



UNHCR's ninth meeting with NGOs partners on preparedness and response to Covid-19 in refugee situations

Theme: How NGOs can best contribute to WHO's COVID-19 response?

13 May 2020

Online

Participants:

UNHCR:

- Kelly Clements, Deputy High Commissioner.
- Arafat Jamal, UNHCR Head, Partnership, and Coordination Service.

WHO:

- Dr. Michael Ryan, Executive Director, Health Emergencies Programme
- Dr. Ibrahima Socé Fall, Assistant Director-General, Emergency Programme

NGOs:

- About 140+, mostly NGOs.

Kelly Clements

- WHO is trying to coordinate global leaders to respond and prevent the spread of COVID-19.
- UNHCR-WHO partnership: we have worked together for many years in the field, closely within the IASC, and at national/local levels to try to minimize process and focus on delivery.
- Time and again we refer to WHO as the experts when we are looking at guidance in terms of how we deliver the very best of protection to refugees, internally displaced, others forced to flee and others.
- We are looking forward to this discussion on how WHO works with NGOs, the first-line responders, who are so important in terms of delivery and prevention and how in particular the NGO community can support the COVID-19 response?
- Our collaboration with WHO has included a very strong focus on ensuring refugees and displaced are included in all the contingency plans of the national frameworks in terms of prevention and response because the virus does not discriminate. People we are serving are often the most vulnerable and the ones most susceptible to this disease.
- Dr. Ryan reached out to the HC to discuss how we can do more together. We know this is coming and we know this is going to be a particularly vulnerable part of our global community.
- WHO has been a huge collaborative force in the interagency system. We always hear from them in interagency discussions, whether on MeDevac or crisis management team or at IASC.
- WHO helped to drive the development of a couple of guidance documents in particular with regard to COVID-19 related to humanitarian settings and situations which have been helpful.
- We have been working with WHO and with Ministries of Health at the country level to enhance the preparation and potential response in support of the national responses.
- We have worked closely with WHO on mental health and psychosocial support which we see is becoming an increasingly important factor in this particular response.
- We have seen a launch of the revised GHRP (USD 6.7 billions), a strong document and much more of a bottom-up approach, which we had hoped with regard to planning. It was launched on May 7. Thank you for all for the partnership and collaboration we have.
- We are talking in the IASC about how we can endeavor to do more, to get more funding not just to the INGO partners but the localization theme has been an important one. ICVA has been championing that along with others particularly in the IASC. We stand behind that; it is not just a Grand Bargain commitment.



- We have made an extra effort, particularly in COVID but beyond, to try to get funding to partners. That has been important in terms of early response in the prevention side. We do need to ramp-up, scale-up and some of those resources limited to refugee-hosting countries, including hiring and training additional staff.
- We will continue to plan some of the essential services, Health, Nutrition, WASH, Protection as part of this next phase and we look forward to continuing to work in partnership with you.
- WHO has been working on this pandemic from day one and you are asked for a bit of a crystal ball in terms of where the infection is spreading and what is your prognosis? NGOs are very concerned about developing countries with fragile health systems and structures and what in particular you see in terms of the communities where we may be working most prevalently. What do you see the prognosis going forward in the next few weeks and months?

Dr. Socé

- We will continue to work together to make sure we have concrete action at the ground level.
- If you look at the trajectory of the outbreak, we are having almost doubling cases from one week to another. We are seeing more low resources countries affected, including countries with humanitarian crisis. E.g. in Sub Saharan Africa over the last week we have seen a doubling of number of cases and close to 30% increase in the number of deaths and we will continue to see this increase.
- We are working on bad scenarios. We have three scenarios 1) Outbreak scenario come, 2) We continue to see a number of small cases, 3) a certain level of transmission, it can be at a lower level but still happening in many areas.
- What is clear is you continue to see more cases in crisis affected settings. That is why it was important together to work with partners including NGOs to adapt our preparedness and response intervention for low resource capacity in humanitarian settings.
- Having more cases is having more challenges, challenges to take care. Because the number of cases is growing, it will be difficult to have the capacity to focus on management.
- We are expecting to see more cases in low resource settings but we need to make sure that we engage communities from the preparedness to response. We need to make sure that we use your specific context and acceptable and affordable mechanisms on intervention to prevent and contain situations in those settings.

