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**Update on public health and HIV/AIDS**

**Summary**

UNHCR aims to ensure that all refugees and other persons of concern enjoy the right to health: specifically, that they are able to access life-saving and essential health care; nutrition; reproductive health services; and HIV prevention, protection and treatment services.

This paper provides an update on UNHCR's public health and HIV programmes in emergency and non-emergency settings. It also discusses UNHCR's contributions as a UNAIDS cosponsor.

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## I. Introduction

1. Many refugees and other persons of concern are affected by disease; the lack of clean water, proper sanitation or HIV or reproductive services; malnutrition; or the death of a child. UNHCR's five-year *Global Strategy for Public Health*<sup>1</sup> provides a comprehensive response to these challenges through 2018. The strategy stresses the importance of mainstreaming refugee health care into national health systems in order to improve refugees' access to health services and enhance their capacity for self-reliance in a protective environment.

## II. UNHCR's public health and HIV programmes

2. Addressing the **essential health needs of newly-arrived refugees in emergencies** is a priority. UNHCR and its partners seek to ensure that in all emergencies, technical public health capacity is strategically-placed and grounded in good practice and evidence-based standards. UNHCR will continue to draw upon internal and external expertise to improve needs assessments, preparedness and response planning, and disease and mortality surveillance. The inclusion of refugees into existing national health systems remains a priority wherever feasible.

3. Recent emergencies in sub-Saharan Africa have seen refugees arriving in very poor health and nutritional status. Some refugees walk for weeks or months before crossing a border; as a consequence, newly-arrived refugee children display very high levels of acute malnutrition. During the first weeks of these emergencies, UNHCR observed high mortality rates for children under five, with measles, respiratory illness and severe acute malnutrition (SAM) as the main causes. Syrian refugees, meanwhile, suffer from high levels of non-communicable diseases that require costly, long-term treatment.

4. Addressing the risk of **vaccine-preventable diseases** has been particularly challenging in these emergency settings. With critical support from host countries' ministries of health, UNICEF and other partners, all newly-arrived refugees are vaccinated against measles. At the same time, the risk of refugees and internally displaced persons (IDPs) contracting poliomyelitis (polio) is at its highest in recent history, most notably for some populations of Afghans, Somalis and Syrians. Coordinating and implementing an effective response at regional, national and local levels requires continuous and concerted efforts by national authorities, WHO, UNICEF, UNHCR and non-governmental organizations (NGOs).

5. In 2013, UNHCR and its partners further reduced mortality in non-emergency settings, especially for children under five. Ninety-three per cent of operations monitoring mortality maintained **under-five mortality rates** well below the standard threshold – a result achieved in part through the integrated management of childhood diseases and routine immunization programmes. Moreover, UNHCR and partners continued to focus on improving infant feeding practices and nutrition interventions.

6. The **control of communicable diseases** focuses on matching disease-specific epidemic management with targeted actions in the water, sanitation and hygiene (WASH) response. In 2013, UNHCR developed guidance on the control of Hepatitis E outbreaks, based on recent experience in Dadaab, Kenya and South Sudan. UNHCR also contributed to inter-agency manuals on hepatitis, malaria and tuberculosis in emergencies. Prevention campaigns – such as the distribution of insecticide-treated bed nets – have yielded significant progress in the reduction of malaria: in just five years, malaria has dropped from the first cause of death among camp-based refugees to the third.

<sup>1</sup> Available at: [www.unhcr.org/530f12d26.pdf](http://www.unhcr.org/530f12d26.pdf)

7. **Prevention and control of non-communicable diseases (NCDs)** is a priority in the health response, in particular for Syrian refugees and refugees in low-income countries in sub-Saharan Africa. For example, in Dadaab, Kenya, 3 per cent of all consultations relate to NCDs, representing a considerable burden on the health system and accounting for nearly 30,000 clinic visits per year. NCDs are predominantly addressed at the level of specialist, rather than primary, care and entail costly treatment. To more efficiently manage the response to NCDs, UNHCR and a clinical training group are developing clinical management tools adapted to primary health care for the most common NCDs among refugee populations in Burkina Faso, northern Iraq, Jordan and Kenya. Training for medical doctors and clinical officers will also be provided. This should reduce the cost of treatment at the level of specialist care, enabling UNHCR to help a greater number of those in need.

