ANNUAL REPORT 2009

Public Health and HIV

UNHCR
The UN Refugee Agency

Annual Report 2009 Public Health and HIV

Table of Contents

List of Acronyms

Anti Retroviral Therapy	ART
Epidemic Preparedness and Response	EPR
Global Acute Malnutrition	GAM
Internally Displaced Persons	IDPs
Information, Education and Communication	IEC
Long Lasting Insecticide-treated bed Net	LLIN
Memorandum of Understanding	MoU
Non-Governmental Organisation	NGO
Primary Health Care	PHC
Public Health and HIV	PHHIV
Prevention of Mother-to-Child Transmission	PMTCT
Person of Concern (to UNHCR)	PoC
Severe Acute Malnutrition	SAM
Standard Operating Procedure	SOP
Sexually Transmitted Infection	STI
United Nations High Commissioner for Refugees	UNHCR
Voluntary Counselling and Testing	VCT
Water, Sanitation and Hygiene Promotion	WASH

Cover photo: © UNHCR/ F. Noy, October 2009

Executive Summary

Public Health

Following the introduction of the Public Health and HIV Guiding Principles and Strategic Plans for 2008-12, UNHCR has progressed considerably in providing PHHIV services to refugees and other persons of concern (PoCs) to UNHCR. Interventions were supported by additional funds received by the High Commissioner and numerous multilateral and bilateral donors.

UNHCR has begun to develop standard operating procedures for urban and other non-camp settings that aim to improve the efficiency and equity of health care assistance to PoCs and surrounding host communities. A new document entitled *Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern* has helped in the development of this process.

The improved impact in UNHCR's malaria programmes since 2005 have seen a substantive increase in 2009 by strengthened implementation of prevention and control activities. In an effort to achieve universal coverage in line with the Roll Back Malaria Strategic Goals and the Global Malaria Action Plan, UNHCR with the support from the "Nothing But Nets" campaign began to effectively distribute one long-lasting insecticide-treated net for every two PoCs in malarial endemic areas.

Epidemic Preparedness and Response projects initiated in 2007 to prepare for Avian Human Influenza have successfully turned into a series of actions to mitigate the consequences of epidemics in general as well as the 2009 H1N1 pandemic in refugee situations. UNHCR has concentrated on reinforcing disease surveillance and early warning systems as well as contingency planning. The emergence of new viruses that could be associated with higher death rates remains a serious threat to vulnerable communities such as UNHCR's PoCs. UNHCR along with its UN sister agencies will continue this project in 2010-11.

UNHCR's standardised health information system has undergone a revision based on evaluations carried out in 2008. Disease surveillance and early warning have been streamlined into the monitoring process. The health information system has been adopted for non-camp emergency settings and was successfully introduced into the internally displaced context in North Kivu, DRC through the cluster process.

HIV/AIDS and Reproductive Health

The Refugee Agency continued to implement comprehensive HIV and AIDS protection, prevention, treatment, care and support programmes for PoCs based on UNHCR's Global Strategic Objectives 3 and 4 and its 2008–12 Strategic Plan for HIV. UNHCR made progress in improving access to antiretroviral therapy; approximately 87% of refugees have access to treatment programmes that are available to surrounding host populations by the end of 2009; an increase of 2% from 2008. Access to prevention of mother to child transmission programmes increased from 56% in 2008 to 75% in 2009.

The development of new guidance on HIV counselling and testing addressed important protection needs for its PoCs and reinforced HIV as a protection priority for the organisation.

The Refugee Agency maintains its advocacy strategy for the inclusion of refugee and internally displaced populations into national strategic plans, proposals and programmes. UNHCR also advocates for the inclusion of HIV programming as a cross-cutting issue into all clusters of the humanitarian reform process.

UNHCR has strategically underpinned the inter-linkages among HIV, reproductive health and sexual gender-based violence to better provide assistance to survivors of rape and reach out to vulnerable groups to target them with HIV prevention activities.

UNHCR reproductive health programmes aimed at reducing maternal and neonatal mortality through reinforcing the implementation of the Minimum Initial Service Package during the initial stages of displacement and emergencies, and by integrating comprehensive services as the situation stabilises. Valuable progress was achieved in countries that received support and additional funds in 2009. Many of UNHCR's operations have adapted the 2008-12 Strategic Plan for Reproductive Health to their specific context and are using it as a reference for programming.

Nutrition and Food Security

UNHCR expanded the Special Project created by the High Commissioner in 2008 to combat high rates of anaemia and malnutrition to seven operations in 2009. Evaluations of these projects in 2009 have shown significant reductions in anaemia in countries where the project has been fully rolled out. Essential nutrition activities included the scaling up programmes to support and promote infant and young child feeding practices occurred.

UNHCR focused on the capacity building of refugees in micro-agricultural production and supported projects such as multi-story gardens and poultry farms to improve food security and nutritional status of refugees at the household level. UNHCR continues to work in collaboration with WFP through the UN Comprehensive Frame for Action and within the UNHCR-WFP memorandum of understanding on mitigating the effects of the food crisis to PoCs at all levels.

Water, Sanitation and Hygiene Promotion (WASH)

The WASH Special Projects 2008/09 to enhance WASH services in 24 selected countries have had a positive impact on the wellbeing and health of refugees. However, challenges to provide sufficient quantity and quality of services to meet the minimum standards remains very real in many refugee and other PoC situations. Resource limitations mean that too often investments in the upgrading of infrastructure like water systems, sanitation and solid waste management fall short of the actual needs. UNHCR has identified that hygiene promotion projects at the operational level require a more integrated approach by the agency and its partners. Technical support and guidance to improve effectiveness and impact will be strengthened in 2010-11.

Introduction

The Office of the United Nations High Commissioner for Refugees (UNHCR) delivers public health and HIV (PHHIV) services through a human rights and protection approach based on humanitarian principles and in accordance with the Refugee Convention of 1951.

PHHIV services are defined as public health, reproductive health, child and adolescent health, epidemic preparedness and response, nutrition, food security, water, sanitation and hygiene promotion (WASH) and HIV/AIDS.

The aim of UNHCR's PHHIV operations is to reduce morbidity and mortality and to enhance the quality of life of refugees, internally displaced persons (IDPs) and other persons of concern (PoCs) to UNHCR. Programmes employ evidence-based public health practices within a framework of protection and international humanitarian standards. Interventions endeavour to deliver durable solutions by addressing root-causes of public health concern.

The refugee agency has a planning, coordination, monitoring and evaluation role. To ensure a strengthened protection response, UNHCR works closely with partners who implement health programmes in a range of challenging settings. The UNHCR public health experts are the focal points for their health partner counterparts. Planning of interventions is based on an assessment of needs, vulnerabilities and risks. Programme implementation is built on a scientific evidence base and follows the principles of results-based management.

UNHCR provides PHHIV programmes to over 10 million refugees and other PoCs in over 120 camps, as well as to millions of PoCs in urban and rural settlements in over 50 countries. The UN Refugee Agency has more than 100 public health, nutrition, HIV and WASH experts working around the globe. This technical expertise helps to ensure that PHHIV programmes and their protection aspects are implemented efficiently and that the PoCs receive quality interventions.

> Under international law, everyone has the right to the highest standards of physical and mental health
>
> Article 12, International Covenant on Economic Social and Cultural Rights, 1966

Facts & Figures

UNHCR Annual Budgets 2009

Sector F - Health*:	USD 103,030,874
Sectors D,E - WASH:	USD 43,650,268

** including nutrition and HIV*
Information extracted from Global Focus on 13/01/2010

Key statistical figures

Refugees and other PoCs benefiting from UNHCR health services	> 10 million
UNHCR PHHIV IPs/OPs worldwide:	>150
UNHCR PHHIV staff:	120
Partner health staff	> 7000
HIS implemented in	17 countries
...covering	87 camps, 1.5 million PoCs
PoCs with access to ART:	87%
PoCs with access to PMTCT:	75%
Average GAM:	8.8% (range 2.7-18.7)
Average SAM:	1.4% (range 0.5-3.5)
Average anaemia (U5):	42.1% (28.3-75.7)

Ifo camp, Dadaab, Kenya - © UNHCR/ B. Heger, September 2009

Public Health

Providing Essential Public Health Services and Ensuring Quality and Access

UNHCR's public health programmes aim at providing preventive and curative primary health care (PHC) services together with limited referral opportunities to higher-level care. Coordination and prioritisation are crucial to ensure the effective and equitable use of limited resources and to sustain high quality care. Public health programmes are implemented with an emphasis on community participation and capacity building. UNHCR supports PHC programmes in over 40 country operations, enabling over 10 million refugees, IDPs and other PoCs to enjoy access to basic health services.