Kelly Clements

- We know that the virus seems to strike in different ways and fortunately, we have not experienced uncontrollable transmission in crowded refugee or displaced sites. How do you advise us and our NGO partners to be responding today? Do we have a window to prevent outbreaks or we are just lucky at the moment? What is the cause of this?

Dr. Ryan

- I am concerned, for many countries particularly middle-income countries and fragile States, where we are very much still at the beginning. There is a lot of people saying, “they have kind of dodged the bullet and everything is going to be ok”, that is not what the data suggest.
- The number of cases in South Sudan is going up to increase in a week. Now everyone says “that is going from a small number to a small number”. Well that is what happened in the USA in February. It went from a small number to a small number, to another small number and a slightly large number.
- In the history of this pandemic, every country has had a long lead time, sometimes it is only 2-3 weeks because the initiator events are around big clusters or some kind of amplification event, e.g. in France, it was probably amplified in Paris around a big street gathering.



- In other places, there were initial events that amplified the disease enough for it to show the signal early. So I assume in some countries, in the fragile States, because of the way people live, it has not had that amplification opportunity yet and it is spreading slowly. Eventually the fire will reach the tender rocks of an overcrowded community in an overcrowded or urban slum or in a refugee camp and we are going to see something much more deadly than we might otherwise have imagined.
- We have to start continuing to get that message out, without being catastrophic in our predictions, we have to remain balanced. Malaria is still much more likely to kill a child in a refugee camp than COVID-19 and equally with measles.
- We need to stay focused on our primary directive which is to serve vulnerable populations collectively with the best services we can.
- We need to read COVID-19 into our response because if we see an uncontrolled outbreak in a vulnerable population, especially in a camp situation then the impacts could be devastating. That means protecting those populations from the arrival of the disease as much as we can.
- We need to put in place filters that allow us to reduce ways in which the disease might arrive in those situations. We need the capacity to know about an outbreak as soon as it happens.
- We all know from measles and from other diseases, that in a camp situation your best friend is the first case that tells you something is wrong, and you can take action.
- We are talking about saving lives and not doing anything about transmission. So, if you are going to impact transmission in these settings you have to get to the earliest cases. After that, all you are trying to do is save the lives of those that are exposed.
- E.g. if we look at the closed environments in which we have seen this outbreak: we saw the military ships, now we see the migrant dormitories in Singapore. Singapore is a good example as the attack rate in the population of Singapore is 0.3% (that have been affected). The attack rate of clinical disease diagnosed in migrant dormitories is 6% among mainly young men. They are not necessarily unhealthy. The only risk factor they have is they live in a closely packed environment with little access to hygiene and no access to physical distance. If you transfer that paradigm anywhere else in the world then what happens next?
- We have seen closed environments where people can physically separate in care facilities. In Europe, in Ireland, 61% of all the death of COVID-19 has been in a long-term care facilities. On average in some States in the USA, it is over 80%. In Sweden, it is over 80% of the death.
- Unfortunately, as we found in the past, we may find that the majority of these severe cases leading to death occur in close settings where people had multiple high exposures and had underlying vulnerabilities or conditions that did not allow them to recover or had a worst disease. So, we, together with UNHCR, IOM, the NGO community need to continue put the message out about our concerns but also go beyond the rhetoric and work together to put in place necessary prevention measures, detection measures and then the response measures.
- The difficulty is, and you are probably going to come back to me and say it, physical distancing, isolation of patients, triage, and intensive care in the context of a refugee camp.
- I would argue to their adaptive strategies, e.g. I believe medical oxygen is saving more patients in this pandemic than any number of ventilators have.
- The vast majority of patients who have moderate to severe disease do not require ventilation but almost all require some form of medical oxygen support, so if we are going to invest in something to help ill patients in the context of a camp, medical oxygen might be our best path.
- There are ways of adapting our strategies. Even a clinical care setting in a crowded camp environment can save lives.
- We need to try to apply the paradigm of the tertiary referral hospital and do what you have done for so many years and adopt the best available technologies to the context in which we are working. If we can help in anyway, we will be very delighted to do so.



- It is good to have a discussion around how we can move from a level of concern to some more realistic set of interventions that we are all behind and actively implementing.

