحية الأساسية، بما في ذلك تقديم الرعاية لمرضى السكري من اللاجئين والجماعات المشتركة من المحتاجين.

التاكيد من أن الرعاية المقدمة لمرضى السكري هي جزء من خطط الإستجابة للنظم الصحية لحالات الطوارئ والحالات اللاحقة، إضافة إلى الأليات اللازمة لتقديم خدمات التشخيص للمرض والأدوية وخدمات التحويل لللاجئين، بما في ذلك الرعاية المستمرة وغير المنقطدة لمرضى السكري.

3. تعزيز الخدمات الصحية المناسبة ضمن السياق المناسب، ذات الطابع الثقافي واللغوي والعمر والعنوان الاجتماعي، إلى اللاجئين والمهجرين.

4. مواصلة الدعوة إلى إيجاد آليات تمويل كافية ومستدامة لتقديم الرعاية الصحية للاجئين، بما في ذلك تقديم الرعاية الفعالة لمرض السكري.

5. تشديد توزيع الشروط والآليات التنسيق المشتركة بين القطاعات المختلفة وبين الوكالات الحكومية وغير الحكومية من أجل تقديم الرعاية الصحية للاجئين، بما في ذلك رعاية مرضى السكري.

6. وضع وتنفيذ المعايير والمبادئ التوجيهية والإجراءات، فضلاً عن تقديم التدريب المناسب القائم على المهام لتقديم الرعاية الصحية المناسبة لتقديم الرعاية الفعالة لمرضى السكري لللاجئين.

7. ضمان أن تشمل النظم الصحية للاجئين المسابين مرض السكري ومرض السكري غير المعدية الشائعة على مستوى الرعاية الصحية الأولية.

8. إجراء بحوث إجرائية لتحسين الرعاية المقدمة للسكري ومرض السكري، بما في ذلك دراسات فعالية التكلفة، وتبادل الممارسات الأفضل.

خامساً: ندعو شركائنا وأصحاب المصلحة من الجهات المعنية إلى:

1. إدراج رعاية مرضى السكري ضمن جميع الاستجابات الإنسانية، سواء خلال المرحلة الحادة أو المرحلة الممتدة من حالة الطوارئ.

2. إنشاء أليات داعمة تشمل وجود حزمة أساسية لرعاية مرضى السكري، وسر النزاعات غير المعدية الشائعة في جميع الحالات الخاصة بحالات الطوارئ.

3. تعزيز النظام الصحي لتقديم الرعاية للأمراض المزمنة غير المعدية الشائعة على مستوى الرعاية الصحية الأولية.

نأمل من خلال هذا الإعلان أن نساهم أنفسنا ونعمل لشركائنا للاحتكاك إلى قدر المسؤولية ونقول قدرة كل منظمة لتوضيح مدى خطورة ارتفاع مرض السكري لدى مجتمعات اللاجئين في جميع أنحاء العالم.
List of all the organizations which have endorsed the Declaration

(Kindly notice that the organizations are arranged alphabetically)

- Aden Diabetes Centre
- American University of Beirut, Lebanon
- Augusta Victoria Hospital, Jerusalem
- Birzeit University, West bank
- Dan Church Aid, Jerusalem
- Danish Refugee Council
- Department of Palestinian Affairs
- International Federation of Red Cross and Red Crescent Societies (IFRC) - Jordan
- International Organization for Migration (IOM)
  - IOM - Jordan
  - IOM - Lebanon
- Jordan Health Aid Society
- Jordanian Red Crescent
- Juzoor for Health & Social Development, West Bank
- Lebanese Diabetes Association
- Médecins Sans Frontières (MSF) OCA-Jordan
- Micro Clinic International
- Ministry of Health - Iraq
- Ministry of Health - Lebanon
- Ministry of Health - Jordan
- Ministry of Health - Northern State/Sudan
- Ministry of Health - Palestine
- National Diabetes Center - Jordan
- Noor Al Hussein Foundation
- Palestinian National Institute of Public Health PNIPH – WHO
- Royal Health Awareness Society (RHAS)
- Santé Diabète Mali, West African Countries
- The International Committee of the Red Cross (ICRC)
- Turkish Diabetes Foundation
- United Nations High Commissioner for Refugees (UNHCR)
  - UNCHR - Jordan
  - UNHCR - Lebanon
- United Nations International Children’s Emergency Fund (UNICEF)
- Jordan Country Office
- World Diabetes Foundation
- World Food Programme-Egypt
- World Health Organization
- World Health Organization – EMRO
- UNRWA
  - UNRWA - HQ (A)
  - UNRWA - Gaza
  - UNRWA - Jordan
  - UNRWA - Lebanon
  - UNRWA - Syria
  - UNRWA - West
## AGENDA

### Day 1: Monday, 10 April 2017

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<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Organizer/Chairperson</th>
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| 08:00-08:50 | Reception, Registration and Capturing Individual Photos  
Meeting with the Media (08:30-08:50):  
- Briefing for the Media on the Conference Objectives.  
- Q & A by Media Representatives | Organizing Committee Members  
Ms. Gwendolyn Carleton  
(WDF) & Dr. Yassir Turki  
(UNRWA) |
| 09:00-09:20 | Opening Session (All distinguished participants are requested to attend):  
- Welcoming Speech by UNRWA (Front Office)  
- WDF Representative (Managing Director)  
- Speech by the Director/ Department of Palestinian Affairs |  |
| 09:40-10:10 | Media interviews with guests and participants |  |
| 10:10-10:40 | Coffee Break |  |
| 10:40-11:15 | **Refugee Patients with Diabetes and Health Care Providers:**  
Sharing Experience in Managing the Disease and its On-site Challenges | **Two refugees:**  
one Syrian  
one Palestinian |
| 11:15-11:40 | Introductory note about the conference agenda (background paper) | Dr. Anil Kapur |
| 11:40-12:00 | United Nations High Commissioner for Refugees (UNHCR)  
Diabetes Care Provision to Refugees Globally and Specifically in the MENA Region. | Dr. Michael Woodman  
UNHCR, Lebanon & Dr. Dina Jardaneh, UNHCR, Jordan |
| 12:00-12:20 | World Health Organization (WHO):  
WHO priority actions to support to improve NCD/diabetes care provision during emergencies | Dr. Slim Slama  
WHO/EMRO |
<table>
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<tr>
<th>Time</th>
<th>Event</th>
<th>Presenter(s)</th>
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| 12:20-12:40 | **World Diabetes Foundation**  
Diabetes in Humanitarian Settings – Experiences from the World Diabetes Foundation | Mr. Jakob Sloth Yigen Madsen, WDF                |                                                 |
| 12:40-13:00 | **United Nations Relief and Works Agency for Palestine Refugees (UNRWA):**  
Diabetes and Hypertension Care Provided to Palestine Refugees | Dr. Yousef Shahin, UNRWA                        | Prof. Jørn Nerup                                  |
| 13:00-13:30 | **Panel discussion**                                                   | Presenters session 1                              |                                                 |
| **13:30-14:30** | **Lunch Break**                                                        |                                                  |                                                 |
| **14:30-14:30** | **Session 2: Practices and Experiences in Delivering Diabetes Care to Refugees** |                                                 |                                                 |
| 14:30-14:45 | **Ministry of Health (MoH), Jordan:**  
Experience in Delivering NCD care, Focusing on Diabetes, to Public and Refugees | Dr. Rifqi Ismail, MOH, Jordan                    |                                                 |
| 14:45-15:00 | **Ministry of Health (MoH), Palestine:**  
Experience in Delivering NCD care, Focusing on Diabetes, to Public and Refugees | Dr. Nancy Falah, MOH, Palestine                  | Prof. Knut Borch-Johnsen                        |
| 15:00-15:15 | **Ministry of Health (MoH), Lebanon:**  
Experience in Delivering NCD care, Focusing on Diabetes, to Public and Refugees | Dr. Ibrahim Bou Orm, MOH, Lebanon                |                                                 |
| 15:15-15:30 | **Ministry of Health (MoH), Iraq:**  
Experience in Delivering NCD care, Focusing on Diabetes, to Public and Refugees | Dr. Riyadh Nayel, MOH, Iraq                      |                                                 |
| 15:30-16:00 | **Panel discussion**                                                   | Presenters in session 2                          |                                                 |
| **16:00-16:15** | **Coffee Break**                                                        |                                                  |                                                 |
| **16:15-16:30** | **Session 3: Practices and Experiences in Delivering Diabetes Care to Refugees** |                                                 |                                                 |
| 16:15 - 16:30 | **Médecins Sans Frontières (MSF):**  
Challenges and Experiences in Delivering Direct Diabetes Care Services to Refugees | Dr. Peter Garrett, MSF                           | Prof. Knut Borch-Johnsen                        |
| 16:30-16:45 | **International Organization for Migration (IOM):**  
Diabetes among Refugees Seeking Resettlement (Approach and Challenges) | Dr. Rasha Shoumoar, IOM                         |                                                 |
| 16:45 - 17:15 | **Panel discussion**                                                   | Presenters in session 3                          |                                                 |
Day 2: Tuesday, 11 April 2017

