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Refugee public health, including HIV/AIDS

Summary

This paper outlines measures taken by UNHCR to ensure that all refugees enjoy the right to health, including access to life-saving and essential health care, nutrition, reproductive health services, as well as to HIV prevention, protection and treatment services. It describes public health interventions, which are underpinned by a common vision and guiding principles, as summarized in UNHCR's five-year "Global strategy for public health" (2014-2018). An update on public health and HIV programmes in new and ongoing refugee situations is provided. It also discusses UNHCR's contribution to improving HIV preparedness and responses during emergencies.

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I. Introduction

1. Public health and HIV programmes are of vital importance in providing protection and services to refugees and other persons of concern under UNHCR's mandate. Accordingly, UNHCR's "Global strategy for public health"[1] provides a comprehensive response to health challenges that refugees face, including HIV. It reflects the Office's commitment to improve and extend public health interventions, which are guided by principles of age, gender and diversity (AGD), access, equity, and sustainability.

2. This paper reviews UNHCR's efforts to enable all refugees to access life-saving and essential health care; HIV prevention, protection and treatment; reproductive health services; nutrition and food security; and water, sanitation and hygiene (WASH) services. The focus is on the Strategy's second year of implementation that seeks to strengthen quality, cost-effective and evidence-based programming and include refugees in national health care structures.

II. Public health and HIV programmes

3. UNHCR's efforts to meet the health care needs of refugees in emergency situations remained an operational priority. UNHCR responded to high rates of mortality among children under the age of 5 during the first weeks of new and emerging crises. Of particular concern were diseases such as measles, respiratory and diarrheal illnesses, as well as severe acute malnutrition (SAM).

4. In 2014, UNHCR adopted a comprehensive multisectoral approach to public health, nutrition and WASH that aimed to reduce preventable mortality among children aged 5 and under within the first six months of new emergencies. By year end, mortality among these children had reached acceptable standards in 93 per cent out of 140 locations monitored. This was the lowest mortality rate since 2010, with only 10 locations in sub-Saharan Africa[2] reporting elevated rates among new arrivals.

5. Funding shortfalls affecting the World Food Programme (WFP) have had adverse effects on food security among refugees and other persons of concern to UNHCR in many operations, with some facing ration reductions of up to 50 per cent. Dependency on food assistance and limited livelihood opportunities increased global acute malnutrition (GAM) levels in 16 locations. Nevertheless, among 58 locations surveyed in 2014, 59 per cent of these had global acute malnutrition levels that were equal or below 10 per cent. In emergency settings, however, eight locations fell short of this standard.

6. UNHCR has advocated at global and country level to ensure refugee access to vaccines and bring children under national immunization programmes. In 2014, UNHCR supported the Global Polio Eradication Initiative[3] to develop guidance to improve access to polio vaccinations in emergencies.[4] Large-scale immunization campaigns were successfully conducted to reduce the high risk of polio outbreaks among displaced populations of Afghans, Somalis and Syrians. UNHCR continued to partner with governments, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), *Médecins Sans Frontières* and other stakeholders to roll out new vaccines within expanded immunization programmes. In 2014, vaccination campaigns to immunize infant children with pentavalent vaccines, combining five vaccines in one, were carried out in Ethiopia and South Sudan. While the global vaccination coverage for measles remained steady at 85 per

[1] Available from http://www.unhcr.org/530f12d26.pdf.

[2] The 10 locations were in Cameroon, Chad, Ethiopia, South Sudan and Sudan.

[3] The Global Polio Eradication Initiative is a public-private partnership led by national governments, WHO, Rotary International, the US Centres for Disease Control and Prevention, UNICEF and the Bill and Melinda Gates Foundation.

[4] Available from http://www.polioeradication.org/Portals/0/Document/Resources/Polio_in_Emergencies.pdf.

cent, UNHCR is prioritizing efforts to improve refugee access to comprehensive immunization programmes.

7. Communicable diseases are the major cause of morbidity among refugees, and in 2014, over 5 million consultations were held. In 25 countries, the majority of these were for respiratory tract infections, malaria and diarrhoea. UNHCR and partners have pursued a systematic approach to disease control, which includes preparedness and response to outbreaks through community awareness, early detection, more efficient case management and cross-sectoral prevention-related activities. In line with the Strategy, UNHCR continued to work towards including refugees in national early warning systems for disease epidemics and the establishment of multisectoral response programmes with strong ties to the WASH sector. While a total of 12 new disease outbreaks were reported in refugee camps in 2014, UNHCR has responded to two new outbreaks from January through mid-May 2015.