Kelly Clements

- You raised a couple of things about urban settings. We had a call with our regional Bureau directors earlier today and over half of them mentioned this is as an increasing concern. We heard a very interesting picture presented yesterday by our representative in Dhaka with regard to social distancing in Kutupalong during a distribution, so even under very difficult circumstances there are ways to be quite creative.
- You are getting to the point of inclusion and we talked together a little about the advocacy required to ensure that the National Health Plans include refugees, migrants, displaced, others that may fall without.
- How, from your perspective, with a global platform, would you recommend that we amplify that both at a national and a local level?

Dr. Ryan

- You are the champions of trying to get governments to put at center the needs of an excluded populations, urban poor or refugees.
- Let's talk about recovery. We all need to get back on the on the bicycle of economic growth. This is one crisis that is exposing the inequities in society. If you can leave people behind in poverty, it does not necessarily come back and bite you but if we leave people behind in this crisis, it will come back and bite because nobody is safe until everyone is safe.
- We have to make the brutal risk management argument as well as the humanitarian. This is not just about human rights, about social justice, about doing the right thing, it is about getting rid of this virus and we do not get rid of it unless we are active everywhere.
- We have to be able to articulate to governments who have excluded and ignored in many cases these populations for decades despite our treaties and our advocacy.
- I do not know what is going to wake them up and get them to recognize it now, with all of the suffering these populations have experienced over the years. We have to sometimes appeal to instincts and say look you are not going to be safe; nobody is unless we serve these people.
- We need to find that duality in the argument, we have to be tough and we have to be challenging on this especially for the urban poor because, thanks to UNHCR, to IOM, to so many NGOs, at least refugees and displaced populations have a voice.
- And we see this now with the lockdowns all over the world. The points of greatest risk of amplification of this disease on the planet are the points of least intervention. That is both a humanitarian and human rights disgrace. It is also a risk management disgrace that gets us nowhere and it is a concern.
- I do think we need to be activists about this now sometimes, but for WHO it is difficult. We cannot directly criticize each and every individual Member State, but we certainly can call out behavior and a practice that is represented in multiple Member States.
- I am happy to work with you to advocate and then speak out more about governments excluding these communities. We speak specifically about it, not only from a human rights perspective but from its obvious stupidity when it comes to managing this disease.
- We do need to come to some consensus around one point, because we are helping find how countries get out of a lockdown. There are many countries in lockdown which should probably never have done that. Lockdown is not in the center of the WHO strategy. Our strategy has been a comprehensive strategy of detection, testing, isolating, feeding and measured short-lived public health and social measures up to and including movement restrictions.



- However, what happened is a lot of countries have literally bounced into almost a level 5 hurricane response. Some of that has been driven by an absolute deterioration in numbers in their countries and they had no other choice but to try to shut the gate. Other countries have bounced into that as almost a political response.
- There are countries in which this is doing a hell of a lot more damage than it is solving issues. In terms of the impact on the urban poor in particular and the impact on poor people in countries where tolerating a lockdown for weeks and weeks and weeks is horrific.
- One would have to question the public health benefit of that in the context of the transmission in those countries. I am not saying we want to move away from physical distancing. We want strong public health measures in place, we also have to start working with some governments on whether or not their actual lockdowns are public health driven and commensurate with the amount of social and economic damage those lockdowns are doing.

Kelly Clements

- We had discussions with this group about the concern that some of these measures may bring difficulties in the long-term for disadvantaged people, maybe including those that are trying to save their own lives and cross borders and get out of harm's way.
- We will continue the advocacy locally and nationally.
- WHO and WFP have been setting up an impressive logistics system including for Medevac but not only. Something that gets a little bit less attention is the care that you are taking about some of the issues of health facilities at local level.
- We got some good news about Bangladesh earlier today, there are other things that are happening country by country in some of the higher risk areas and underserved but also on supply chain and trying to get goods into areas.
- How do you think it is working and how NGOs in particular can benefit or are benefiting already? Where do you see it going?