Tools for the provision of NCD care during emergencies and refugee situations

Session 1: Research and studies on delivering diabetes care in the MENA region

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<th>Time</th>
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<tr>
<td>08:30-08:50</td>
<td>American University of Beirut: Operational Research on Diabetes Care in Refugee Setting</td>
<td>Dr. Fouad Fouad, AUB</td>
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<tr>
<td>08:50-09:10</td>
<td>National Center Diabetes, Endocrinology and Genetics, Jordan, (NCDEG) The NCDEG Experience on Diabetes Care to Patients with Diabetes and Refugees in Jordan</td>
<td>Dr. Mousa Abu Jbaraa, NCDEG</td>
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<tr>
<td>09:10-09:30</td>
<td>Birzeit University: Diabetes Research in Palestine</td>
<td>Dr. Abdullatif Hussein, BZU</td>
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<tr>
<td>09:30-10:00</td>
<td>Panel Discussion</td>
<td>Presenters in session 1</td>
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10:00-10:30 Coffee Break

Session 2: Other countries’ experiences in delivering diabetes care to refugees

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<tr>
<td>10:30-11:00</td>
<td>The West African Experience on provision of Diabetes care: (Presentations followed by Q&amp;A)</td>
<td>Mr. Stéphane Besançon, CEO of NGO Santé Diabète</td>
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<tr>
<td>11:00-12:00</td>
<td>Panel discussion (Diabetes care in Turkey, Yemen and Sudan with Focus on Refugees) Prof. Sehnaz Karadeniz; (Head of Board) and IDF EUR President) Dr. Abdulla M A Almatary; Associated Prof. of Medicine Faculty of Medicine Aden University, Head of Aden Diabetes Friends Association, Director of Aden Diabetes Center Dr. Sulieman Abdgabbar Abdullah, Director General of the Ministry of Health</td>
<td>Panel Discussion with the 3 Speakers</td>
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<tr>
<td>12:00-13:00</td>
<td>Preparation for group discussion</td>
<td>Dr. Anil Kapur and Prof. Jørn Nerup</td>
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13:00-14:00 Lunch Break

Chairperson Dr. Anil Kapur
### Session 5: Working Groups Session

**14:00-15:30**

**Working groups session:**
- To improve the provision of Diabetes Care during Emergencies and Refugee Situations:
  - Access to NCD Care with Focus on Diabetes
  - Surveillance; Monitoring and Evaluation of NCD with Focus on Diabetes
  - Promotion and Awareness of Healthy Life Style among Refugees with Diabetes.
  - Psychosocial Support to Patients (Refugees) with Diabetes

<table>
<thead>
<tr>
<th>Group Discussion</th>
<th>Representatives of the Working Group</th>
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<tr>
<td>Dr. Anil Kapur, Prof. Jørn Nerup Prof. Knut Borch-Johnsen</td>
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<th>15:30 -15:45</th>
<th>Coffee Break</th>
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<th>15:45-16:00</th>
<th>Presentations by Working Groups</th>
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### Day 3: Wednesday, 12 April 2017

**Way Forward and Actions for Better Diabetes Care to Refugees**

**Session 7: Wrap up and Conclusions by Consultants (presentations)**

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<tr>
<th>9:00-9:30</th>
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<td>9:30-10:30</td>
<td>Panel Discussion (Consultants A&amp;Q)</td>
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<th>10:30 -11:00</th>
<th>Coffee Break</th>
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**Session 8: Action plan by Consultants**

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<thead>
<tr>
<th>11:00-12:30</th>
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<tr>
<td>12:30-13:00</td>
<td>Declaration of the Conference Call Concerning Refugees and Diabetes</td>
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<tr>
<td>13:00-13:30</td>
<td>Wrap up and Conclusions</td>
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<tr>
<td>13:30-14:00</td>
<td>Final Remarks and Closing (UNRWA &amp; WDF)</td>
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<tr>
<th>All participants</th>
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<tbody>
<tr>
<td>Dr. Anil Kapur, Prof. Jørn Nerup Prof. Knut Borch-Johnsen</td>
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<tr>
<td>Dr. Yassir Turki, Health Communication Officer, UNRWA,HQA</td>
</tr>
<tr>
<td>Drs. Slim Slama, Rifqi Ismael, Dina Jardaneh &amp; Yousef Shahin</td>
</tr>
<tr>
<td>Dr. Akihiro Seita Mr. Anders Dejgaard</td>
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International Conference on Refugees and Diabetes
10-12 April 2017
Dead Sea, Jordan

Background
The first International Conference on Refugees and Diabetes under the patronage of HRH Princess Muna Al-Hussein was held from 10-12 April 2017 at Crowne Plaza Hotel, Dead See, in Jordan. The Conference was co-chaired by United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) jointly with the World Diabetes Foundation (WDF), who kindly offered the financial support for this very important event. It was attended by experts and representatives from different UN organizations, Governmental and non-governmental as well as Academia and local community representatives.

1. The main goals of the Conference were:

A) Proposing practical solutions for better coordinated health care for refugees, with a focus on diabetes prevention and management among them based on their experiences and best practices.

B) Building up an action plan to implement best practices in diabetes care for refugees and a declaration on that at the end of the conference.

2. The main objectives were:

A) To share experiences and best practices among participates concerning diabetes prevention and management among refugees.

B) To establish a joint coordination mechanism between different key organizations providing NCD care (and in particular diabetes care) to refugees.

C) To identify tools for the provision of NCD care during emergencies and refugee situations; including medicines supplies and medical devices required for the management of the most common NCDs in primary care.

D) To establish working groups with relevant key organizations from refugee host countries to ensure the implementation of action plans and to enhance the sustainability of quality diabetes care for refugees.
Day 1 (10 April 2017)

Views and Experiences on NCD Care, with Focus on Diabetes Care provided to Refugees

SESSION 1: Practices and Experiences in Delivering Diabetes Care to Refugees

Refugee Patients with Diabetes and Health Care Providers: Sharing Experience in Managing the Disease and its on-site Challenges

Um Mohammad, a Syrian female refugee and mother of Mohammad, a 9-year-old boy diagnosed with Diabetes Type I eight months ago. The family lives in Za’atari camp and she brought her son to the health center when she noticed that he was listless and frequently going to the toilet to pass urine. The boy was tested and referred to the hospital in the camp where he was tested again and found to have very high blood sugar. At the beginning she didn’t believe the diagnosis as she thought that diabetes is a disorder that can only be inherited and nobody in her or her husband’s family had it. The doctors explained to her and referred them to Jordan Hospital where he was admitted for a 7-day treatment initiated under close supervision until his sugar levels were stable. The mother was referred to the hospital nutritionist who explained her how to prepare healthy food. At the beginning she was upset that she could not offer sweets and chocolates to her son, but now he has adapted to the new diet and he is careful and active again. Initially, his blood sugar would fluctuate a lot and he would get low and high blood sugar levels. Until he became stable, he didn’t go to school but now teachers know about his situation and support his care. There was a lack of coordination between the health and educational sectors - she had to explain her son’s condition to the teachers and ask them to permit him to eat in the class if he felt hypoglycemia and be lenient with his requests to visit the toilet. She explained that Mohammad is entitled to free insulin and medical follow up in the camp; and they also were provided cover for hospitalization and transportation for the time they were in hospital. They don’t have 24/7 electricity in the camp so she stores the insulin in the refrigerator of neighbors. She wishes one day there will be a cure. Her major concern now is that the injections are painful. She received health education about food and where and how to give insulin injections. The boy can test himself but cannot do the injections so she wishes they could get access to insulin pens which are easier for self-injection and less painful.