The UNHCR Public Health and HIV Section consists of a network of approximately 105 regional and country coordinators, supported by a small team of technical officers at headquarters. In addition, most UNHCR operations without a technical expert have a designated health and/or HIV focal point in order to benefit from the expertise and to streamline public health and HIV policies into all operations.

UNHCR's coordinating role becomes apparent in the way the Refugee Agency works with implementing partners (IPs), who are in most settings the direct care and assistance providers. In the sectors of health, HIV, nutrition, food security and WASH alone, UNHCR works with over 150 partners with more than 7000 staff, including international and national non-governmental organisations (NGOs), Ministries of Health and other national authorities, faith-based organisations and refugee community-based organisations.

Health Services for Urban Refugees

Many of the health strategies, policies and interventions for refugees are based on camp-based refugee contexts in low-income countries. In such situations, existing national health services are often insufficient to meet the needs of their nationals or to be extended to cover refugee needs. Refugees are often located in remote and isolated areas where the only practical alternative is parallel health services provided and implemented primarily by NGOs, and coordinated and monitored by UNHCR. This situation leads to a relatively circumscribed population that is often dependent upon most services including food aid and health care. An exacerbation of existing communicable diseases often punctuated with epidemics and acute malnutrition are the most common illnesses, often aggravated by WASH issues and poor shelter.

Almost half of the world's refugees now reside in non-camp settings including urban areas. Furthermore, a larger proportion of refugees are now fleeing from middle income countries. In the latter settings, the demographic and disease epidemiologic profiles are that of an older population with chronic diseases. These changes have had major consequences for UNHCR and its partners. In 2009, UNHCR published its *Policy on Refugee Protection and Solutions in Urban Areas* (*http://www.unhcr.org/4ab356ab6.html*). The key message of this policy is that the location of a refugee does not determine their protection status. Refugees living in urban areas are recognized as having the same protection needs as those living in camps, even if the needs and the delivery of services may be different.

UNHCR must ensure that urban refugees and other PoCs have access to affordable health services, and that access to affordable health services for urban refugees will follow UNHCR's PHHIV Guiding Principles (*http://www.unhcr.org/488600152.html*). Taking into account the specific needs of urban refugees in accessing these services, UNHCR has developed a three-pronged strategy:

Advocacy: UNHCR will advocate on behalf of refugees and other PoCs to ensure that national authorities make public services such as health care, nutrition programmes, and water and sanitation services available to these populations at limited or no cost.

Support: UNHCR will support urban refugees and other PoCs by integrating them into the existing public health services and by augmenting the capacity of these systems.

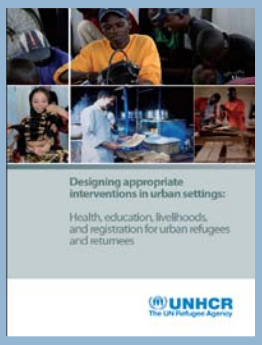
Cost of Tertiary Care for Iraqi Refugees in Syria in 2009

In 2009, UNHCR spent ~USD 4 million on tertiary health care budget for Iraqi refugees in Syria. Out of this amount, 69% were allocated to the 4 major causes of tertiary care: cardiac, orthopedic surgery, cancer treatment and renal dialysis.

Type	Nr.	Total Cost	Av. Cost/ Case
Cardiac surgeries	300	$0.755 m	$2,517
Cancer	455	$1.4 m	$3,077
Renal dialysis	32	$0.120 m	$3,750
Other renal cases	30	$0.250 m	$8,333
Orthopedic surgeries	60	$0.250 m	$4,167
TOTAL	**877**	**$2.775 m**	**$3,164**

High Commissioner's Dialogue 2009

Strategy for designing appropriate interventions in urban settings.



http://www.unhcr.org/4b2789779.html

Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern

http://www.unhcr.org/4b4c4fca9.html

Monitor: UNHCR will assess, monitor and evaluate the public health (including water, sanitation and access to health care) and nutritional status of urban refugees and other PoCs to ensure that they do not fall below acceptable standards.

Outlook 2010: *UNHCR will develop a standardised health information system (HIS) for urban refugee settings that will enable the agency to collect information and to analyse data that will help improve the access and level of care provided to displaced urban populations. Case studies and practical guidance for interventions will be developed.*

Referral Care

The focus of UNHCR's health programmes is a combination of preventive and curative PHC that employs a public health and community development approach. If medical conditions cannot be managed at the primary level, referral for emergency or essential medical, obstetric and surgical care to the nearest appropriate health care facility is required. Based on the identified need to provide programmatic guidance to its operations in order to ensure that referral systems are being set up in an efficient and effective manner, standard operating procedures (SOPs) and tools for monitoring and decision making were developed by UNHCR in a consultative manner with colleagues from country operations and implementing partners to develop *Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern.*

Outlook 2010: *UNHCR will continue to work in a consultative manner to ensure that referral SOPs are being developed, referral systems set up, and monitoring mechanisms put in place. UNHCR will evaluate this process by the end of 2010 to draw important lessons learnt in order to streamline the process into its assistance programmes.*

Republic of Congo - © UNHCR/ P. Spiegel, March 2009

Republic of Congo - © UNHCR/ F. Noy, March 2010

Malaria Prevention

In 2009, UNHCR engaged in a partnership with one of the leading global malaria fund-raising networks, the United Nations Foundation "Nothing but Nets" campaign. Together, the two organisations raised in excess of USD 8 million with the aim of covering refugees in Africa with lifesaving long lasting insecticide bed-nets (LLINs). The project has already been implemented successfully in 5 countries with 11 more countries preparing for roll-out in 2010.

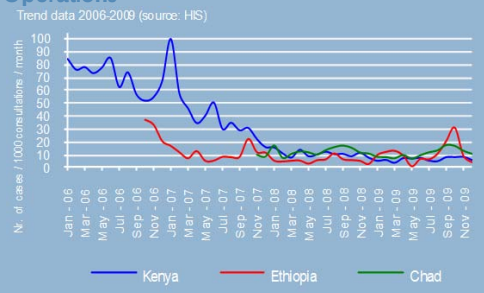
The project's objective is to raise the level of LLIN usage amongst refugee communities at risk from malaria to full coverage (1 net for every 2 persons to sleep under), a target that without the help of the UN Foundation, UNHCR would lack the resources to reach. LLINs are particularly effective in preventing malaria transmission in a community if used consistently and at high coverage (above 60%). LLINs retain the active insecticide for 3 to 5 years without the need for re-impregnation. Bednet use in conjunction with early diagnosis and access to effective treatment are the essential malaria control components to achieve durable reduction in malaria infection and avert deaths from malaria.

Outlook 2010: *The significant improvement in UNHCR's malaria programmes will be sustained by improved diagnosis and treatment. In 2010, UNHCR will work closely with malaria and laboratory experts to engage with partners and health care providers to strengthen the capacity of laboratory and clinical staff and to improve the quality of malaria diagnosis.*
In an effort to achieve universal coverage in line with the Roll Back Malaria strategic objectives stated in the Global Malaria Action Plan, UNHCR aims to distribute one LLIN for every two PoCs in malaria affected areas by the end of 2010, and to sustain coverage through continuous sensitisation and education campaigns as well as targeted routine distributions of LLINs.

Malaria Trends in Selected Malaria-Endemic Operations

Incidence rates of malaria continued their downward trend in 2009 due to a concerted approach of prevention practices such as LLIN use and early clinical management of malaria with effective combination therapy. The graph below depicts trend data from Kenya, Ethiopia and Chad.