8. UNHCR's Health Information System (Twine)<sup>2</sup> collects data on **mental, neurological and substance use (MNS) disorders** in refugee camps. An analysis of data covering a population of 1.4 million refugees in 15 low and middle-income countries over the period 2009-2013, conducted with the Johns Hopkins Bloomberg School of Public Health, revealed a wealth of information valuable for programme planning and implementation. For example, the greatest proportion of MNS-related visits was attributable to epilepsy/seizures and psychotic disorders. Controlling for population size, disparities were seen among countries based on age and gender. Recent data on Syrian refugees in Za'atri camp in Jordan suggests that 19 per cent of MNS consultations concerned severe emotional distress, while in Lebanon this figure is more than double, at 42 per cent. The disparity is likely affected by different patterns in help-seeking behaviour, as well as varying capacities of the health care systems to identify and manage MNS conditions.

9. UNHCR's field operations are implementing the Office's first *Operational Guidance: Mental Health and Psychosocial Support Programming in Refugee Operations*.<sup>3</sup> In 2013, UNHCR and WHO developed a new module, *Assessment and Management of Conditions Specifically Related to Stress*, for WHO's existing Mental Health Gap Action Programme (mhGAP) *Intervention Guide for Mental, Neurological and Substance Use Disorders*.<sup>4</sup> The module contains assessment and management advice related to acute stress, post-traumatic stress and grief in non-specialized health settings, which is highly relevant for refugee operations. Moreover, a new version of the mhGAP *Intervention Guide* is forthcoming in 2014 on the management of relevant conditions in humanitarian settings with limited access to specialists and treatment. UNHCR and partners will test the new *Intervention Guide* in operations in Bangladesh, Kenya and Uganda.

10. The availability of **comprehensive reproductive, maternal and new-born services** affect not only individuals, but also families and their broader communities. In 2013, 63 per cent of UNHCR's operations had an obstetric fistula detection programme, an increase from 50 per cent in 2012. More than three-quarters of UNHCR's Asian operations have achieved the standard of 90 per cent skilled birth attendance at deliveries; this is followed by the East and the Horn of Africa (69 per cent). Across other regions, the prevalence of skilled birth attendance remains at less than 50 per cent, underlining a need to focus efforts. UNHCR continues to place high emphasis on maternal death audits. In 2013, 25 UNHCR operations complied with the UNHCR standard of conducting 100 per cent of maternal death reviews within 48 hours, an increase from 22 operations in 2012. In 2013, UNHCR cooperated with the Centers for Disease Control to conduct verbal autopsies for all neonatal deaths recorded among persons of concern in the United Republic of Tanzania and Chad. Consolidated lessons learned will feed into practical operational guidance on neonatal health in refugee camp settings.

11. Anaemia affects the health and well-being of women and increases the risk of adverse maternal and neonatal outcomes. Failure to address anaemia condemns refugee

<sup>2</sup> Available at: <http://twine.unhcr.org/app>

<sup>3</sup> Available at: <http://www.unhcr.org/525f94479.html>

<sup>4</sup> Available at: [http://www.who.int/mental\\_health/publications/mhGAP\\_intervention\\_guide/en/](http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/)