Abu Jamal introduced himself as a Type 2 diabetes patient. He was diagnosed 10 years ago with a fasting blood sugar level in excess of 400 mg/dl. He was forced to leave his home in south Palestine in 1948 and he went to Gaza where he lived until 1967 when he was expelled again due to conflict and moved to Jordan. He was well received in Jordan and is very grateful to the Kingdom of Jordan and UNRWA that are providing support. He discovered he had diabetes at the health center in Marka Camp in Amman. He explained that life in a refugee camp is very difficult and living there is an open invitation to diabetes, high blood pressure, kidney failure, heart attacks and early death. He explained that his blood sugar values are quite high and the anxiety and stress make the condition worse. Because of his poor control he has had several complications, particularly related to the foot including ulcers and near gangrene. But he stated that he was provided good care by the UNRWA staff which prevented amputation and they gave him health education and they follow him closely through home visits, even calling him to check his status and remind him of the appointments for checkup.
Introductory note about the conference agenda: Challenges for diabetes care in low resource settings by Dr. Anil Kapur

The diabetes burden is global, but 79% of patients live in middle and low income countries and 88% of deaths due to diabetes occur in these countries. It is important to understand the challenges of diabetes care in low resource settings in order to fathom how conflict situations and refugee settings worsen the problem further. The slow, insidious onset of type 2 diabetes and its asymptomatic nature, coupled with poor knowledge and health awareness, results in people with diabetes seeking help only when serious complications have developed. The window for prevention is small as there is little opportunity or incentive for screening and the condition is asymptomatic until very late.

Health care systems are built around delivering clinical care, not patient empowerment, but diabetes demands a lot of discipline and self-care. Because of its chronic and unrelenting nature, diabetes causes mental fatigue and coping difficulties leading to drop outs; this requires counseling, encouragement and emotional support. Health systems fail to involve non-medical social networks - patient peers, family and community to provide such support.

Poverty is a predictor for higher risk, delayed diagnosis, ineffective care, poor outcomes and higher mortality. And poor outcomes are drivers for catastrophic expenses, indebtedness and a decreased future earning capacity. So the economic impact of diabetes affects the present as well as the future. Treatment
and prevention of diabetes is cost effective. Not treating the disease is expensive, and treating it badly is even more expensive.

Funding for diabetes is a problem because donors don’t see diabetes as important. There are a lot of myths about diabetes and NCDs prevention – for example, these conditions are a problem of rich people, a consequence of personal choices, inevitable due to aging, not a threat for global health, and/or very costly to treat.

Conflict and displacement multiply the problems for people with diabetes: the need to balance medications, food intake and physical activity is under threat in conflict situations. Moreover the health system’s challenges in delivering care are exaggerated by the fragile environment.

Relief agencies need to have policies and operating procedures to ensure that diabetes supplies including oral drugs and different types of insulin are included in standard relief packages.

The cost of care is a big challenge for refugees: people may be forced to seek private care or pay out of pocket for medications and diabetes supplies.

Significant reductions in health-related quality of life are more likely to affect the vulnerable – those in lower socio-economic strata, women and the elderly. Rising obesity levels among women in the refugee populations, including those in the reproductive age, increase the risk of hyperglycemia during pregnancy and without proper screening this may be missed. Pregnant refugee women have delayed initiation as well as poor access to antenatal services. Poor access may result in missed or delayed diagnosis of hyperglycemia during pregnancy resulting in greater maternal and perinatal morbidity.

Moreover, starvation or inadequate nourishment during pregnancy, even for a few days during critical phases of fetal development, increase the risk of future diabetes and NCDs through developmental programing. Similarly, maternal obesity or overweight and gestational diabetes also increase the risk of diabetes in the offspring. So while diabetes and other NCDs are labelled non-communicable because they cannot be transferred from one person to the other, in fact due to fetal programing the risk factors for diabetes and other NCDs are being transmitted from mother to child. This is particularly relevant in refugee settings where maternal nutrition and health may not receive adequate attention.

The rise of diabetes among refugee populations has the potential to exacerbate another major public health problem: tuberculosis. Diabetes mellitus triples the risk of TB and increases the probability of adverse TB treatment outcomes such as delayed sputum conversion, treatment failure, recurrence and death.

But diabetes also offers the best opportunity for integrating prevention and care of communicable diseases, nutrition, mental health and NCDs at the primary care level.

**Diabetes Care Provision to Refugees Globally and Specifically in the MENA Region**

**By Dr. Dina Jardaneh, UNHCR, Jordan and Dr. Michael Woodman UNHCR Lebanon**

The Household Assessment in 2016 done by UNHCR showed that half of the interviewed people had one adult with a chronic health condition in the family. 30-40% cannot access medical care mainly due to the inability of the facilities to offer services in Lebanon, and in other countries because of the high cost.

The top two NCDs are diabetes and hypertension.

Premature deaths due to NCDs are as high as 32.3% and constituted 18.4% of overall mortality in Za’atri camp in 2016.
UNHCR Public Health Strategy is to promote integration of refugee health care within the existing health system wherever possible, and to support MoH in the hosting country to enable this and to provide parallel service only when necessary to fill gaps. The strategy is to shift from specialist care to general practitioners and nurses, especially for the routine management of stable patients.

The main challenges are:

- Improving access to care and moving towards universal health coverage for refugees and the host community
- Improving and ensuring quality of care
- Access to affordable medication (free or highly subsidized, but often there is a lot of out of pocket). It is important to lobby the pharmaceutical industry to make quality low-priced products available.
- Acceptability of and compliance to treatment
- Task shifting
- Active case finding (a lot of people are unaware of their status)
- Addressing risk factors and behavioral changes
- Reducing the need for expensive secondary and tertiary care caused by poorly managed NCDs at the primary level

**WHO priority actions to support improvements in NCD/diabetes care provision during emergencies By Dr. Slim Slama WHO/EMRO**

The world is aging, we are facing an epidemiological transition, populations are becoming more urban, and there are an increasing number of man-made complex emergencies.

NCDs burden in Eastern Mediterranean Region: NCDs account for more than 57% of all deaths. EMRO has experienced the greatest rise in diabetes prevalence and is the region that accounts for more than 50% of the world’s refugees.

From a regional situation analysis, it appears that conflict, denial of humanitarian access with protection, and attacks on healthcare facilities and providers are the main barriers in acute and protracted emergency situations. Shortages of medicines and medical supplies and out of pocket expenses for medicines are important factors for access to care for refugees. Often the insufficient readiness of health system and humanitarian actors due to lack of capacity (human and infrastructure) and protocols for emergency care, poor quality of care, tension between host population and refugees in accessing the same scarce resources are other aspects affecting the care and management of diabetes and other NCDs for refugees.

Advocating for inclusion of NCDs in humanitarian relief response, documenting and learning from current experiences for future improvements, and developing tools and service packages and coordination mechanisms between the different stakeholders (WHO, UN agencies, NGOs) should be prioritized.
WHO is working on a NCD health emergency kit: a pre-packed set of essential medicines, medical materials and devices to meet the needs of 10,000 people for three months and to be used in settings where regular supply has been disrupted. This will include specific items for diabetes management and will initially be deployed in Iraq and Syria.

A coalition of partners can help support advocacy, facilitate access to essential drugs, support and carry out operational research to develop innovative service delivery packages, help build capacity and tailor guidelines and protocols suitable for emergency situations.

**Diabetes in Humanitarian Settings – Experiences from the World Diabetes Foundation**

*By Mr. Jakob Sloth Yigen Madsen*

The World Diabetes Foundation has 15 years of experience supporting multiple projects in Jordan, Lebanon and Palestinian territories that specifically address diabetes prevention and care for refugee populations.

The West Bank and Gaza projects deal with a complex health care system where 56% of population has little or no access to health care.

WDF has worked with Dan-ChurchAid and the Augusta Victoria Hospital over the last 15 years and supported many projects; a center of excellence for diabetes care in Palestine was established at the Augusta Victoria Hospital, supported mobile clinics to operate in remote areas, and helped build capacity of PMoH and UNRWA staff. These initiatives catalyzed the development of the national guidelines by the PMoH and improved capability to prevent and manage diabetes complications. Moreover, these projects have advocated for increased investments and support with local and international stakeholders.

WDF partnerships with UNRWA introduced foot care for refugees in Gaza, psychosocial support for diabetes patients in West Bank, an assessment of the quality of care provided by UNRWA and a clinical audit of 1,600 diabetes patients in West Bank, Gaza, Jordan and Lebanon.