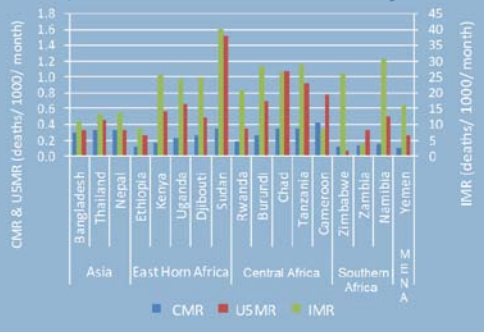
Crude Malaria Incidence in selected Refugee Operations



Mortality Rates

A positive trend for crude, under-five and infant mortality rates continued with rates below emergency thresholds (CMR=1.5, U5MR=3.0 per 1000 population per month; IMR=60 per 1000 live births per year). These rates are indicative of the health status of a population and are proxy measures for access to health care and management of emergencies.

Crude, Under-fives and Infant Mortality Rates



Immunisation Coverage

Good immunisation programmes are the cornerstone to avoiding outbreaks of vaccine-preventable diseases, in particular measles. Positive data trends show that with concerted efforts and coordination with national Expanded Programme on Immunization (EPI) programmes and UNICEF, achieving high coverage rates is possible. However, many operations have yet to achieve and sustain sufficiently high coverage rates.

Epidemic Preparedness and Response including Pandemic Influenza H1N1

In 2009, epidemic preparedness and response (EPR) projects were implemented in 22 countries with a total budget of nearly US$ 1.5 million. These projects targeted a wide range of interventions such as raising outbreak awareness, improving WASH programmes, rehabilitating basic health infrastructure, contingency planning, building isolation wards, stockpiling essential medicines and laboratory tests, and improved infection prevention and drug management.

The 2009 Pandemic Influenza H1N1 brought increased focus on surveillance in collaboration with the HIS programme and operational response. Although individual H1N1 cases were recorded among refugees, no major H1N1 outbreak was observed in refugee communities in 2009.

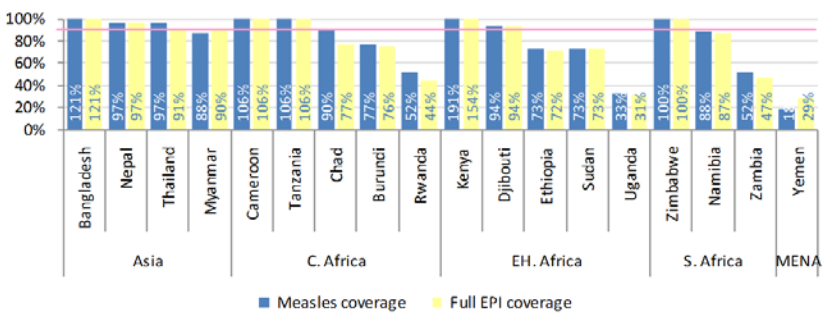
Outlook 2010: *In 2010, UNHCR will document, country by country, the actual level of operational preparedness and response towards local epidemic threats. The major gaps identified will be addressed. After this review, it is expected that UNHCR should be able to maintain and monitor the readiness of routine system to prepare and respond to epidemics.*

Health Information System (HIS)

UNHCR's HIS is a standardised tool to design, monitor and evaluate refugee and other PoC PHHIV programmes. The aim is to improve the health status of refugees and other PoCs to UNHCR through evidence-based policy formulation and improved management of PHHIV programmes.

At the end of 2009, a total of 18 operations in Africa, Asia and Middle East and North Africa (MENA) regions were reporting into the HIS using common tools and guidelines. The total population under surveillance was approximately 1.5 million across 87 refugee camps and 25 different IPs. The system was able to report core indicators required for UNHCR Standards and Indicators, UNHCR's PHHIV Section Strategic Plans 2008-2012, Sphere and other international standards.

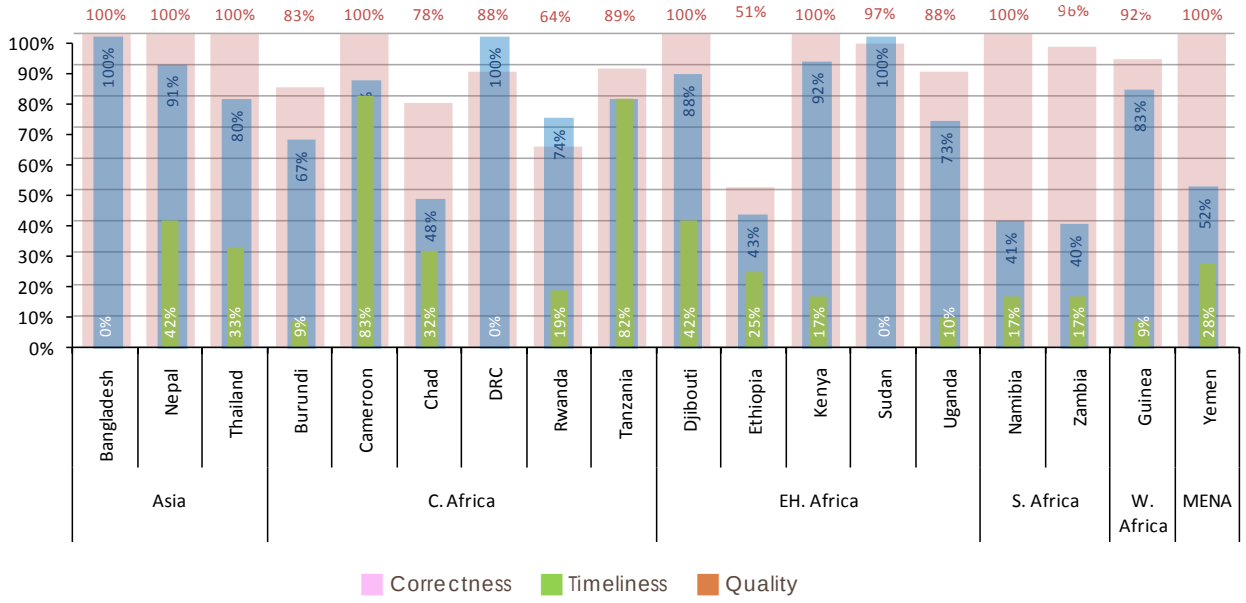
Measles and full EPI Coverage Rates



A major achievement in 2009 was the adaptation of the HIS to emergency settings and its endorsement by the Global Health Cluster as a core operational data management tool for humanitarian emergencies. The latter has led to the introduction of HIS in a number of non-refugee emergencies, including among IDP operations in Pakistan and DR Congo and as part of the response to the earthquake in Haiti. It has also been deployed in support of emergency refugee operations in the Central African Republic and the Republic of Congo. During 2010, UNHCR will maintain a stand-by capacity to deploy the emergency HIS at short notice to other humanitarian operations as required.

The performance of the HIS in each operation is being monitored as to the overall quality, timeliness and completeness of data. Quarterly bulletins with performance indicators and feedback as to monitoring of services as well as missing and erroneous data are sent to country coordinators. This evaluative approach is intended to increase the performance and contribute to the utilisation of HIS for programmatic decision-making.

Performance of HIS Reporting in 2009



Outlook 2010: *An additional initiative in 2010 will be the development a web-based version of the HIS. This will enable data to be more readily shared and accessed by both UNHCR and external users, such as donors, other UN agencies, NGOs and academia. It will also provide a platform from which the routine HIS data can be visualised and compared with other forms of data, such as surveys, assessments and narrative reports. This will be done in coordination with other UNHCR initiatives (such as Focus, Livelink and the Geoportal) as well as other projects within the Global Health Cluster (such as the IRA and HNTS). As mentioned in the urban refugee section, a more systematic urban HIS will be developed in 2010.*

Eastern Sudan- © UNHCR/ C. Haskew, 2008

HIV and AIDS and Reproductive Health

Ensuring Universal Access to Prevention, Treatment and Care

In 2009 UNHCR continued to advocate for the inclusion of refugee and IDP populations into National Strategic Plans (NSPs) and programmes for HIV and malaria at global, regional and country levels in order to successfully ensure that refugees and IDPs are included in national disease-specific plans.

Unfortunately, the inclusion of refugees in HIV NSPs has reduced over time. While there was an increase from 2004 until 2006 in planned specific activities for refugees that were mentioned in the plans, the trend is reversing.