women to diminished health and quality of life; generations of refugee children to irreversibly compromised development and learning; and refugee communities to decreased economic productivity. UNHCR's **strategic plan for anaemia prevention, control and reduction** was developed in 2008 in response to extremely high prevalence of anaemia among refugees. A review of the first five years of its implementation (2008-2013) revealed encouraging reductions in severe and moderate anaemia, especially among populations with very high anaemia prevalence; nonetheless, anaemia remained a public health problem for children in all camps. In Bangladesh total anaemia rates declined from 47.5 to 22.2 per cent of the population, while rates of severe and moderate anaemia declined from 23.5 to 2.1 per cent. Kakuma camp in Kenya experienced a 56 per cent reduction in total anaemia and 37 per cent reduction in moderate and severe anaemia, despite receiving a continuous influx of refugees in poor health. These findings will inform a revised anaemia strategy to be developed in 2014-2015, which will emphasise joint programming with other sectors, most notably reproductive health, to achieve more cost-effective interventions.

12. In recent years, **new scalable and sustainable models** have been developed for providing health care in countries with significant unmet needs, including those of women and girls. These models support inclusion of refugees in local and national health services. In Rwanda and Uganda, refugee girls of 11 years of age have been included in national human papillomavirus vaccination (HPV) programmes, partially subsidized by the Global Alliance for Vaccines and Immunization (GAVI). UNHCR is promoting inclusion of refugee women in national screening programmes for cervical cancer, where existing and affordable treatment is available. In Malaysia, refugee women are offered cervical cancer screening in government-run maternal and child health clinics in urban areas.

13. While the primary health care strategy remains at the core of all interventions, **access to secondary and hospital care** is important. Depending on the context, UNHCR's operations are confronted with a wide variety of disease patterns, some of which require referral care. Based on the specific referral care guidance<sup>5</sup> and available funding, each operation determines the extent of support to be provided for such advanced care. In several operations, UNHCR and partners therefore focus support for referral care on immediate life-saving and obstetric care. Based on these criteria, in Lebanon in 2013, UNHCR and partners supported the referral of 41,168 cases, 41 per cent of which concerned obstetric care, 7.9 per cent gastrointestinal conditions, 7.3 per cent trauma and 5 per cent neonatal and congenital conditions. In Jordan, UNHCR supported a total of 16,782 Syrian refugees in accessing secondary and tertiary health care.

14. In protracted and urban refugee communities in Asia, West and Central Africa, inclusion into national health and nutrition services, or **alternative financing models, such as health insurance schemes**, are important means of supporting equitable access and sustainability. UNHCR is assessing, implementing and evaluating health insurance options in Guinea, the Islamic Republic of Iran, Jordan, Malaysia, Mali, the Russian Federation, Rwanda and Senegal. Promising steps have been made to synergize the health services for refugees and surrounding host communities in Ghana, Niger and Pakistan.

15. UNHCR continues to anchor its **HIV programme** in principles of protection and human rights. Over the past five years, the proportion of countries in which refugees receive access to antiretroviral treatment (ART) at the same level as nationals has increased from 79 to 97 per cent. In 2013, the proportion of operations reporting the inclusion of refugees in national HIV strategic plans stood at 87 per cent. Progress toward legislation protecting the rights of HIV-positive refugees and asylum seekers, including protection from mandatory HIV testing, is slower and requires more attention.

16. UNHCR will intensify its efforts in reaching young people (10-24 years) in refugee camps, as they have special HIV-related prevention and response needs. The HIV programmes for young people will focus on evidence-based preventative interventions adapted to the context. In 2013, UNHCR and the Women's Refugee Commission mapped

<sup>5</sup> Available at: <http://www.unhcr.org/4b4c4fca9.html>

global good practices on adolescent sexual reproductive health in humanitarian situations. With this information, UNHCR launched a pilot project in Goma, Democratic Republic of the Congo, to improve adolescent (10-19 years) knowledge, attitudes and behaviour regarding sexual and reproductive health.