With St. John's Eye Care Hospital, WDF established a referral center for eye care service for patients with diabetes.

With Microclinic International WDF promoted a regional project (Jordan, Lebanon and Palestine) to change lifestyle among refugees and increase capacity of UNRWA health personnel.

As a consequence of these efforts WDF partners have held more than 3,000 awareness/screening camps, trained more than 3,000 health personnel, and treated more than 47,000 patients.

There is still a huge unmet need among the vulnerable refugee and host population (who have an estimated 12.9% - 15.9% diabetes prevalence) and there are a lot of significant risk factors (overweight and obesity, instability, psychosocial stress, lack of healthy food, physical exercise, and insufficient access to care).

There is a big opportunity to share the learnings and best practices from these projects, which can be replicated in similar situation elsewhere. The clinical audit conducted by UNRWA is a good start and an important planning tool. Also the Dead Sea Declaration and Action Plan that emerge from this conference will serve as reference for further direction, action and coordination.
Diabetes and Hypertension Care Provided to Palestine Refugees by Dr. Yousef Shahin UNRWA

The rates of people with diabetes and hypertension receiving care by the UNRWA health services increase 5% every year. Currently they account for 256,000 refugees seeking UNRWA health care of which 141,000 have Diabetes.

UNRWA is implementing three main strategies:

- Primary prevention: including common diabetes risk factors in the community health education provided to those attending UNRWA clinics
- Secondary prevention: early detection by screening
- Tertiary prevention: effective case management

All health centers (except for Syria) are using e-health. UNRWA is doing research and updating guidelines, and NCD management is an integral part of all healthcare service.

In 2012 we screened 1,600 patients for a clinical audit program and found that 64% patients were obese and 26% overweight. So UNRWA started a campaign (2013-2014) promoting physical exercise and healthy food.

Through a Micro-clinic International (MCI) project supported by WDF almost 1,000 UNRWA (Lebanon, Jordan, West Bank and Gaza) and 100 Ministry of Health nurses (West Bank and Gaza) were trained to provide education for diabetic patients.

UNRWA is currently working on an NCD Booklet but there is a need of funds for that. It was piloted in 2 Health Centers in each field with a positive feedback.

The new Family Health Team (FHT) approach is the basis for integrating diabetes and hypertension prevention and care at the primary health care level. The staff is very motivated. In fact they volunteered and got involved in painting the healthcare facilities and in drawing health messages on the walls.

E-health is integrated in FHT and UNRWA is using an SMS system to remind patients of appointments. The E-health system provides info on patients, processes and outcomes and is also a monitoring tool.

UNRWA is hosting a lot of interns to do research: they can benefit from UNRWA’s long experience, and UNRWA is benefited from their research and ideas.

The way forward is to expand partnerships: we need to work together and this conference can be a good opportunity to start.
Q&A SESSION 1:

Q: How can we improve adherence and compliance?
A: It is important to involve paramedics, nurses, and nutritional staff: they can participate in teaching patients on self-care and motivate and communicate with patients.

Q: There is resistance at clinical level on task shifting: do you have good examples to share?
A: UNRWA moved to task shifting so that there is a better distribution of workload through the empowerment of paramedical staff and nurses. In Gaza a good example of that is the diabetic foot exam done by nurses. It may not be possible in all fields because the hosting countries have different rules about what can be done by doctors and nurses, etc.

Q: Mobile clinics increase access and decrease transportation costs, but we have found that they pose challenges: these include privacy issues, weather conditions, documentation and follow up (which can be difficult because of lack of space).
A: Using only mobile units for chronic disease management may not be the best approach in all settings. They may be useful in bringing care to hard to reach populations. On the other hand based on our experience in India we have found them very useful in bringing advanced diagnostic equipment to the primary care setting to allow diabetes patients to be screened for foot, eye, and vascular complications. Through use of these mobile units, a primary care setting which cannot afford all equipment is converted into a secondary level care setting once a month or once a fortnight, thus improving compliance to annual screening and early detection of complications as well as training local staff and improving their capacity. So local context should determine how mobile units are deployed.

SESSION 2: Practices and Experiences in Delivering Diabetes Care to Refugees

Ministry of Health (MoH), Jordan by Dr. Rifqi Ismail

Health care in Jordan is provided by the Ministry of Health (MOH), the Royal Medical Services, Universities hospitals, UNRWA, the private sector and NGOs.

In Jordan, hypertension and diabetes are seen in 40% in the population over 18 years, 66.4% are overweight or obese and 29% are smokers.

Non-communicable diseases account for 76% of all deaths in Jordan.

The Jordan MoH provides preventive, health educational and promotional services in addition to primary, secondary and tertiary healthcare to refugees in the same quantity and quality as provided to Jordanian citizens.

The prevalence of hypertension and diabetes among Syrian refugees is similar to that in Jordan residents.

The Syrian crisis has eroded the MoH of Jordan’s ability to provide basic health service coverage. Despite the increase in the total number of beds, there has been a decrease in the number of hospital beds/10,000 population. Also the number of health workers/10,000 population decreased.

A national public health surveillance system (IERS) is being implemented in 510 sites (health centers and hospitals) across Jordan to improve the collection of epidemiological data and the quality of care.
Main challenges are: high rates of smoking, unhealthy diet, aging population, low economic growth, unemployment, shortage of financial resources (government and households).

Primary Health Care should take a patient-centered approach rather than a disease-centered approach, should improve accessibility and offer a broader range of services according to population needs.

It is important to increase awareness, health promotion advocacy, networking and cooperation between different stakeholders, develop a national strategy and build capacity to address the problem.

**Ministry of Health (MoH), Palestine by Dr. Nancy Falah**

NCDs cause 70% of death among adults in Palestine. 80% of MoH's budget is spent in NCDs. 23.9% of population is smoker, 71.9% overweight or obese.

Primary Healthcare is provided by MoH and UNRWA to refugees. Secondary and tertiary care are mainly provided by MoH.

National NCD policy addresses the major risk factors, such as passing of the Anti-Tobacco Law in 2005. The WHO Primary Essential Package (PEN) Approach was adopted in 2013 and fully implemented in 2015; it is a comprehensive way to manage and screen NCD patients according to their level of risks.

For people with diabetes an appointment system has been implemented requiring them to visit the clinics every 3 months. Cases that need advanced care are referred to specialists.

Challenges of the program are shortage of specialized care units and qualified staff, service overlap among healthcare providers, and instability of NCD supplies.

**Ministry of Health (MoH), Lebanon by Dr. Ibrahim Bou Orm**

The private sector is the main provider of healthcare in Lebanon. Life expectancy is 81.2 years. The total expenditure on health has declined from 12.4% of GDP in 1998 to 7.2% in 2012 and the proportion of out of pocket expenditure has also decreased from 60% to 37%.

NCDs are now the major concern: Lebanon has had its epidemiological transition in the early 1990s.

In Lebanon the 207 PHCs, regulated by agreement with the MoH, provide a standardized package of essential healthcare services to 1.5 million Lebanese and Syrians in 2016. The MoH NCD Initiatives aim to integrate NCD prevention and control at the PHC level. It is tackling diabetes and cardiovascular disease through prevention, screening, health education, and disease management. 146 PHCs have been involved and testing equipment was distributed to the centers along with training.

Chronic medication program: MoH in partnership with a local NGO distributes medicines for chronic conditions with nominal charges to 140,000 Lebanese and 15,000 Syrians.

NCDs remain the most important primary health care concern in Lebanon.

**Q&A SESSION 2:**

Q: Is there any data about diabetes complications?

A: In Lebanon there is some unofficial data. In Palestine there was no info about complications before 2013, but by the end of August 2017 all the data with complications and trends should be ready. In Jordan there is
no data about complication at the PHC level, but now with the new electronic system - Hakim data will become available.

Q: Do you regularly get feedback from patients?
A: In Lebanon with the health info system they can monitor patient feedback. In Palestine patients are more satisfied now than before because we are treating them as patients, not as diseases.

Q: About the decrease of the service due to the Syrian influx and decrease of health staff per 10,000 population, are health professionals among the refugees contributing to provide services?
A: They cannot because the law does not permit it.

Q: What are the most important problems to be solved considering the challenges of the refugee influx?
A: Financial resources are the main problem. In Jordan refugees are provided a food subsidy of 1 JD per person per day – this means that they go and buy the cheapest food, not the healthiest, so more funds are needed! In Lebanon the expansion of PHC sector needs funding, human resources and training.