UNHCR will continue to advocate for improved coordination among Governments, the UN system and civil society during the planning and revision of NSPs and in donor funding requests at country level. This will become more important as the Global Fund moves towards funding NSPs in the future.

UNHCR strengthened its sexual reproductive health and HIV programmes to ensure that interventions better address the needs of the populations most at risk. An important area has been the development of multi-sectoral programmes to reduce the vulnerabilities and risks related to HIV and sex work. A range of multi-sectoral programmes were developed to address the immediate concerns related to sexual and gender based violence (SGBV) and to prevent HIV and sexually transmitted infection (STI) transmission.

Key protection concerns regarding HIV counselling and testing were addressed in the development of specific guidance on HIV testing among refugees and other conflict-affected persons. This guidance is particularly needed in countries where stigma and discrimination is high and refugees are mistakenly seen as 'bringing HIV into the country'.

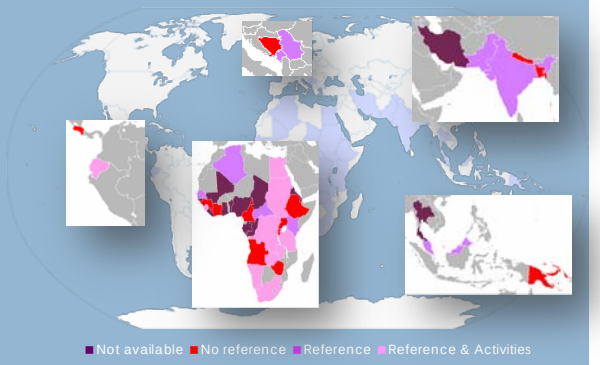
HIV and GBV awareness campaign in Southern Africa- © UNHCR/ May 2009

Inclusion of Refugees in HIV National Strategic Plans (NSPs)

In 2006, 46 countries hosted ≥5000 refugees. From these countries, 35 had a current NSP for HIV, 12 (34%) did not make a reference to refugees; 8 (23%) made a reference and 15 (43%) referred to specific activities.

In 2008, 46 countries hosted ≥5000 refugees. From these, only 32 countries had a current NSP for HIV, 14 (44%) did not reference refugees; 9 (28%) referenced refugees and 9 (28%) referred to specific activities.

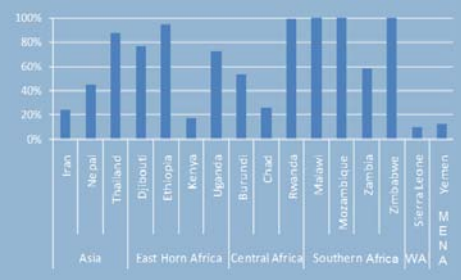
Inclusion of Refugees in HIV/AIDS NSPs in Countries with ≥5,000 Refugees in 2008



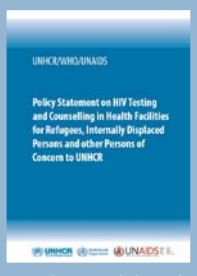
Access to ART and PMTCT

UNHCR made some progress in improving refugees' access to ART globally. Currently ~87% of refugees have access to treatment programmes when they are available to the surrounding national populations; an increase of 2% from 2008. Access to PMTCT programmes increased from 56% in 2008 to 75% at the end of 2009. Although coverage rates vary among countries.

PMTCT Coverage Rates



Policy Statement on HIV Testing and Counselling in Health Facilities
for Refugees, Internally Displaced Persons and other Persons of Concern to UNHCR



http://www.unhcr.org/4b508b9c9.html

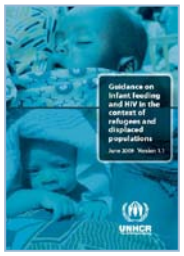
UNHCR continued to address the inter-linkages between HIV and SGBV. Training and support were provided to improve the quality of the clinical management of rape. Advocacy to ensure that national legislation on HIV and the respect for the human rights of PoCs to UNHCR was undertaken.

Strong collaboration with UNFPA has led to important support of commodities, whereby UNFPA is providing male and female condoms to all refugee programmes. Furthermore, there continues to be strong collaboration in the field on reproductive health, clinical management of rape, HIV prevention and response for young people and HIV, and sex work. Other key UN partners for HIV for UNHCR are WFP, WHO and UNICEF.

UNHCR has been fully integrating the HIV indicators into the health facility-based HIS. Since 2009, ART coverage and adherence have been included as well in the health facility-based information system.

Guidance on infant feeding and HIV

in the context of refugees and displaced populations (***UPDATED VERSION 2009***)



http://www.unhcr.org/4acb0c111b.html

Funding for HIV programmes has been provided through the agency's own resources as well as from contributions received from UNAIDS and joint partnership programmes. Earmarked contributions for HIV have been received from the Danish and US Governments for HIV programmes in Africa. At country level, support has been provided through the US President's Emergency Plan for AIDS Relief. Regional programmes were supported through the Great Lakes Initiative against AIDS and the Interagency Regional HIV/AIDS Partnership Programme by World Bank as well as the OPEC Fund for International Development.

Outlook 2010: *UNHCR will focus on ensuring quality and sustainable HIV programmes embedded in multi-sectoral response to HIV, further strengthening the inter-linkages between HIV programmes and reproductive health and SGBV as well as HIV and Tuberculosis. UNHCR will strengthen its advocacy efforts to ensure that PoCs are included into NSPs and programmes for universal access.*

The organisation continues to be an active cosponsor of UNAIDS and leads in the field of HIV in humanitarian settings. UNHCR will continue to advocate for PoCs to be meaningfully included in national HIV policies, strategies and proposals. The agency will continue to ensure that global guidance is adapted to the operational context in which UNHCR is acting, and will work with others to ensure that HIV is properly and effectively integrated in a multi-sectoral and cross-cutting manner in the humanitarian reform process.

HIV Testing and Counselling in Kakuma camp, Kenya © UNHCR/ A. Webster, December 2006

Clinical Management of Rape

The number of rape survivors having access to post exposure prophylaxis (PEP) increased from 53% in 2008 to 88% in 2009. The number of survivors having access to emergency contraceptives within 5 days increased from 46% to 69%, and the access to presumptive treatment for STIs increased from 72% to 76% from 2008 to 2009.

Differences are still seen within and among countries. The below table provides the data available from countries that have a functioning camp-based HIS.

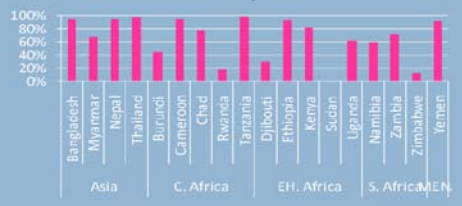
	Total no. of rapes reported to health facilities	% ECP <120 hrs	% PEP <72 hrs	% STI <2 wks
Standard		100%	100%	100%
Global	264	69%	88%	76%
By country				
Bangladesh	15	71%	92%	93%
Burundi	1	0%	0%	0%
Cameroon	1	100%	100%	100%
Chad	7	86%	N/A	N/A
Djibouti	7	0%	0%	14%
Ethiopia	4	100%	N/A	N/A
Kenya	32	N/A	N/A	N/A
Nepal	25	79%	95%	92%
Rwanda	6	N/A	N/A	N/A
Sudan	0	N/A	N/A	N/A
Tanzania	41	49%	48%	80%
Thailand	7	100%	N/A	N/A
Uganda	98	46%	N/A	83%
Yemen	17	N/A	N/A	N/A
Zambia	3	0%	0%	33%

N/A = data not available

Antenatal Care

The coverage of antenatal care is dependent on the availability, access, quality as well as awareness and acceptance of services. Aiming at full coverage and universal access, the graph below highlights successes in some operations and need for further improvements in others.

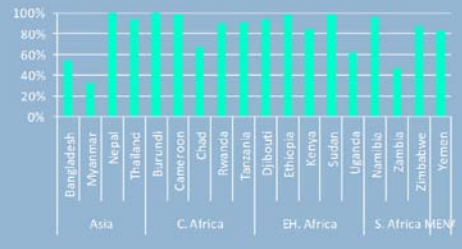
Antenatal Care Coverage



Safe Delivery Practices

Substantive progress has been achieved in providing pregnant women access to safe delivery and emergency obstetric care. A majority of operations has improved access to skilled birth attendants.