Dr. Ryan

- We often dealt with supply chain issues, e.g. food, and in normal circumstances, the supply chain challenge is temporal in nature, it is a short-lived problem of getting particular material to a particular geographic area in a short period of time to solve a problem.
- That is not what happened here but what we have had is a fundamental breakdown of all global supply chains in effect, raw materials, production, procurement, distribution, and delivery, every single piece of the global supply chain has just collapsed at almost the same time, so you do not fix this by hiring a few planes and you do not fix this by doing some procurement. We, as UN system and as international community of NGOs, have effectively been competing with some of the most powerful nations in the world to get access to things like PPEs, gloves, tests. It has been a fight to get access to those materials and products.
- I commend the Global Fund, UNITED, UNICEF who come together and develop a purchasing consortium so that we try have more power in our ability to buy material but also putting pressure, e.g. on the diagnostic side. We have to go through a whole cycle and spend USD 1 million validating 25 different producers of PCR based tests. We would have validated tests available and then have production capacity and be able to tell countries these are valid access pre-approved suppliers who will give you a quality product.
- We have to ensure that anything we are sending, or offering is of high quality as well and validation and pre-qualification become a big part of that system.
- What we do have now is a collective capacity to procure, an ability to match that to the country needs across three main product categories 1) the diagnostics 2) PPEs and 3) the essential medical supplies including ventilators, oxygen concentrators.



- With WHO, WFP, UNICEF and others, we are putting together a distribution mechanism that fixes the last part of the distribution problem, getting stuff to the countries. Nobody realized, except WFP, that the vast majority of cargo that moves in the world moves on passenger planes and when the passenger service collapsed then transportation supplies around the world collapsed. It is another massive failure in the system.
- We have put together a big purchasing capacity through the Global Fund, nearly USD 200 million into WHO sourced funds.
- We have just concluded an agreement with the Gates Foundation which will give us purchasing guarantees for hundreds of millions of dollars, so we can purchase more into the system with the guarantee.
- We have put together the architecture of a system that could supply up to 30-40% of lower middle-income country needs, particularly for fragile countries. That system should be open to countries or anyone else who wants to come in and purchase through that system.
- The other important thing about WFP's action with UNICEF and others is that the actual distribution system is open for all humanitarian supplies, this is not just for COVID. WFP is guaranteeing through their six hubs and their scheduled flights that they are prioritizing humanitarian supplies other than COVID. By fixing COVID supply chain process we are also trying to make sure that essential supplies are transported. You have to ask WFP how that system is going to work from a practical point of view in each organization, but the principle is there. This could be for HIV, TB drugs, etc.
- It would be worth to reconvene at some point and get WFP and UNICEF, get the task force to come and brief you on progress with this mechanism, also see how we can more systematically involve NGOs in it. I would love to have NGOs come in Geneva, sit and work on the task force
- We are not there and there is a lot of frustrations but six weeks ago we had an entirely chaotic system and we got to something that is at least going to be predictable for the next five months and we know exactly what we can buy.
- We have a dedicated logistics system in China for centralizing all of this material at WFP warehouses in Guangzhou and in Beijing. We also have our humanitarian village and our hubs in Dubai, plus the six sub regional hubs that WFP has developed.
- We have probably collectively managed to solve this global crisis, global logistics and supply chain crisis, quicker than the private sector has, even moved to solve those critical gaps.
- Aware about the frustrations and the lack of clarity, how much we can explain better, how much we can give access to organizations in a more transparent way too.

Kelly Clements

- Medevac is a big concern and there has been extensive discussions with the interagency. We are reaching conclusion on this important discussion on Friday. The SG will then hopefully take a first step towards establishing regional hubs for those few colleagues that may need to be evacuated for medical reasons. Many of us in the system are pushing hard on this.

Discussion

Norwegian Refugee Council

- Thanks WHO, UNHCR, IOM and many others for the collaboration in developing IASC Guidance on COVID-19 preparedness and response in low capacity humanitarian settings.
- There is a large role for NGOs for the preventive public health outcomes that can be achieved through nonclinical intervention such as WASH, shelter, camp management and education.



- We are interested to apply some of our engineering, construction capacities and experience that we have to support the public health response, e.g. facility construction, extensions, modifications or improvements, sanitation upgrades.
- We could benefit from clear instructions from WHO, health doctors and health authorities on what we can do to support the national and local authorities in terms of infrastructure in places where we are serving displaced communities, refugees, and IDPs.