Q: Do you share information from PHC with hospitals in Jordan?
A: Yes, we have referral system from primary to secondary to tertiary health care with a form.

Q: Due to the fact that smoking is a risk factor, why don’t we take $1 from each packet of cigarettes and use this money for health?
A: In Palestine more than 80% of the cigarette packet cost is tax. In Lebanon this is being discussed.
SESSION 3: Practices and Experiences in Delivering Diabetes Care to Refugees

Challenges and Experiences in Delivering Direct Diabetes Care Services to Refugees

By Dr. Peter Garrett, MSF

NCDs were previously known as ‘Western diseases’ but are now becoming prevalent in low and middle income countries. Also in high income countries they are more common in lower social-economic groups.

In the 2nd half of 20th century migration and acculturation has brought about a lot of change - an individual in Bangladesh ate a high residue diet and worked actively in the field, the same individual when he migrated to Europe or North America changed to a low residue diet and a desk job. Thus this individual, who is programmed to survive in a particular way of life, when exposed to a very different lifestyle develops obesity, hypertension, and type 2 diabetes. This nutrition and lifestyle transition is likely to impact all migrants.

Sometimes this epidemiological transition is forced, as seen in the conflict in Syria.

The enforced displacement from Dara’a (South Syria) to Irbid (North Jordan) produced a big change in lifestyle. Dara’a was a rich agricultural region, most of the population was involved directly in farming or agriculture associated industries and had an active life, a frugal diet, and strong family and cultural support. They smoked during their limited free time. In Irbid the same people are living in a large city, many of them work in administration, catering or other services, most are sedentary and unemployed. They eat cheap fast food. They face social isolation, hopelessness and have post-traumatic stress disorder (PTSD). They smoke all day long because they do not have anything to do.

The Medicines Sans Frontier (MSF) NCD Project started in late 2013 now has a total cohort of 3,700 patients in 2 clinics. They undergo regular clinical assessment, lab tests, appropriate medications, health education, food care, retinopathy screening, home visits and counseling.

Continuing challenges are that it is very difficult to change behavior, that referral pathway for secondary and tertiary care is difficult, that there should be a more horizontal cooperation with maternal and child health programs, and better community network, and that 20% of the cohort is currently unaccounted for.

Diabetes among Refugees Seeking Resettlement (Approach and Challenges)

By Dr. Rasha Shoumoar, International Organization for Migration (IOM) Amman and Dr. Ramona El Haddad, IOM Lebanon

IOM assists migration under all difficult situations and challenges believing that every migrant is an asset to every host country where they are bringing their labor.

IOM conducted a study on 67,000 Syrian refugees mainly in Jordan and Lebanon but also Turkey, Iraq and Syria. Among them, 39.2% had endocrine, nutritional and metabolic diseases.

IOM approaches diabetes at three levels. The first is health assessment, then during the follow up interventions and in the pre-departure check and treatment.
This year IOM conducted health assessments for more than 36,000 refugees. These included detailed medical history, physical exam, and assessment of the level of diabetes control with glucose test in accordance with requirements of different resettlement countries.

IOM followed up on 97 people with diabetes in need for stabilization. The most common challenge was that they have just one clinic in Amman and it was difficult for those residing outside to access this. Follow up by phone was not effective. There is a need for NGOs that can help with follow up. Moreover, IOM is dealing with vulnerable people who think that information about their health status can compromise their possibility for resettlement. Finally, IOM also has to deal with country-specific SOPs.

Pre-departure clinic screening is done to determine what refugees need to do in order to comply with the SOPs of the new host country, to provide them information, recommendations and medications for travel. It is also important to decide if the refugees need medical assistance during travel.

Q&A SESSION 3:

Q: Does IOM cover hospital admissions?
A: Yes, with MoH in Jordan. We coordinate with UNHCR for hospital admissions in Lebanon.

Q: How do you coordinate between different organizations to avoid duplication?
A: IOM has a specific population to deal with - refugees that are accepted in a resettlement program. Therefore there is no duplication of work with other organizations.

Q: How does IOM deal with the stress of resettlement that can be a risk factor?
A: IOM conducts counseling sessions before travel to support refugees: some cultural orientation sessions are provided concerning the new country (refugees’ rights, the history of the country and any other questions and issues) and this provides a big psychological support. IOM also sends a medical escort with the refugees who need it.

Q: Does MSF have a plan to sensitize refugees on risk factors?
A: We are trying but in the actual conditions there is not a lot of opportunity for them to exercise, or to eat healthy food or to reduce stress. We are not aware of any projects to give them even a small amount of land to cultivate so that they can improve their conditions (move and grow healthier food) but this is a good idea. In any case if there are no livelihood options there is no future and control of diabetes is very difficult.

Q: It was said often that changing in behavior is very difficult. Are the tools used wrong? What should we do? How can we proceed in this?
A: In Western countries going to the gym, cycling, and eating healthy food are status symbols for rich people and this is helping in the changing of behavior of the population as it is aspirational. This is not the case in the middle and low income countries, where the status symbols are not the same and we cannot use the same approach. We still don’t know how to do it.
Day 2 (April 11 2017)

Tools for the provision of NCD care during emergencies and refugee situations

SESSION 1: Research and studies on delivering diabetes care in the MENA region

The NCDEG Experience on Diabetes Care to Patients with Diabetes and Refugees in Jordan

By Dr. Mousa Abu Jbara, National Center for Diabetes, Endocrinology and Genetics, Jordan, (NCDEG)

Glycaemia control and its associated factors in type 2 diabetic patients in Amman, Jordan was a prospective study done by NCDEG in 2006. The sample size was 1,000. Type 2 diabetic men and non-pregnant women aged 25 years and above and with at least one year of regular follow up at the center were studied. The aim was to investigate the extent of glycaemia control measured by HbA1c. 90% of the group was obese or overweight. ABC goal was achieved by 9%.

Factors associated with poor glycemic control among patients with Type 2 diabetes was a cross-sectional study done by NCDEG in 2008. The sample size was 1,000 patients; again 90% of them were obese or overweight. The factors associated with poor glyemic control were: duration of the diabetes for more than 7 years, type of treatment (insulin), following the eating plan, negative attitude.

Hypertension among 1000 patients with type 2 diabetes attending a national diabetes center in Jordan was a cross-sectional study of 1,000 patients to assess the prevalence of hypertension and the level of awareness about the control of hypertension. 90% were obese or overweight, 72.4% with hypertension, 7% of them unaware of the condition.

Glycemic, Blood Pressure & Dyslipidemia Control in Type 2 Diabetic Patients at the National Center for Diabetes, Endocrinology and Genetics in Amman, Jordan was a cross sectional retrospective study of 1,576 patients. Again 90% were obese and overweight, 92.8% had hypertension, and 96.3% had dyslipidemia.

Hypertension Prevalence, Awareness, Treatment and Control, and Associated Factors: Results from a National Survey, Jordan was a national population-based survey done in 12 governorates in Jordan of 4,117 adults in 2009. They were compared with pooled community-based data from 1994 to 1998. Prevalence of hypertension was 32.3% of these only 56.1% were aware, of these only 63.3 of them were on treatment and only 39.6% were controlled.

It is clear from these studies that obesity, diabetes, hypertension and dyslipidemia are quite common in adults seeking care at the NCDEG, many of them unaware of their health condition and among those aware a significant portion not on treatment and very few among those on treatment achieving targets. Thus a lot needs to be done to improve care however the limited capacity and resources both financial and human makes the task difficult. The situation among refugees is likely to be similar if not worse. However no specific data on the refugee population is available.

Diabetes Research in Palestine by Dr. Abdullatif Husseini, Birzeit University

Concerning the burden of diabetes in Palestine the first studies were done in 2000 and 2001.
The rural vs urban prevalence was considered and found at 9.8% in rural areas, 12% in urban settings. Nationally the prevalence of diabetes is 9% with 67% obesity and overweight in women and 47.8% in men.

In 2009 diabetes was the 10th leading cause of death in Palestine, in 2014 it has moved up to becoming the 4th leading cause of death.

Concerning diabetes control and complication a cross-sectional clinic-based survey was designed in 2012 to estimate the prevalence of selected diabetes complications, to assess the level of glycemic control and the level of self-management. 517 patients from 11 PHC were studied.

Laboratory data was collected and a physical examination covering all the complications (neuropathy, retinopathy, foot problems, obesity, and hypertension) was done. Questionnaires on self-care were administered.