17. In 2013, 95 per cent of UNHCR operations ensured refugees' access to "prevention of mother-to-child transmission" programmes (PMTCT) on par with nationals. UNHCR works with partners to ensure that a full range of services is provided, including universal access to counselling and testing for all pregnant women; access to appropriate antiretroviral regimen for pregnant women and exposed babies, including adherence counselling; counselling on infant feeding practices; and early infant diagnosis and follow-up testing at 18 months. Services are integrated within strengthened maternal and child health systems, including focused antenatal care and skilled birth attendance at delivery. Ninety-four percent of UNHCR operations in 2013 ensured continuous access to emergency obstetric care during the day for refugees and the hosting communities.

### III. UNHCR and UNAIDS

18. Pursuant to the UNAIDS Division of Labour, UNHCR and WFP, as co-conveners of the area *Addressing HIV in Humanitarian Emergencies*, continue to work with United Nations and NGO partners and national AIDS control programmes to strengthen the HIV response in emergency settings. At the global level, Inter-Agency Task Team on Addressing HIV in Humanitarian Emergencies (IATT) spearheaded several efforts to strengthen advocacy, develop guidance and provide technical support to regions and countries, and to improve coordination and monitoring and evaluation. The IATT promoted increased awareness among government representatives, donors, policy makers, humanitarian NGOs and development partners in the Central African Republic and South Sudan on the need for a strengthened HIV response for IDPs.

19. UNHCR conducted a situational analysis in the Central African Republic, with the aim of helping patients to continue or resume their ART. Before the onset of the crisis in March 2013, between 12,000 and 15,000 people living with HIV were on ART; however, the crisis disrupted care for patients living with HIV and tuberculosis in Bangui and other provinces, and an IATT CAR task force was established in response. UNHCR's analysis helped to estimate numbers of patients whose treatment had been disrupted, establish which health centres were functional, and determine the locations where international and national partners were still operational. UNHCR, the Global Fund To Fight AIDS, Tuberculosis and Malaria (Global Fund), the Centre Nationale de Lutte contre le SIDA (CNLS) and other partners developed a joint roadmap towards the restoration of ART services.

20. To strengthen evidence-based PMTCT programming in emergencies and support the *Global Plan Towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive*,<sup>6</sup> UNHCR joined UNICEF and Save the Children in developing recommendations for PMTCT in humanitarian action. A systematic review of available literature as well as interviews with key informants working on PMTCT in humanitarian settings will be completed in 2014.

21. A UNHCR-WFP workshop in Myanmar with stakeholders in the national HIV response resulted in the inclusion of HIV in humanitarian settings in the National Strategic Plan for HIV and AIDS. In Kenya, the National AIDS Control Council, in collaboration with UNHCR, UNAIDS, IOM and other partners, supported the development of *National Guidelines for HIV Interventions in Emergency Settings*. In addition, national and international partners developed contingency plans in one context in which civil unrest and violence were anticipated as possible. The contingency planning exercise led to the establishment of decentralized ART distribution hubs areas that previously experienced violence that had disrupted patients' access to treatment.

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<sup>6</sup> Available at <http://www.unaidsrsta.org/resources/reports>

22. In 2013, UNHCR, UNICEF, WFP and UNAIDS trained UN and partners staff, including government officials, from five states in South Sudan on HIV in the humanitarian response to emergencies, including rapid assessment. In addition, WFP, UNHCR and the Asia Pacific Network of People Living with HIV/AIDS developed a regional action plan and tools for community-based organisations involved in emergency preparedness and HIV response.

## **IV. Conclusion**

23. Significant progress has been made toward ensuring that refugees and other persons of concern have access to public health, nutrition and HIV services. The recent advances and updated protocols and guidance highlighted in this paper will require sustained advocacy and support, if UNHCR and its partners, including host governments, are to build upon these improvements and, in particular, to enable and ensure that refugees are included in national health services. Where such inclusion is not possible, parallel services provided to refugees must, nonetheless, be harmonized with national systems. UNHCR will continue to advocate with partners and support host governments to deliver evidence-based services in a cost-effective manner.

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