Plan International

- Plans support the focus on COVID for the different groups and particularly about the worsening risk for girls and young women in this health crisis. We know that adopting gender and lifesaving approach are essential in response and recovery. Dr. Tedros said already that COVID-19 pandemic must be gender sensitive.
- How has this gender sensitivity been translated in practice, in the preparedness and response effort, particularly in humanitarian settings?
- We know that all refugees, migrants, IDPs women and girls are facing the increased risk of violence, exploitation and lack of access to essential health services due to COVID. How is WHO supporting efforts to make sure protection from gender-based violence and sexual and reproductive health needs, including psychosocial support, are prioritized, showed continuity and recognized as life-saving?

International Rescue Committee

- On testing and testing kits, at the moment we are still in the dark in terms of facilitating increased testing in countries. Can you comment on the case definitions and any work to adapt them? Particularly in the context where we work where there is little or no testing and will be still limited for the weeks to come.
- WHO point about getting to the earliest cases and surveillance is critical. How do we do with the fact that case definition is still very wide and without sort of the relevant testing available?

International Association for Hospice and Palliative Care

- How can WHO support our efforts on the ground to provide palliative care in emergency situations, in refugee camps and other places for displaced persons?
- We would welcome support and a shout out for that because we do not get much visibility. We crucially need supplies of internationally controlled essential medicines, e.g. morphine which are important.

International Federation of Medical Student Association

- In our organization we have young students working in more than 95 countries against COVID. We noticed that NGOs role is crucial to supporting vulnerable populations, educating those populations, and fighting COVID. But this cannot be done without proper coordination, communication and resource support from decision-makers. Can there be a model or recommendations to ensure the inclusion of those NGOs and young people's representatives in the official response?
- From our health care workers background, we face burnout, stigma, bad working conditions, and support materials to deal with those populations. How can we push stakeholders to prioritize and support these workers and what are some concrete measures to assist them?

Dr. Ryan

- The issue of infrastructures and adaptation mentioned by NRC is important, particularly in camps, for managing COVID patients. We need to create enough space, create enough patient



flow. It is very similar to the cholera treatment camp model. It is not highly sophisticated, but it is adapted to reducing the risks of transmission from person to person, from health workers, from patients to health workers. It is about doing it systematically and then having support from people who can work on engineering adaptation.

- We have built an international network of architects and engineers who are working with us now and we have been advising countries on how to adapt existing facilities, how to build new facilities, and how to build temporary facilities, e.g. in Italy.
- We also have been working with the network with architectural drawings adaptation guidelines, e.g. in Portugal, which will bring together a crucial element of a COVID-19 treatment center in one place with many different organizations supporting. I will be very interested to follow-up with you on whether we can drag you into this engineering group and see how we can best collaborate on and maybe find adaptation for camp settings.
- On the issue of girls and young women raised by Plan, the disease in itself is not targeting girls and women in the way many other diseases do, e.g. women social role in Ebola leads to much higher attack rates and by extension fatality rates, paradoxically what is happening in this epidemic is the opposite, the infection rates are about the same but the death rates are much higher with men. Not easily understood, probably related to underlying conditions.
- That does not mean the circumstances created by the pandemic have the potential to increase domestic violence, sexual exploitation, exclusion, isolation, exploitation; not by the disease itself but by the circumstances that the disease is exacerbating and amplify.
- Related to IRC question and on case definitions, it is a difficult issue and we have been working with countries, e.g. in Africa around syndromic case definitions and we have asked to be included in syndromic disease surveillance.
- Severe respiratory diseases in adults is not a common syndrome and people need to be very worried up no more than the child with a fever in a camp. Anyone other than a child with a fever and a significant respiratory syndrome should be considered to be a suspect COVID-19 case and immediately isolate regardless of the diagnosis.
- I would be happy to work with IRC, other NGOs like MSF to see if we can agree on what would be a standardized syndromic approach particularly with displaced and refugee populations.
- Definitely give a big shout out to the hospital palliative care and again everyone deserves to both live and then die with dignity and die in the least possible pain and with the most possible comfort. We will highlight that issue and agree on the fact that essential medicines, e.g. morphine, because of the trade and borders restrictions, are actually much harder to move around now than they were before.

WHO

- There have been actions and supporting women and girls since the beginning of the pandemic, having strong evidence base from previous experience. What is encouraging is seeing gender analysis and studies coming out of a number of contexts, e.g. Cox's Bazar.
- The news highlights the vulnerabilities of women and girls and we are using that opportunity to work hard to provide and ensure that evidence is available for planning both at national level but also in future updates data plans of the various clusters.
- WHO works closely with others in the Global Protection Cluster and GBV AoR.