67.9% of the population studied was female, the mean duration of diabetes was > 7 years for 51.1%, and obesity was seen in 62% cases. Good glycemic control was seen in only 20%. There was sub-optimal level of diabetes self-management: medication adherence was noted as 75%, while all the rest of the indicators (healthy eating plan, diet, physical activity, foot care) were very low; in particular 16.6% said that they did not have had any advice about diet, and 24.8% said that they did not have any advice on exercise.

Some projection models have been used to provide estimation for the future prevalence of diabetes and give a platform for policy maker to take decisions. According to these models in 2030 the prevalence of diabetes among Palestinian population is expected to reach 23.5%.

With the Markov model it is possible to forecast the future burden of diabetes complications for the Palestinian Population: the medical cost, excluding complication has been estimated to be $30 million, $139 per patient. Including cost of complications will almost triple the amount. And these are just the direct medical costs.

Challenges to the accuracy of this modeling are: availability, completeness, and quality of data. Moreover the capacity and know-how of the persons involved with the modelling studies, lack of collaboration and of funding are other challenges in conducting such studies.

The lessons learned are that the models are very context specific, and more research and collaboration is needed.
Q&A SESSION 1:

It is important to apply the lessons learned and to plan the interventions based on data. If the implementation is not backed up with data, it is unlikely to produce the desired results and without data it will be difficult to monitor and evaluate the success or otherwise of the intervention. Similarly if the research done does not lead to change in delivering care it is just a waste of money and time.

Q: Is there any study done on the patients themselves and on what kind of barriers they face that prevent them from reaching their objectives, and to understand what are their needs, their perceptions?

A: There are barriers regarding treatment itself (some have needle phobia...). To overcome them we need educators: starting with nurses, their attitude towards patients and their explanations were reflected positively on the patients. A supportive approach is very important.

There is information available: a study was published on patient perceptions but it is not reaching a large population. Providing a supportive environment is very important: you cannot talk about healthy food and ask people to eat it if they cannot afford it.

Augusta Victoria Hospital in Jerusalem works perfectly. There is a really an interactive approach between patients and professionals there.

We need more research to understand patient and care provider perceptions and challenges. While a lot of knowledge attitude and practice (KAP) studies are done, unfortunately they do not get published because journals do not accept such studies and they are not seen to be interesting.

Q: Are there other players in the country? It is important to highlight research from other centers as well as to advocate together and to coordinate the research agenda for diabetes.

A: Most of the research shown has been done in collaboration with other agencies but it is not always possible to collaborate and sometimes collaboration is not successful.

Q: Do we know the burden on the patient himself, beside the medical cost?

A: It is a work in progress.

Q: Most of the patients are living on less than 500 JAD per month. This is not just an economic issue; it also influences social determinants of health. Did you consider that in the research?

A: We used socioeconomic stratification. The social determinants of health are very important, they should be considered now and taken into account in calculating the present and also the future burden.

SESSION 2: Other countries’ experiences in delivering diabetes care to refugees

The West African Experience on provision of Diabetes care

By Mr. Stéphane Besançon, CEO of NGO Santé Diabète

Mali is a very poor country but diabetes and its risk factors are becoming a huge public health challenge. Prevalence of diabetes is just 3% but hypertension is 20% in the population. There is a high level of risk factors: 20.9% of the population is inactive, 21% are overweight and 5.7% obese.
In 2004 Santé Diabète started to work in Mali: the assessment done revealed a very bad situation: just 1 diabetes consultation center in the capital, no access to treatment outside.

From 2005 to 2010 with financial support from World Diabetes Foundation Santé Diabète worked with MoH to strengthen the human resources, improving national and local access to drugs, providing the materials and tools for assessment at national and regional hospitals.

The evaluation of 2010 showed an improved situation: endocrinologists were present in national hospitals, consultations were available in 7 regions, equipment was available for screening and testing, drugs were available and prices had come down. Moreover now we had 250 children with diabetes being supported with care.

In 2012 Mali went through a severe crisis: the conflict and the division of the country made the access to the northern part impossible. As a consequence human resources were lost, access to care, monitoring and medicines was reduced and many diabetics, in particular children, developed acute complications.

The main difficulty in responding to the situation was the fact that diabetes, like many others NCDs, is not a priority for the international humanitarian response. There was no policy or kit for NCD management in emergencies.

After unsuccessful attempts to lobby for assistance for vulnerable people with diabetes, Santé Diabète decided on its own to develop a humanitarian response. Thanks to funding from the French development assistance and generous donation of insulin by Novo Nordisk, between 2012 and 2015 Santé Diabète managed to provide care for 1,814 patients, providing them their monthly treatment supplies. In 2014 MSF and ICRC also joined in the efforts.

Santé Diabète developed two kits: one for diabetic ketoacidosis (DKA) and one for diabetic foot treatment.

The current status is a post-crisis, transitional situation: the north is still occupied; the south is going back to development. Santé Diabète continues to provide treatment for fragile patients and is rebuilding the system with training.

NCDs are not considered in response to crisis situations. But a simple, carefully planned response in Mali managed to save a lot of lives. There is an urgent need to develop international advocacy to ensure NCDs are included in humanitarian emergency response and protocols, procedures and kits are developed to deal with diabetes and other common NCDs in crisis situations.

**Diabetes care in Yemen with Focus on Refugees**

**By Dr. Abdulla M A Almatary, Aden Diabetes Centre**

Yemen is a country in conflict and during conflicts there are a lot of complications.

Aden is the temporary capital of Yemen. In 2009 the Diabetes Center was opened in Aden. It was the first place where diabetic patients could find professional medical care. The MoH didn’t have a strategy so with the support of WDF we implemented a project between 2012 and 2015. The activities of the project were: establishment of the diabetes clinic, training of health care providers, screening people at risk of diabetes, health education for patients and public awareness. It was the first time any action on diabetes was taken in Yemen. Before this there was nothing and no data on the diabetes situation. The project has trained 450 health care providers, treated 7,500 diabetes patients, provided structured education to 3,000 people, screened 7,000 people for diabetes, and reached 50,000 persons with health awareness messages.
In 2016 WDE financed a second project because of the increased incidence of amputation due to diabetes. The activities of the project are: establishment of a diabetic foot clinic, training of health providers (150), screening of patients for diabetic foot problems, health education for patients (1,500), public health awareness (30,000).

In Yemen there are a large number of refugees from Africa mainly because without a strong and effective government the borders are porous and easy to cross both for people and smugglers. Those restricted in camps are provided services by UNHCR, those in urban areas have the same rights as Yemeni people.

**Diabetes care in Sudan with Focus on Refugees**

*By Dr. Suleiman Abdgabbar Abdullah, Director General of the Ministry of Health*

Sudan is the 2nd largest country in Africa, it shares border with 7 countries, it is populated by 35 million people; of these more than 2 million are internally displaced people (IDPs) and have the same challenges as refugees, plus Sudan is hosting 800,000 refugees mainly from South Sudan.

The health system structure is decentralized and MoH has more than 90% of the healthcare facilities. It has a horizontal coverage of more than 90% but it has a suboptimal coverage of standard service packages.

Prevalence of diabetes is 9% but in some states it exceeds 15%. It is a big socioeconomic burden for the country. With support from WDF Sudan has established 12 specialized clinics for diabetes healthcare services and established a diabetes care association which supports diabetic patients in mobilizing additional resources to support improvements in quality of service and health education.

Under the MoH, a Comprehensive National NCDs strategy in line with the Global NCD Strategy is developed and is being implemented, including participation of all stakeholders to provide adequate primary prevention and care beside the secondary and tertiary care.

Sudan is working on universal health coverage by developing an essential healthcare services and health insurance scheme to be fully implemented by 2020. Refugees are currently asked to pay just 25% of the medication costs. Moreover Sudan is working on the integration of PHC services across the entire healthcare system and due to the high turnover of medical skilled personnel shifting tasks to the middle level (medical assistants) health care workers.

In December 2016 the *Khartoum declaration for Promotion of Diabetes Program* focused on community awareness by health personnel, sustainable provision of adequate diagnosis and treatment for vulnerable, adequate trained staff and equipped centers, provision of funds, propagation of information, and strengthening of the health information system. MoH should lead these efforts.

**Q&A SESSION 2:**

Q: Diabetes was not a priority in Mali. Is it because of the low prevalence? Hypertension is high. Do you think it is underreported?