Proportion of Births Attended by Skilled Personnel



Practicing Baby Care at Mae La camp, Thailand © UNHCR/ T. Falise, June 2009

Reproductive and Child Health

UNHCR continued to support the establishment of comprehensive reproductive health programmes. In 2009, UNHCR ensured a further strengthening of the linkages of reproductive health services to HIV prevention.

In partnership with UNFPA and the International Planned Parenthood Federation, UNHCR initiated the establishment and capacity building of multi-functional country teams to ensure a strong coherent response to reproductive health in newly emerging crisis situations and foster coordination mechanisms.

UNHCR focuses on the establishment of comprehensive quality safe motherhood services to avoid preventable maternal and neonatal deaths. The investigations of maternal death were reinforced in camp settings and actions were taken to strengthen the referral system for emergency obstetric and neonatal care.

A new e-learning programme on the clinical management of rape was developed and will continue to be rolled out to ensure that all clinical staff have skills to provide quality post rape services.

The online course is available at: *http://iawg.net/cmor/*

Outlook 2010: *During 2010-2011, UNHCR will continue to support reproductive health in emergencies and promote integrated interventions with all stakeholders to strengthen the overall service delivery in terms of increased access to better quality services and appropriate use of allocated resources. Emergency obstetrical care as well as care and treatment of rape survivors will continue to be a priority during and after the emergency phase while improved quality of family planning programmes will be a priority in the post emergency phases.*

WATER, SANITATION AND HYGIENE PROMOTION

Access to water, sanitation and hygiene promotion (WASH) is a fundamental human right and essential to life, health and dignity. Timely and adequate provision of clean WASH services to uprooted people is particularly important, given the vulnerability of their situation. The overall objectives of UNHCR's WASH programmes are to minimise avoidable mortality and morbidity among displaced people and to mitigate the resulting impact on the local environment including fresh water.

Based on various assessments of UNHCR operations in the past two years and the gaps thus identified as well as the strategic objectives set out by the High Commissioner for 2009, the Office has initiated a Special Project in mid-2008 to enhance WASH services in selected operations. This Special Project continued in 2009; a sum of $4,010,000 was allocated to improve existing water supply and sanitation systems in 17 UNHCR operations in Africa, Asia and MENA regions. Projects focused mainly on improvement and rehabilitation of existing systems, the provision of non-food items, enhancing technical capacity to monitor and improve quality of services, and the implementation of hygiene promotion activities. This effort has build synergy with the High Commissioner's Special Projects in health and nutrition, and thus contributed to improving the impact on the health and well-being of refugees and other PoCs. The 2009 WASH Special Projects will be mainstreamed in 2010 to integrate WASH activities into regular programmes.


Dadaab, Kenya © UNHCR/ E. Hockstein, December 2008


Umpium camp, Thailand © UNHCR/T. Falise, June 2009


Gbagbio, Cameroon © UNHCR/ F. Noy, October 2009


Larama camp, Pakistan © UNHCR/ H. Caux, June 2009


Mae La camp, Thailand © UNHCR/T. Falise, June 2009


Yemen © UNHCR/
R. Nuri, March 2009

Outlook 2010: *UNHCR will focus on 10 priority countries by supporting them through technical advice, field missions, training, and some additional funding to improve the WASH situations in specific camps. The agency will strengthen its existing partnerships with NGOs and donors and create new ones with universities and research centres that will allow UNHCR to be more innovative on issues related to overcrowded camp settings and the management of limited resources. UNHCR will continue to contribute and participate in global water initiatives such as global WASH cluster activities and UN-Water to raise the profile of refugees and other PoCs and to ensure that our concerns are adequately addressed in such international fora.*

A set of guidelines for hygiene promotion will be developed that will help to build the capacity of staff and improve coordination for hygiene promotion interventions in refugee situations. The document is expected to be available mid 2010.

The collection and sharing of WASH information and data are areas that will be strengthened in 2010. Specific and standardised WASH indicators will be integrated with UNHCR's HIS.

Mazrak IDP camp, Yemen © UNHCR/ H. Macleod, November 2009

Malnutrition & Anaemia Rates

While 62% of operations where nutrition surveys were conducted in 2009 displayed severe acute malnutrition (SAM) rates within acceptable standards, only 46% reached the GAM target. And despite advances in individual operations in reducing high levels of anaemia through the anaemia strategy, anaemia rates were found to be elevated in all operations.

This elevation is not surprising considering the need to not only address nutritional gaps and micronutrient deficiencies, but also to address root causes of anaemia in refugee camp settings. The impact of the strategy is expected to show its full potential after 3 years of targeted programming.

	GAM (%)	SAM (%)	Anaemia (%) U5 children	Anaemia (%) WORA
Standard	< 10%	< 2%	< 20%	< 20%
Global	8.8	1.4	42.1	25.6
By country				
Bangladesh	18.7	2	28.9	N/A
Chad	12.3	0.8	30.9	30.9
Djibouti	12.7	2.9	67	45
Ethiopia	10	0.8	38.8	20.2
Kenya	13.8	1.3	75.7	60.8
Myanmar	21	2.6	N/A	N/A
Nepal	7.2	1.4	35.9	14.4
Sudan (east)	14.8	3.5	58	N/A
Syria	5.4	1.9	54.4	N/A
Thailand	2.7	N/A	N/A	N/A
Uganda	3.3	0.5	54.35	32.7
Yemen	9.3	0.6	60.9	N/A
Zambia	3.1	1.1	48.3	12.7

N/A = data not available

Nutrition and Food Security

Anaemia Control

A novel strategy for addressing micronutrient deficiencies

Significant achievements were made in 2009 towards reducing anaemia in children in the camps in Bangladesh and in Nepal, where 40% and 17% reductions, respectively, were observed. Algeria and Djibouti both undertook formative research into acceptability of products to prevent and treat anaemia. The findings of this research were instrumental in guiding programme planning such as in culturally appropriate delivery mechanisms and packaging designs. Kenya continues to be the largest operation to benefit from the micronutrient powder distribution and much work has been accomplished in rolling out the distribution while investigating underlying causes of the challenges to uptake. These lessons have been invaluable in feeding into the planning of other interventions especially amongst other Somali populations in Yemen and in Ethiopia.

UNHCR worked very closely with its nutrition and food security partner, WFP as well as the Institute of Child Health at the University College London on developing the technical expertise necessary to implementing the anaemia strategy in refugee settings.

Outlook 2010: *Plans for 2010 include the roll out for Algeria, Ethiopia, Djibouti, Yemen and further development in Kenya. Evidence-based field guidance based on the experiences gained so far will be field tested and finalised, thus facilitating roll out to other countries. Some detailed technical challenges remain, such as which form and what quantity of iron to use in malaria endemic areas. We aim to resolve these issues for UNHCR programmes during 2010. Furthermore, as these are pioneering interventions, quality data collection and management is essential. Thus, the project will strive to facilitate and to improve the quality of monitoring and evaluation, as well as to document their impact.*

Food Security

In light of a worsening global economic situation and food crisis

2009 was a devastating year for the world's hungry, significant worsening an already disappointing trend in global food security since 1996. The global economic slowdown, following on the heels of the food crisis in 2006–08, has deprived an additional 100 million people of access to adequate food. According to the 2009 FAO report on the state of the world food insecurity, there have been marked increases in hunger in all of the world's major regions, and more than 1 billion people are now estimated to be undernourished. More than 70% of them reside in Asia and Africa.

Refugees and IDPs, who often live in remote and barren areas with limited access to fertile lands and livelihood activities, continue to be negatively affected by this situation. Situations in countries where refugees used to cultivate and have other self reliance projects like Uganda and Zambia have reduced access to food because of the combined effects of the food crisis, financial crisis and climate change.

All through this critical context, UNHCR and WFP continued a smooth collaboration serving refugees and other PoCs. The two organisations collaborated particularly in areas of nutrition, logistics, school feeding, biometrics, advocacy, joint assessment missions, regional meetings and trainings, to cover the food and nutrient needs of more the two millions refugees and 10 million IDPs in 26 countries in the world. Joint assessment missions were undertaken in 11 countries. This collaboration culminated in the organisation of two High Level Meetings in 2009. These meetings were good opportunities for the newly appointed Executive Staff on both sides to meet for the first time and discuss pressing issues such as joint fund raising, biometric, urban refugees and the anaemia strategy. Several commitments were taken to support each other in order to improve food assistance delivery to refugees and IDPs in this context of increasing financial crisis and shortage of resources.