Discussion

International Medical Corps

- What can we do from the perspective of WHO and UNHCR to ensure an ongoing and better integration of mental health into our COVID-19 response?



World Federation of the Deaf

- WFD represents 7 million deaf people all around the world.
- Regarding the information about COVID-19 in sign language, how can deaf people avoid impacting other people with this disease and how to prevent it?
- It is very important that you get this information in sign language. What is WHO doing to ensure that the information provided can be transferred into sign language? E.g. press meetings at Geneva level happened without sign interpreter.
- Is UNHCR aware of this problem and these challenges faced by deaf people in refugee camps, and how do they get access to sign language interpreting, so they are informed?

Global Health Council

- We want to be mindful that coordination needs to be manageable, but it is unclear what are entry points.

International Society of Radiology

- Would like to mention the ISR collaboration with WHO on the guidelines related to imaging use for the management of COVID-19.
- WHO is currently developing a guideline to provide health workers and health care decision makers with recommendations on the appropriate use of different imaging modalities to support diagnosis, patient management decisions, taking into account feasibility, acceptability, equity, and cost questions in different settings around the world.
- Several recommendations are now being finalized and will be released soon and ISR has been providing scientific and technical support in this endeavor.

Caritas

- How do WHO and other partners plan to further engage with faith-based organizations?
- FBOs have a strong faith-based health system, e.g. Catholic health system with 38,000 health facilities worldwide to serve those populations usually underserved by a governmental facility.

Dr. Socé

- How can partners and civil society engage? In countries where you have cluster coordination mechanism, this is the right platform to engage with. With the GHRP, we have a specific stream of funding to target global population and low resource settings. We need to make sure they are part of the planning process first, from the preparedness and planning process and we have an opportunity to have regular GHRP iteration and country response plans.
- We continue to advocate with our Representatives at county level to make sure we are coordinating not only for the humanitarian response plan but also for the national preparedness and response plans and to make sure that we have civil society and FBOs. In this emergency outbreak control, you cannot be effective if you do not have a decentralized coordination, making sure that communities, civil society, FBOs are involved because they are even closer to the population, they know the population, and they have some mechanism to reach out to them.
- On deaf people, it is an important gap. We need to find a way to work very closely with WFP to make sure that when we do our briefings and press conferences, we have this interpretation in sign language.

WHO

- Mental health is positioned clearly in the GHRP and there is updated guidance from the interagency reference group. They are engaging with ourselves in the health and protection



clusters. What we can do is ensure that you all have access to this updated guidance around key messages and key actions that can be taken within all communities to ensure inclusive discussion and adaptation of services in the context of COVID.

- A number of our resources include the recommended activity from IASC on mental health psychosocial support and also the messages that we developed for children, using a children story book available in 62 languages and also being developed in 5 sign languages by partners for deaf children. It also includes an audio book for blind children. UNHCR played a leading role also in adapting some of these messages for Rohingya children in camps.
- This can be found here:
 - <https://www.who.int/teams/mental-health-and-substance-use/covid-19>
 - <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing>
 - <https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/my-hero-you>

Dr. Socé

- On the impact on other diseases and on health services in general, we have a group working to make sure that we can protect other health services and prevent and respond to other diseases. E.g. from the projection you are seeing on tuberculosis, the projection is if it continues like this, next year will have the number of cases going back to the level of 2013.
- It is important to make sure that we are also continuing our work on other diseases, otherwise everything we invested for many years will be lost because we are only focusing on COVID.

Kelly Clements

- Many of you have been involved heavily in the GHRP. From UNHCR side this is something that we saw as a critical gap, with you at the field level. The GHRP deserves more support in addition to be integrated into our comprehensive health service provision. It includes community networks, supporting individual cases in high distress, managing uncertainty and anxiety, investing in prevention awareness raising. There are good examples in Lebanon and Bangladesh in this regard.
- We have an eye on the caregivers, aid providers, relief workers who are facing their own forms of stress in this situation and that is something that from a duty-to-serve and duty-of-care perspective we take very seriously.
- On the sign language and looking at the needs of the deaf in terms of this response, it is a very important part of a broader attention in the system and certainly in UNHCR too.

Arafat Jamal

- Topic of next week UNHCR-NGO will be on sexual exploitation and abuse.