A: MoH prioritized diabetes, but the international community did not in responding to the crisis. HIV, Malaria, TB are priorities. All NCDs are not a priority.

Q: Did you develop any tracking system to cover the movement of the population?
A: In Sudan there is no tracking system: the patients can bring their papers with them.

In Mali Santé Diabète developed a tracking mechanism to follow up when the patients were going back to the north to be sure that they have access to treatment.

In Yemen there normally are files for each patient and they are followed up according to risk categories. In area of conflict, however, nothing is guaranteed.

Q: Diabetes is a problem but we still do not know the size of problem. Does WHO have more data?

A representative from WHO Headquarter in Geneva informed that they do not have precise and accurate data but they extrapolate: the numbers are remarkably similar in the whole region. Either the prevalence is high or, like in Sub Saharan Africa, it has been rising rapidly.

Q: If diabetes is not a priority in the humanitarian response is it because we are not making the case properly?

A: In humanitarian response we need to prioritize lifesaving treatments: it is a problem to understand what should be put in NCD baskets in an emergency. The donor community is hesitant because they want to make a quick and meaningful impact and with NCDs this is not so easy. Essential services packages for NCDs do not exist. We need to help countries to draw them.

The accuracy of data is very important. It can attract donors.

Advocacy should be done to promote and integrate continuity of care in all programs also in conflict areas or emergency situations.
SESSION 3: Working group session – how to improve the provision of Diabetes Care during Emergencies and Refugee Situations

GROUP A: Access to NCD Care with Focus on Diabetes

Governance should be led by local government in coordination with stakeholders to avoid duplication.

The Health Response Plan should be done in coordination with all partners, prioritizing together and deciding together on implementation and monitoring.

NCDs should be a priority within the Emergency Response Plan.

Ability to respond in an emergency situation is dependent on the robustness of the existing health system. We need to strengthen the existing healthcare system, expanding its ability to provide services for diabetes and other NCDs through capacity building, diagnostic tools, and development of guidelines aligned with international standards.

Existing PHC facilities should be supported for primary and secondary prevention and care for diabetes.

Funding should be improved at all levels.

A clear referral system should be established for complicated cases.

Monitoring and evaluation mechanisms should be established with proper recording and reporting of cases and complications.

GROUP B: Surveillance; Monitoring and Evaluation of NCD with Focus on Diabetes

The main challenges identified were: identifying the right target population, the use of preexisting data, the decision on what type of data to collect and how, protection of confidentiality, coordination between actors, security of the data, sharing the data with others, use of data to improve the quality.

Tools that need to be available are guidelines, forms, registers, ID documents (file number, passport number, et al) and the required infrastructure to support the system.

Coordination should be strengthened, clear roles and responsibilities should be decided, an efficient division of labor should be promoted, the protection of the privacy of the patient should be assured and supervision of data collection should be put in place.

To get more funding it is important to demonstrate the problem clearly and to work on performance integrating data and using them to build a national system.

GROUP C: Promotion and Awareness of Healthy Lifestyle among Refugees with Diabetes.

The main challenges identified are: overlap of services, lack of coordination and communication between stakeholders, lack of unified health messages, lack of policies or enforcement of policies, lack of structured funding and often imposition by donors on what to distribute, sustainability of the service.

There are different levels of intervention: stable condition is different from new arrivals and it is different if the refugees stay in camps or outside the camps.
For the new arrivals it is important to prioritize the services. The identification of the target group and treatment according to vulnerability criteria should be realized. The main focus should be to prevent life- or limb-threatening complications or complications that could lead to prolonged hospitalization. A mapping of the services should be done so to be able to communicate to refugees where they should go and from where they can receive the services. This can be done through standard messages to be distributed upon registration. During registration it is important also to collect some critical data such as presence of preexisting complications if known. Communication stressing that patients need to take special care of them to avoid complications as availability of health services may be uncertain and stretched. A healthy food basket should be distributed with certain specifications and food coupons should deny access to junk food.

Human resources involved should be staffed from the community, mapping for the professionals that might be present, after establishing clear SOP and guidelines for the different roles and responsibilities. Health personnel from among the refugees may be recruited for ancillary support and counselling even if they cannot be recruited for care delivery directly.

Action Plan should be: to draw an emergency plan well before the crisis hits so that staff is already aware of what to do and they can implement it directly. Moreover there is a need to advocate for creating and enforcing national policy on NCDs and ensuring its sustainability through integrating the new services within the existing PHCs and clinics.

For the stable post crisis situation UNRWA should lead and coordinate with all on the ground, setting clear strategies and policies based on its vast experience.

For stable refugees opportunistic screening should be done as part of primary prevention efforts, in coordination with other actors promoting health awareness on healthy lifestyle and ensuring security of data and protection of privacy.

Recommendations are: identify the target group, set policy in line with the host country, promote lifestyle modification using media with clear and simple standardized messages, and advocate cultural awareness of donors. The monitoring and evaluation process should be led by the MoH where applicable. Capacity building of health and non-health staff is paramount, especially for counseling. If needed during emergencies task shifting of health staff should be done. Linking maternal health and early childhood health with health promotion and NCD prevention would be helpful.

GROUP D: Innovative ways in providing care and support to refugees with diabetes.
A multidisciplinary team approach should be used: MDs, nurses, nutritionists, community health workers, psychologists, pharmacist all should be involved and empowered.
The target population is at risk, pre-diabetes and diabetes patients.
Screening is important, as is screening for complications (with simple and non-expensive tools that can give information).
An emergency plan should be prepared in advance and standby kits for emergency should be stored and deployed whenever needed.
A mobile health team should support the local clinics to reach patients. Telemedicine should be used with the same idea using simple technology tools to keep contact with the patients and help them self-manage their condition.
Patients should have access to their health records because the refugees can move from one place and center to another.
Outreach for health education and community engagement should be promoted.
Support and supervision for staff (staff still need help) should be provided and sustainability of supplies ensured. Adequacy of premises, privacy, confidentiality of data and dignity are a must: free of charge service should not mean that there is no dignity for refugees. Multi-sectorial collaboration should be promoted. Proper follow up, tracking systems and referral systems should be established. An adjustment of the food basket for people with diabetes under the supervision of a nutritionist is recommended. Generic medicines should be available in local market (insulin, with pen, statins, metformin, aspirin, and ACE inhibitors) and syringes and needles. Ensure HbA1c testing: it is less expensive to do it at a central level. Ensure cold chain and storage of sensitive materials and self-monitoring devices and supplies for type 1 diabetes. Additional issues to be provided are technical guidelines and protocols, a hotline for emergencies, and protection of human rights.

**Q&A SESSION 3:**

Q: Targeting patients at arrival is very good idea, how can it be implemented?
A: Emergency plans can be useful in this sense because if there is a plan and a set of structures this makes it feasible.

The best prevention is to prevent the destabilization of the condition due to the crisis situation: adequate food, information about services but also about what to be careful about are very important. Once the situation is stabilized we can think about the rest. The vulnerable are those at risk: old people, pregnant women and children.

It is important to prioritize the messages according to situations but for example at arrival the messages should not focus on the need for exercise, but on medications (where to find them, what to use, how to use) and on distribution of water and healthy food. Later on, the main aim was to focus on lifestyle.

Refugees fear that if they declare their health status, this can become a barrier for them to enter so it is not easy to collect this information on arrival, especially when there is influx of 2,000-3,000 arrivals per night.

Q: If the patient is keeping the medical records because he is moving the risk of losing it is very high. Do you have ideas of what to use?
A: There is an experience in West Bank where the patient is provided with a short copy of his/her data so that the new healthcare provider can know. There is also a pilot project of NCD booklet.

Q: Why don’t we select the staff from refugees themselves to support care?
A: It is difficult because this can cause problems with the local population and local governments have different rules about permitting foreigners not qualified locally to provide care. An accreditation process can be done but often it is long. It is an issue that should be advocated and discussed.

**Statement:** Adolescents and children need insulin pens, but each manufacturer of pens only allows use of their penfills with their insulin pens. These manufacturers should be lobbied to allow generic insulin to be used in their pens.

A study was conducted but it is still not published on the stability of insulin over 12 weeks not stored in cold chain and it is 100% perfect.
Day 3 (12 April 2017)

Way Forward and Actions for Better Diabetes Care to Refugees

Opening remarks by Dr. Akihiro Seita, UNRWA

This has been a wonderful conference with everyone’s passion, commitment, diligence, openness and empathy to patients and their families. All sectors were able to come together for this conference including front-line heroes, governmental officials, civil society members, NGOs and UN staffs.