In Djibouti, UNHCR and WFP developed a post-distribution monitoring system to better understand how refugees use the food aid at the household level. In Sudan, the agencies worked together to combat the high levels of malnutrition through a blanket feeding programme for young children. In Uganda, discussions are underway regarding a possible cash transfer programme in lieu of food to improve refugee market purchasing power and nutritional outcomes.

Outlook 2010: *UNHCR will focus on the capacity building of refugees in micro-agricultural production, support projects such as multi-story gardens and poultry farms to improve food security. UNHCR will work closely with WFP through the UN Comprehensive Frame for Action and within the UNHCR-WFP MoU on the food crisis, at all levels, to ensure that the food needs of refugees and IDPs are taken into account in all programmes responding to the food crisis.*
UNHCR and WFP will continue to undertake Joint Assessment Missions in all major operations at least once every two years. In 2008, the Joint Assessment Mission guidelines were revised to include more elements on food security and self-reliance, a focus that will continue playing a dominant role throughout 2010/11 Joint Assessment Missions along with the development of specific assistance modules for urban refugees.

Regional Public Health and HIV Activities

Asia

Public Health

In spite of the global economic uncertainties and the outbreak of H1N1, refugees and PoCs in Asia remained largely unaffected from emergencies. However, the security situation in Pakistan continued to be a major challenge for UNHCR to provide assistance and protection to its PoCs. Technical support from a distance was often not possible because of the mercurial changing situation necessitating staff evacuations from the field to Islamabad, hence disrupting normal delivery of services across the board.

Besides technical support and coordination to the countries of Nepal, India, Iran, Malaysia, Bangladesh and Thailand, the Regional Public Health Officer and Epidemic Response Officer represented the concerns of PoCs at international fora that addressed regional and global issues of health responses to natural disasters, held in Sichuan, China, the Intergovernmental Immigration and Refugee Health Working Group in Bangkok, and meetings on the H1N1 pandemic response held in Bangkok and Hanoi.

The High Commissioner's Special Project on anaemia in Bangladesh and Nepal were evaluated (in Nepal by CDC and in Bangladesh by HKI) and results after one year of implementation were encouraging. They showed improvements in the levels of anaemia among under fives, pregnant and lactating women. The challenge now is to mainstream these projects into the annual country programmes.

Intensive advocacy to include refugees and other PoCs into national pandemic preparedness and response plans were renewed as a response to the occurrence of H1N1 cases in the region. Cases among refugees were confirmed in Thailand and India (only one case in each country); there were no other documented cases in other refugee settings of avian human influenza and H1N1. However, increasing rates of Influenza-like Illnesses were reported in Bangladesh, Nepal and Thailand, warranting enhanced active disease surveillance throughout the year. The cases were diagnosed as seasonal Influenza and were appropriately managed without any fatalities. Essential drugs and medical supplies particularly for the camp-based refugees and also for avian human influenza and H1N1 were procured and strategically stockpiled and managed.

A regional review of the drug management system revealed many bottlenecks faced in procuring drugs locally. UNHCR and its partners should aim for international procurement of drugs. UNHCR's central Supply Management System has the necessary expertise and logistics capacities.

Missions undertaken to India, Iran, Malaysia and Thailand identified the need for addressing urban refugee health care challenges in a more systematic and holistic manner than has previously been the case. Medical referral guidelines and SOPs together with good urban HIS were identified as issues that needed to be addressed so that evidence-based delivery of health services could be guaranteed to the urban refugees and asylum seekers. In the case of Malaysia, where the number of registered urban refugees and other PoCs are well over 75,000, the lack of funds to put in place a package of comprehensive PHC programmes severely undermined the ability of the office to address the challenges of urban health care delivery.

An extensive review of the refugee health care programme in Iran resulted in a constructive dialogue with the Ministry of Health and BAFIA, culminating in the Ministry of Health accepting to take over implementation of PHC activities for the refugees as well as medical referrals at the secondary and tertiary hospitals.

In Nepal, resettlement programmes were undertaken by UNHCR and IOM; 20,000 refugees underwent health and nutrition screening and were successfully resettled. As result of this resettlement process, staffing shortfalls were experienced as trained and skilled refugee health workers left for resettlement. The number of maternal deaths were higher (4 deaths compared to only 2 the year before) in the camps. All measures necessary at the primary and secondary levels of health care were instituted, including staff changes and orientation, to address the problem. Community management of acute malnutrition was introduced in the camps in Nepal to more effectively address the root causes and treatment of malnutrition in the refugee communities. The project found broad support by UNICEF, WHO and the Ministry of Health.

In Bangladesh, the prevalence of GAM increased from 8.8% to 18.7% while SAM was 2% (using WHO 2006 WHZ-scores). Action was taken by initiating a blanket distribution of a lipid-based nutrient supplement for all children between 6 and 35 months old. Action Contre le Faim was brought on board as the implementing partner of UNHCR for food and nutrition to more comprehensively address the situation

HIV

In 2009 HIV activities focused on eight countries in Asia (Iran, Pakistan, Nepal, India, Bangladesh, Myanmar, Thailand and Malaysia), ensuring that PoCs to UNHCR have access to comprehensive HIV services, strengthening HIV-related protection and fulfilling UNAIDS lead agency obligations by strengthening the response to HIV in humanitarian situations.

An advocacy paper for Asia "Specific Inclusion of Refugees and IDPs in National HIV and AIDS Strategic Plans, Policies and other Initiatives: A Rationale" was completed and is currently being used at regional and country level to support UNHCR in its role to advocate for access and inclusion of PoCs into national HIV strategic plans and programmes. A link was established with the Australian Federation of AIDS Organisations and agreement made to cooperate on joint advocacy efforts in relation to Australia's treatment of HIV in the context of resettlement.

Behaviour change communication activities were strengthened with the completion of a formative assessment and strategic framework for addressing HIV in mobile males in refugee camps in Thailand by the HIV Programme Officer funded by Ausaid. Availability of context appropriate information, education and communication materials (IEC) was strengthened with the completion of the IEC database of regional materials on HIV and related areas which was distributed to all countries in the region.

HIV prevention activities in most-at-risk populations increased in scope throughout the year. In Bangladesh an innovative project to reach men who have sex with men was initiated with over 75 men who have sex with men regularly reached with key HIV prevention services and commodities. Nepal continued to strengthen activities amongst women and girls engaged in sex work in and around the Bhutanese refugee camps with measures to expand access to female condoms, HIV prevention information, IEC materials, STI and VCT services. In Myanmar HIV prevention in most-at-risk groups continued to be strengthened in Mon State through UNHCR's implementing partner working with community-based organisations. Technical support and small grants were provided to community-based organisations to build their capacity to provide a range of prevention, care and support services especially to key populations (migrants, sex workers and men who have sex with men). Interventions relating to substance use were expanded at country level in Thailand, Iran, Pakistan and Nepal. The emphasis in Nepal and Thailand focused on reducing the harms associated with excess alcohol consumption and specifically expanding access to screening for harmful and hazardous alcohol use and dependence and provision of brief interventions or referral for assessment of treatment options. In Pakistan and Iran activities to increase the access of Afghans to harm reduction measures relating to injecting drug use were increased. In Iran a number of drop in centres were established in areas densely populated by Afghans. The drop in centres provides awareness sessions on HIV, STIs and substance use prevention to substance users and families. Outreach teams include Afghan ex-substance users. In Peshawar, the IP Pakistan

DOST continued to receive support from UNHCR for its HIV prevention programme among different Afghan high risk groups. A key component is to reach-out to street-based drug users including intravenous drug users through mobile teams and drop-in centres with a standard package of services including care and support for those already living with HIV.

Reducing the vulnerability of women and girls to HIV continued to be a key component of HIV programming. In Delhi an assessment was undertaken to identify specific factors which increased the vulnerability of women and girls and develop interventions to increase their access to reproductive health services and protection interventions when indicated. These will form the basis of activities in 2010.