8. A core strategic objective in the Strategy is improved childhood survival. UNHCR and partners have worked extensively on strengthening the linkages among nutrition, health services and reproductive health programmes. Together with Save the Children, UNHCR developed a holistic, multisectoral framework for infant and young child feeding (IYCF) programmes that stressed the importance of behavioural factors and cost-effective methods. The IYCF framework is being piloted in Bangladesh, Jordan and Kenya in 2015 and will be rolled out in 2016.

9. A serious challenge among refugee children and women is the risk of anaemia. The condition can have far-reaching effects on the overall health of children in particular and on their development and learning. It also can lead to reduced economic opportunities and productivity over their lifetime. With this in mind, UNHCR carried out projects aimed at reducing levels of anaemia among refugee children and mothers in 10 countries where rates were particularly high. In Bangladesh and Nepal, for example, they received additional micronutrient vitamins and iron with their food. UNHCR's efforts to improve IYCF practices and address other causes of anaemia, such as malaria, have reduced the number of anaemic refugee mothers and their children. Moreover, since the introduction of fortified peanut butter paste supplements for infants, which are taken on a daily basis in camps in Chad, trends in anaemia levels are decreasing, drastic reductions in food assistance notwithstanding.

10. Refugee access to reproductive health services improved in 2014. While skilled birth attendants assisted with 90 per cent of deliveries globally, regional differences vary from 97 per cent in the Middle East to between 60 per cent and 100 per cent in sub-Saharan Africa. In Lebanon, UNHCR supported over 30,700 women with their delivery in hospitals in 2014. In Jordan, UNHCR is seeking innovative ways to ensure access to safe delivery care for vulnerable refugees living outside of camps. Because the reproductive health needs of refugees residing outside of camps differ from those living in camps, UNHCR has partnered with the United Nations Population Fund (UNFPA) to develop a toolkit for planning reproductive health programmes and interventions in both contexts. This includes a five-step decision-making process designed on the basis of best practices, as well as the findings of a study on reproductive health in four urban situations in Jordan, Malaysia, Uganda and South Africa. In 2015, UNHCR will continue to bolster reproductive health services as an important and integral part of its public health programmes.

11. In four countries in the Middle East, refugees and asylum-seekers undergo mandatory HIV testing upon renewal of their identity cards or entering the country. UNHCR does not support mandatory HIV testing, as the HIV positive serostatus should not adversely affect a person's right to access the territory of the country of asylum, seek asylum or avail oneself of durable solutions. With this in mind, UNHCR, in partnership with WHO and the UNAIDS Secretariat, has updated the "Policy statement on HIV testing and counselling for refugees and other persons of concern to UNHCR."[5] The policy

[5] Available from http://www.unhcr.org/53a816729.html.

statement stresses that HIV testing should be voluntary, conducted with informed consent, and provided with counselling and privacy.

12. Non-communicable diseases (NCDs), which are chronic and longer-lasting, have increasingly become a public health burden for refugee communities. Over 246,000 consultations for NCDs were held in 2014. NCD consultations in primary health care settings in Asia and the Middle East accounted for 10 per cent and 13 per cent of consultations, respectively. Because NCDs are mostly addressed at the specialist care level, which often result in expensive referral care and prescriptions, these diseases have important implications for health care services. UNHCR continues to support governments with the development of clinical protocols and trainings in order to help manage NCDs at the primary health care level. Since 2013, programmes, including capacity building, are continuing in Burkina Faso, Jordan and Kenya. At the global level, UNHCR has initiated an inter-agency dialogue with WHO, as well as NGO partners, to share experiences and harmonize NCD strategies and tools in refugee situations.