Plan of Action 1: UNRWA and partners will organize a follow-up conference within two years.

Plan of Action 2: Four groups will discuss the following three issues:

1) Coordination between countries – it is crucial to have reliable statistics on prevalence of DM, number of patients. How can we coordinate DM care for refugees? Participants will be divided into four groups where Group 1 and 2 will discuss this issue in the context of Jordan and Lebanon, facilitated by Dr. Ismail (MoH Jordan) and Dr. Ibrahim (MoH Lebanon), respectively.

2) Technical package – Many are already in place but standardization has not been achieved or the meaning of it remains unclear. What are the key components on technical package? Group 3 will discuss this issue, facilitated by Professor Nerup.

3) Political arena – How can we make DM an important part of humanitarian response? Group 4 will discuss this issue, facilitated by Dr. Slim.

Time frame for the action plans should be a) by end of 2017, and b) by end of 2018.

GROUP 1: Action Plan of Jordan

In coordination with the national steering committee, to re-establish the working group for NCD’s (including Diabetes) inviting actors providing NCDs care along with the agencies working in NCDs that attended this conference and agreed to be part of it.

MoH, WHO and UNHCR should develop the Term of Reference for the working group.

A sub group from the conference should contact the head of the PHC directorate to update him about the outcome of the conference and the need to re-activate the working group.

From a technical point of view effort should be to:

- Standardize NCD care provided to refugees using existing or international guidelines;
- Standardize health education messages;
- Integrate NCD care (especially diabetes and hypertension care) in PHC through training;
- Establish referral pathways to secondary care;
- Coordinate with Community Health Task Force, Nutrition Working Group and Food Security.

Funds are needed for training, standardizing guidelines and IEC materials, medications, lab testing, equipment, operational and applied research.
GROUP 2: Action Plan of Lebanon

Currently in Lebanon for refugees with diabetes:

MOH: provides services through PHC

UNRWA: has health care services for Palestinian Refugees in Lebanon and Palestinian Refugees in Syria

UNHCR: subsidizes health care services for Syrian refugees (registered/not registered) with NGO partnership

IOM: part of emergency response participates in funding NCD in PHC, in addition to pre-departure follow up and treatment for refugees accepted under resettlement program American university of Beirut

AUB: technical support, capacity building, evaluation, design of evidence based intervention

Under the leadership of MOPH and in coordination with UNHCR and WHO a health working group was established at the beginning of the Syrian crises for all the issues concerning the Syrian refugees. To have a common strategy, identify challenges and gaps, coordinate actors and avoid duplication the working group also involves available NGOs and partners through regular meetings and briefings on services providers based on their location.

For the Palestinians, UNRWA is the service provider for the Palestinians eligible in Lebanon and it is part of WHO health working group with local NGOs involved in health care in Palestinian community.

To improve coordination the group recommended creation of a specific NCD task-force with a focus on diabetes with the objective to analyze the situation, map the actors present, prioritize the action plan, avoid duplication and develop a unified electronic platform for data and information sharing.

Monitoring and evaluation to improve the quality of care, capacity building, and communication on the availability of services, advocacy and fund raising are also recommended. Sharing experiences is also very important.

GROUP 3: Action Plan of Technical Package

To deal with the challenge of a significant number of refugees in different countries four drivers were identified:

1. Development of treatment facilities for diabetes and hypertension

Given the heavy patient load, there is an urgent need to establish standard Diabetes Care Units within the context of PHC, and mobile clinics with advanced equipment to support 4-5 diabetes clinics, empower the nursing staff to take more tasks, authorize task shifting, establish and improve the system for the health home visit program, update guidelines applicable in crisis situation and clearly define the referral system.

2. Development of diabetes prevention and awareness program:

Develop a comprehensive prevention and health promotion program (including schools, civil organizations, et al) and the use of campaigns when needed. A special program should be developed for vulnerable groups (pregnant women, old people, and children, adolescents).

3. Training and education program

Education programs should cover all the aspects of diabetes care. On-the-job training should be promoted with a lot of efforts on team building that can promote task shifting and sharing.

These programs should be context specific and should be built on the already existing experiences and should include the recruitment of experienced teams.
Training for the patients should be organized in order to empower them for self-care.

4. Quality of Care and Health Information System

Improving quality of care through use of guidelines and protocols is an important aspect. Clinical audits with specific indicators, objectives and outcomes to improve quality of care should be implemented. Systematic recording and reporting on diabetes status should be promoted and also a system of monitoring and evaluation.

Challenges to these four drivers are:

- Shortage of human and financial resources
- Inadequacy of premises (there are often problems of access, privacy, confidentiality, lack of suitability for people with disabilities)
- Low cooperation and coordination between partners and stakeholders

GROUP 4: Action Plan on political arena

There are a lot of challenges in bringing diabetes to the center of the humanitarian agenda because it is not perceived as a developmental issue and not a life threatening problem. There is no social movement for NCDs and very little advocacy with no action plan for donors.

To change this it is necessary to:

- link diabetes to SDGs
- highlight numbers and statistics that support the message
- link current refugee crises and the heavy burden of diabetes among them with potential threat of spread of infectious diseases (TB)
- highlight the life- and limb-threatening complications that can occur when people with diabetes under stress and injury do not receive appropriate care
- Use global events (Ex. In September the UN declaration on refugees and the 2018 2nd UN Assembly summit) as a means to highlight diabetes through humanitarian messages
- integrate diabetes treatment into emergency kits
- develop easy to read booklets and infographics using patient stories and case studies to highlight the misery and hardship of refugees with diabetes
- link the advocacy to appropriate emergencies

In our key messages we need to have humanitarian stories, to underline that an immediate response contributes to saving lives, to stress that it is better to manage before complications start, and to emphasize the right to life for a child who can die for lack of insulin.

Q&A SESSION:

Q: This seems to be broad recommendations: do you have a time frame? Who will do what when?
A: For Jordan the timeframe for the reactivation of the working group for NCDs is one month.
In Lebanon the timeframe to create a specific NCD taskforce with a highlight on diabetes can be done within one month.

Q: Diabetes is a syndetic disease: this means that it goes with depression and poverty. Creating specialized diabetic clinic is going against the Family Health Team approach.

A: The first point of care should be the PHC, then there can be differences: the integrated approach should be the base, the elements that should be there are fixed, then how to create the model is a decision of each country. In any case the refugee crisis is an opportunity to develop the PHC system. And it is clear that there is an urgent need for capacity building of health staff at PHC level on treating diabetic patients.

The Dead Sea Declaration and Call to Action on Refugees and Diabetes was released at the end of the conference in which the participants committed to address the prevention and care of diabetes in refugee populations by working to:

1. Strengthen health systems to provide universal access to essential health services, including diabetes care to refugees and displaced populations in need;

2. Ensure that diabetes care is part of health system response plans for emergencies and refugee situations, with the mechanisms required to deliver diagnostics, medicines, and referral services to refugees, including for uninterrupted diabetes care;

3. Promote migrant-sensitive health services that are culturally, linguistically, age, gender and context appropriate;

4. Continue advocating for adequate and sustainable financing mechanisms for providing health care to refugees, including effective diabetes care delivery;
5. Emphasize and promote partnerships and inter-sectoral/multisectoral coordination mechanisms among governmental and non-governmental agencies to deliver health care to refugees, including diabetes care;

6. Establish and implement standards, guidelines and procedures as well as proper task-based training for available health care providers to deliver effective diabetes care to refugees;

7. Ensure proper mechanisms for data collection, to document, monitor, evaluate and continuously improve care for refugees with diabetes while respecting patient privacy; and

8. Conduct operational research to improve prevention and diabetes care for refugees, including cost-effectiveness studies, and sharing better practices.

9. The declaration also called upon other partners and stakeholders to:

10. Include diabetes care in all humanitarian responses, both during the acute phase and protracted phase of an emergency;

11. Establish supporting mechanisms including an essential package for diabetes and other common non-communicable diseases in emergency kits; and

12. Strengthen health systems to provide care for common non-communicable diseases at the primary care level.

Conference participants delved into making action plans to fulfill these commitments and agreed to continuously review progress and revisit the achievements in two years.
List of participants

Important: Kindly notice that participants were arranged alphabetically based on their organizations’ names, and then based on their names under each organization.

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