Access to HIV counselling and testing services continued to be promoted. In Nepal HIV counselling and testing is available in all camps and one site was established in Damak to serve the surrounding host community. In Thailand the uptake continues to be very high in the three camps in Tak province. In the first nine months of 2009, 3,825 persons were counselled and tested in three camps with a population of 79,000. The increased uptake is due to a number of factors including strong community engagement; provision of mobile VCT; rapid testing and same day results; referral of STI and tuberculosis patients for routine offer of testing; and mass community awareness.

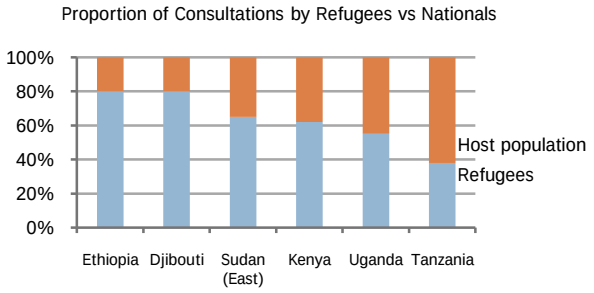
Access to care, support and treatment continued to be improved with strengthened community level support mechanisms for urban refugees on ART in Delhi and Malaysia. Now all countries in the Asia region with more than 5000 refugees have access to ART under the same conditions as nationals (with the exception of Papua New Guinea).

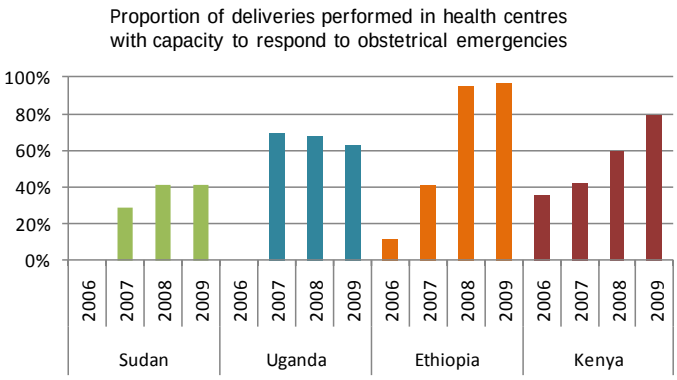
East and Horn of Africa

Public Health

In 2009, regional public health efforts focused on four priority countries: Sudan, Ethiopia, Djibouti and Uganda. The regional coordinators at the Regional Support Hub in Nairobi provided inputs into country-level reviews including Country Operation Plans/Global Needs Assessments, reviews of Somali contingency plans, and numerous public health work plans.

The review of Country Operation Plans enabled the Regional Support Hub to advise country programmes on funding gaps in health, nutrition, food security and WASH sectors. Some programmes are particularly affected when the number of refugees is used as a planning figure for resource allocation, where members of the host community also greatly benefit from those services.





A review of maternal deaths occurring in Dadaab, Kenya in 2008, conducted during the annual coordination workshop organised by Regional Support Hub, led to the development and implementation of new strategies that effectively reduced the number of maternal deaths in 2009.

Efforts to improve maternal and newborn health through improved access, quality and acceptability of maternal services remains a priority in the region. Utilisation of

services has greatly improved in particular in Ethiopia, where 97% of women delivered in health centres in 2009 as compared to 11% in 2006 and Kenya where 79% of women delivered in health centres in 2009 as compared to 35% in 2006.

Following a steady decrease of malaria cases in the region over the past two years acute respiratory tract infections have, for the first time, become the main cause of morbidity both for children under the age of five and for the rest of the population. The decrease of malaria morbidity (below 100 cases/1000 consultations/month in most camps) can be attributed to a combination of interventions including better diagnosis using rapid diagnostic tests and access to timely and effective health services associating with prevention and awareness activities. The region benefited from a donation of LLINs through the UN Foundation "Nothing But Nets" Campaign and as a result LLIN coverage has increased to full coverage (i.e. general distribution of 1 LLIN for every 2 persons to sleep under) in Uganda, Kenya and East Sudan. The donation allowed UNHCR to change its focus from targeting vulnerable groups during emergencies to general distribution in stable settings in line with UNHCR's Malaria Strategic Plan 2008-2012. Donations from Novartis Foundation of antimalarial drugs (Coartem) for Uganda and Kenya sufficient for 6 months enable to avoid stock-outs due to pipeline shortages.

Over 80% of camps in the region now have pandemic influenza contingency plans and these were reviewed and updated following WHO's declaration of the influenza A/H1N1 pandemic. Implementation of these plans has remained a challenge for a number of reasons including inadequate funding and organisation-wide delays in the implementation of these plans.

Challenges, such as the lack of epidemic and pandemic preparedness and response plans for some camps in the region, remain and this will dictate priorities for 2010.

Country operations in their efforts to secure funding from the avian human influenza project to improve water and sanitation infrastructure in Ethiopia, Uganda and East Sudan and construct isolation facilities in Kenya.

Over the course of the year, the region continued to experience disease epidemics, including cholera and measles. However, due to targeted support in the form of trainings on HIS use for epidemic surveillance and strategic stockpiling of essential medical supplies led to improved capacity of country operations to detect early and effectively respond to epidemics.

HIV

The implementation of the IGAD Regional HIV/AIDS Partnership Programme for East Africa started in Djibouti, Ethiopia, Kenya, Southern Sudan, Eastern Sudan, Somalia and Kenya addressing the HIV needs of refugees, returnees, IDPs and surrounding communities. The programme supports a comprehensive range of services, including provision ART, support for orphans and vulnerable children, and services targeting most-at-risk population.

In 2009, HIV programmes expanded to ensure that sex workers and their clients have access to comprehensive HIV services meeting their specific needs. The programmes aims to ensure that sex workers have access to specialised target HIV and reproductive health services, ensure protection, partnership and provide alternative livelihood programmes. The programmes pro-actively link HIV and sex work, gender-based violence and protection through community-based responses in multi-functional teams.

In line with global goal for universal access to HIV services, UNHCR and its IPs strived to scale up HIV services in the region. At the end of 2009, refugees in Ethiopia, Kenya, Uganda and Tanzania have access to a whole range of HIV services including, ART, prophylaxis and treatment of opportunistic infection, and HIV testing services. In the four countries, over 1,800 refugees are on ART and over 3,000 receive prophylaxis for opportunistic infections Services expanded in Eastern Sudan, where more than half of the camps are providing comprehensive HIV services that include including HIV testing services.

Central Africa and Great Lakes

Public Health

Coordination across the region remained difficult due to the lack of a Regional Public Health Coordinator for most of the year; the post was filled only in October 2009. Support to the region, in particular to Chad and Eastern DRC, was extended from headquarters to ensure technical support to the operations. The regional Epidemic Preparedness and Response Coordinator conducted regular field visits focusing on capacity building and surveillance to all countries in the region.

The situation in the eastern part of the DRC remained volatile throughout the year. UNHCR was present in the North Kivu region where the Refugee Agency covered basic non-food and shelter needs through the cluster mechanism. UNHCR's standardised HIS for camp settings was successfully adapted to the IDP context in the North Kivus where it was deployed as primary surveillance tool to partners in the Health Cluster. Outbreaks of cholera were responded to by cluster partners. UNHCR provided trainings for cholera and H1N1 preparedness and response. Cholera was successfully controlled in the Kipatin IDP camp in North Kivu and prevented in other camps.

In the later part of 2009 the situation in Province Oriental of the DRC further de-stabilised resulting in displacement of populations into the Republic of Congo. Information on the number of refugees was based on estimates. Difficult access and high cost of accessing refugees through the river remained a major challenge. The refugee populations outnumbered the resident populations in many sites. In response, UNHCR conducted an initial rapid assessment and deployed a Public Health Officer to help coordinate the early response to the needs of refugees.

The year saw a renewed influx of Central African refugees into southern Chad, resulting in the opening of new camps. Health programmes in the East continued to be hampered by security restrictions. Several missions from headquarters and support by the regional Epidemic Preparedness and Response Coordinator helped address training needs and the improved management of drug supplies as well as the establishment of a referral system. UNHCR identified gaps in the quality of therapeutic nutrition programmes and addressed these together with UNICEF and WFP.