13. In *Twine*[6] – UNHCR's web-based application that combines streams of public health information to inform decision making – a detailed analysis of the data on mental, neurological and substance use disorders showed significant differences in rates across 90 refugee sites. On average, there were 4.3 consultations for these disorders per month/per 1,000 refugees, with a considerable spread from relatively high (e.g. 15.8 in Nepal, 12.7 in Burundi) to very low (e.g. 0.3 in Bangladesh, 1.5 in Ethiopia). The difference between countries is not considered to be related to refugee needs; rather, it results from the varying capacities of health care providers to correctly identify and manage mental, neurological and substance use disorders.

14. Given resource limitations and the high costs of specialized care, UNHCR will ensure that partners routinely include mental health care in primary health care services. Based on existing guidance, WHO and UNHCR jointly issued the "Mental health gap action programme - humanitarian intervention guide (mhGAP-HIG)"[7] in May 2015. This practical tool will assist non-specialist health care providers to better identify, assess and manage mental health needs and offer first-line care in humanitarian emergencies. In 2015, the mhGAP-HIG will be used to improve mental health services for refugees in at least 10 operations.

15. Another important component of UNHCR's public health programmes is refugee access to referral care. Due to resource constraints, the criteria to access referral care have been tightened, and cost recovery mechanisms have been strengthened in many countries. UNHCR operations with large-scale referral care programmes are now using an automated database tool, which was introduced in December 2014. The tool establishes a monthly reporting framework to monitor and examine data on referrals to secondary and tertiary level care. It provides information on costs, trends and variations in local referral rates.

16. In the Strategy and UNHCR's "Policy on alternatives to camps,"[8] the Office called for synergies with national development planning by contributing to local infrastructures and bringing refugees within national social protection and service delivery systems. Several factors affect refugee access to national health care, including varying funding mechanisms and levels of coverage for health and social services in the host country. As States work to develop strengthened national social protection mechanisms, UNHCR will carry out its inclusion strategy in sub-Saharan Africa, Asia, Europe and the Middle East, building on lessons learned and expertise gained through pilot projects.

17. Access to health insurance reduces overall health care expenditures. Insurance coupled with free primary health care improve access to health services. Where health insurance options are available, costs are reduced by avoiding the duplication and inefficiencies of parallel structures. In 2014, UNHCR gained valuable experience when assessing the potential of refugees to be included in national health insurance schemes in

[6] See UNHCR's health information system (HIS), http://twine.unhcr.org.
[7] Available from http://www.who.int/mental_health/publications/mhgap_hig/en/.
[8] Available from http://www.refworld.org/docid/5423ded84.html.

Ghana, Nigeria, the Russian Federation and Rwanda, and public-private schemes in the Islamic Republic of Iran and Malaysia. In Ghana, refugees were included in the national health insurance scheme, and approximately 1 million Afghan refugees in Iran (Islamic Republic of) will soon be covered by the national health insurance programme.

18. A strategic objective of the Strategy is to ensure that refugees have access to water of sufficient quality and quantity, and to improve sanitation and hygiene, including in schools, health facilities and other institutions. In 2014, the average amount of potable water available to refugees living in camps and settlements was maintained at 19 litres of water per day/per person. The WASH sector promotes a demand-led approach that places people rather than engineering at the heart of interventions. As such, solutions that reduce longer-term operational costs and environmental impact are sought, without compromising quality. UNHCR focused its efforts on reducing the operational costs of water supply systems in 2014 by increasing the use of solar energy powered water pumping facilities. In Kaya refugee camp in South Sudan, for example, the conversion of 80 per cent of fuel powered boreholes into hybrid systems reduced fuel consumption by half.

19. To promote the sustainability and cost effectiveness of WASH programmes, UNHCR and the IRC[9] are developing a decision-making tool to more effectively manage water supply in camps and settlements. The tool supports UNHCR and its partners with longer-term planning and budgeting for water services, and initial assessments in Chad and Ethiopia are promising. Research is also ongoing to explore innovative technologies that support more sustainable and efficient sanitation and waste management solutions for refugees and surrounding communities. In addition to reducing pressure on natural resources, a "waste to value" study is examining options for converting waste into useful by-products, such as cooking fuel and compost.

20. UNHCR continues to closely monitor progress in the Strategy's implementation. *Twine* offers a range of practical tools for assessments, monitoring and evaluation. However, monitoring the access to health services for refugees living in non-camp settings has proven more challenging. In *Twine*, UNHCR developed the health access and utilization survey (HAUS) to help assess opportunities, obstacles and costs for accessing health services in urban areas. In 2014, UNHCR conducted a household HAUS in Jordan and Lebanon and subsequently undertook a review of the newly tested tool.

21. To ensure quality health care services, UNHCR monitors service delivery. To do so, the Office uses the "balanced scorecard"[10] approach – a set of five instruments designed to assess the quality of care provided in primary health care facilities and a detailed laboratory assessment tool. In 2014, UNHCR prioritized strengthening the quality of reproductive health to achieve better results. In partnership with the Center for Refugee and Disaster Response at the Johns Hopkins Bloomberg School of Public Health, UNHCR developed, piloted and completed a "balanced scorecard" project to evaluate the quality of reproductive health care in camps in Rwanda and Thailand. To further support efficiency in WASH programming, UNHCR also has developed the WASH "monitoring scorecard," which monitors the water supplied to refugees and access to sanitation, and is designing a standardized knowledge, attitude and practices survey to better understand issues relating to access, and the quality and utilization of these services.

III. Partnerships on HIV and other communicable diseases

22. UNHCR is a UNAIDS cosponsor and, in partnership with WFP, co-convenes the Inter-Agency Task Team on HIV in Emergencies (IATT),[11] which aims to improve HIV preparedness and responses during emergencies. The IATT partners with local and national health authorities, as well as NGOs, to ensure a minimum HIV response at the onset of an

[9] The NGO is formerly known as the IRC International Water and Sanitation Centre.

[10] The "balanced scorecard" and other systems, tools and guidance mentioned in paragraphs 19-20 may be accessed through registration at http://twine.unhcr.org.

[11] See http://hivinemergencies.org/.

emergency in the context of internal displacement. UNHCR also promotes the inclusion of internally displaced persons in national treatment programmes, most notably in the Central African Republic (CAR), the Democratic Republic of Congo and South Sudan situations. These countries are all UNAIDS high impact countries. In 2014, collaboration and coordination resulted in strengthened inter-agency assessments, comprehensive programming, and the publication of the "Guidelines for the delivery of antiretroviral therapy to migrants and crisis-affected persons in sub-Saharan Africa,"[12] which also apply in refugee situations. The findings of the 2014 UNAIDS Gap Report, which provides data and information on people living with HIV, highlights the need to take measures to end the AIDS epidemic in emergencies globally. In follow-up to the findings of the Gap Report and to discuss the way forward, UNAIDS, in collaboration with UNHCR and other cosponsors, is planning a full-day thematic session on "HIV in emergency contexts" on the margins of the 36th UNAIDS Programme Coordination Board meeting in July 2015.

23. UNHCR has worked closely with the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) to support the Global Fund's Emergency Fund. The Emergency Fund seeks to provide quick access to financial resources to enable the Global Fund to fight HIV, malaria and tuberculosis in humanitarian emergencies. To prepare for its operationalization, UNHCR compiled 10 country-specific case studies examining the potential impact of emergencies on HIV and tuberculosis treatment and essential services. Based on these studies, the Global Fund developed guidelines to request and use its funds.

24. UNHCR also worked with partners at national level to elaborate a refugee-specific emergency proposal for tuberculosis in Jordan and Lebanon. The Office further provided technical support in CAR to national stakeholders in areas of tracing, the development of contingency plans and unique identifiers for persons living with HIV, including travel health cards. UNHCR included an HIV component in sexual and gender-based violence prevention and response programming. These efforts were complemented by reinforced HIV programmes targeting CAR refugees in neighbouring countries.

IV. Conclusion

25. With the growing number of refugees and other persons of concern, the demands on public health services have significantly increased. New and ongoing crises have stretched UNHCR's capacities, but the Office continues to respond in a strategic way, allocating its resources according to an integrated cross-sectoral approach and ensuring maximum access to quality health care, HIV, reproductive health, nutrition, and WASH services. Working closely with governments, UN agencies, NGOs, and other partners has been critical for ensuring synergies to fight HIV and, in some cases, including refugees into national health structures. This has reduced the operational cost of otherwise expensive parallel programming. While aiming to be sustainable, cost-effective measures are an integral component of the "Global strategy for public health" and are crucial to enabling refugees to gain access to quality health services over the short and longer term.

[12] Available from http://www.unhcr.org/541fe8a19.html.