HIV

UNHCR is providing HIV prevention, care and treatment programmes in a wide variety of complex situations including IDP situations, programmes for local integration and return. The HIV programmes have a strong focus on further advocating for access to national programmes for PoCs to UNHCR.

HIV prevention programmes have been strengthened significantly in the region. In Cameroon, targeted HIV prevention programmes have been established through peer education systems and the development of materials in the languages of the refugees. In addition, HIV programmes have established for returning refugees to Burundi and the Eastern part of the Democratic Republic of Congo. In the transit centres, returnees are receiving HIV awareness packages containing HIV prevention commodities and information booklets as well as information on access to HIV services in the areas of return. Persons on ART receive a 3 month supply to ensure that they have sufficient medication to fill the gap before they enroll in their national programmes.

Modest progress has been made in access to PMTCT services. New services were established in Chad. While many country operations offer PMTCT services, these are not utilised sufficiently. UNHCR will continue to ensure full access to quality PMTCT services through the integration into the existing reproductive health programmes.

The Great Lakes Initiative on AIDS continued to support UNHCR operations. The project has been instrumental in supporting regional dialogue on access for refugees to national HIV plans and access to comprehensive HIV treatment and care programmes, including nutritional support to people living with HIV. The project will come to an end in 2010.

Southern Africa

Public Health

By December 2009, Southern Africa was hosting approximately 100,000 refugees. Voluntary repatriation of 16,971 Congolese refugees from the Northern camps in Zambia plus a significant increase in the number of asylum applications in South Africa (346,000) occurred.

Only two countries in the region use UNHCR's HIS- Namibia (since July 2009) and Zambia. The rest of the countries host small numbers of refugees and the Ministries of Health are in charge of health provision and information. Refugee health data are collected through national HIS; unfortunately, they are not very often disaggregated by refugees and nationals. Two countries in the region (Angola and South Africa) do not host refugees in camps but in urban areas, which limits the existing information on refugee health at present. Overall, refugees in the region access Government health services at a similar level to that of nationals.

Cholera is endemic in Southern Africa, with Angola, Malawi, Mozambique, Zambia and Zimbabwe all reporting cases during 2009, although on a smaller scale than during the large-scale epidemic in 2008. Refugee camps remained cholera free in 2009. H1N1 reached the region and UNHCR conducted prevention activities including refresher trainings with health personnel, community health workers and health promoters, hygiene campaigns and soap distribution targeting vulnerable refugees, and stockpiling of essential medications.

UNHCR provides food for camp-based refugees in Botswana, Zimbabwe and Mozambique and with the support of WFP in Malawi, Namibia and Zambia. Self-reliance and food security opportunities for refugees are difficult in some countries in the region due to the lack of available land and Government restrictions on the free movement of refugees. Vulnerable urban refugees in Angola and South Africa might receive food support on an individual basis after assessment by either UNHCR or its partners. Nutritional surveys were conducted during 2009 in Namibia and Zambia showing 'acceptable' rates of anaemia, global and moderate acute malnutrition.

Most of the camps in the region were built many years ago and maintenance and upgrading of WASH systems according to the current needs pose a challenge to UNHCR. The number of family latrines is below UNHCR standards in some of the refugee camps in the region. Water quantity is adequate for human consumption. There are insufficient gardening activities in the context of protracted situations and self-reliance.

HIV

PoCs have access to national programmes in camp and urban settings except in Botswana. In the latter, the Government continued to exclude refugees from the ART component of the national HIV programme. UNHCR with support from its own funds and those of USAID rolled out an ART programme through a private clinic in Francistown. A total of 120 refugees have access to ART by the end of 2009. However, the private clinic does not provide PMTCT services. Thus, UNHCR established a community-based PMTCT programme in Dukwi camp. In Angola, most treatment sites are located in provincial and district hospitals making it difficult for refugees and nationals to access treatment due to long travel distances.

HIV prevention programmes in Southern Africa have expanded with a strong focus on young people and community participation. In Mozambique, the UNFPA supported programme "Geracao Biz" was introduced into the refugee camp and young people have been trained as lay counsellors. In Namibia, the youth are actively involved in the HIV task force at Osire refugee camp. In Zambia, youth and sports clubs, outreach and facility-based VCT, door to door campaigns, and drama and TV shows have been expanded in all refugee camps. In Zimbabwe, a local organisation (Connect), has trained networks of 13 community counsellors in Tongogara refugee camp. HIV awareness sessions are conducted in the health facility twice per week as well as in community centres

West Africa

Public Health

Public health and nutrition interventions in West Africa support the overall regional objective to find durable solutions for protracted refugee situations by promoting access to health care services available in the country of asylum as well as through advocacy and support to ongoing interventions in refugees hosting areas with a focus on local integration for rural and urban refugees and returnees. Strong collaboration occurred with the local integration unit to ensure public health issues are well articulated into the self reliance and livelihood strategies; this included joint programming and joint field missions. UNHCR provided medical assistance through a selected number of public facilities for urban refugees. The Refugee Agency provided support in term of training, rehabilitation and supplies to public health centre in refugee hosting areas.

HIV

HIV interventions are embedded in the region's objectives to advocate for durable solutions for protracted refugee situations with a focus of local integration of refugees and returnees. UNHCR worked with partners and national Governments to ensure that refugees and returnees have affordable access to ART. In many countries in the region, ART medication is free but related services such as testing or additional medical costs require payment. While UNHCR is working with Governments to develop long term sustainable solutions including the development of income generating activities, UNHCR is contributing to the costs of transport, additional laboratory tests and medication for the most vulnerable groups. In Sierra Leone, UNHCR facilitated and funded a self-support group for people living with HIV for both refugees and nationals. The group organises livelihood activities, HIV awareness activities and psychosocial support. In Guinea, UNHCR continued to support the provision of testing reagents, drugs for opportunistic infection, and materials to VCT centres and clinics in refugees hosting areas. In Cote d'Ivoire, UNHCR supported the construction of an HIV and Reproductive health centre in the Tabou district hospital. The centre provides VCT, PMTCT and family planning services. The Positive Lives Exhibition toured through Liberia and Sierra Leone, addressing issues of stigma and discrimination.

Middle East and Northern Africa (MENA)

Public Health

The Iraq refugees in Jordan and Syria constitute the largest number of PoCs in the region. Operations in Syria and Jordan were streamlined in 2009 with the introduction of SOPs for health care resulting in a more efficient use of resources by partners. Health care monitoring efforts were coordinated across the two countries to utilise health information for needs assessments and planning as well as to enable partners to base their delivery of care on an evidence base. A review of the exceptional care provided to Iraqi refugees in costly tertiary treatment facilities was carried out. Recommendations of this review were used to further refine referral procedures and vulnerability criteria.

The operation in Yemen was confronted with an increase of newly arriving Somali refugees during the year. Due to concerted efforts by the office and partners, refugees in the reception centres, camps and urban areas continued to enjoy access to basic PHC. Yemen conducted a joint anaemia/ malaria baseline survey revealing very high rates of anaemia among children under five years. The anaemia project in Yemen began in 2009 with first results expected in 2010. Anaemia rates were also found to be high amongst women and children in Algeria's Sahrawi refugee camps. Assessments in 2009 will lead to the implementation of anaemia interventions in 2010.

HIV

The relatively low prevalence rate in the region calls for unique strategies to work with and protect vulnerable and high-risk groups. UNHCR strives to ensure that the rights of PoCs affected or infected

with HIV are guaranteed and equal access to HIV prevention, treatment and care is provided through the national HIV programmes. Protection and human rights of people living with HIV and their families are the cornerstone of the HIV programmes in the region. In Egypt, the National AIDS Control Programme, Refugee Egypt and UNHCR continued to support refugees and hard to reach migrant communities in Cairo to ensure their access to ART and PMTCT programmes. Under the National AIDS Programme, Egypt is providing free ART to refugees as well as access to PMTCT services for pregnant refugee women living with HIV. Yemen continued to provide ART for refugees in their two treatment centres in Aden and Sana'a. Stigma and discrimination are high and both Yemenis and refugees living with HIV have difficulties to access health services.

Americas

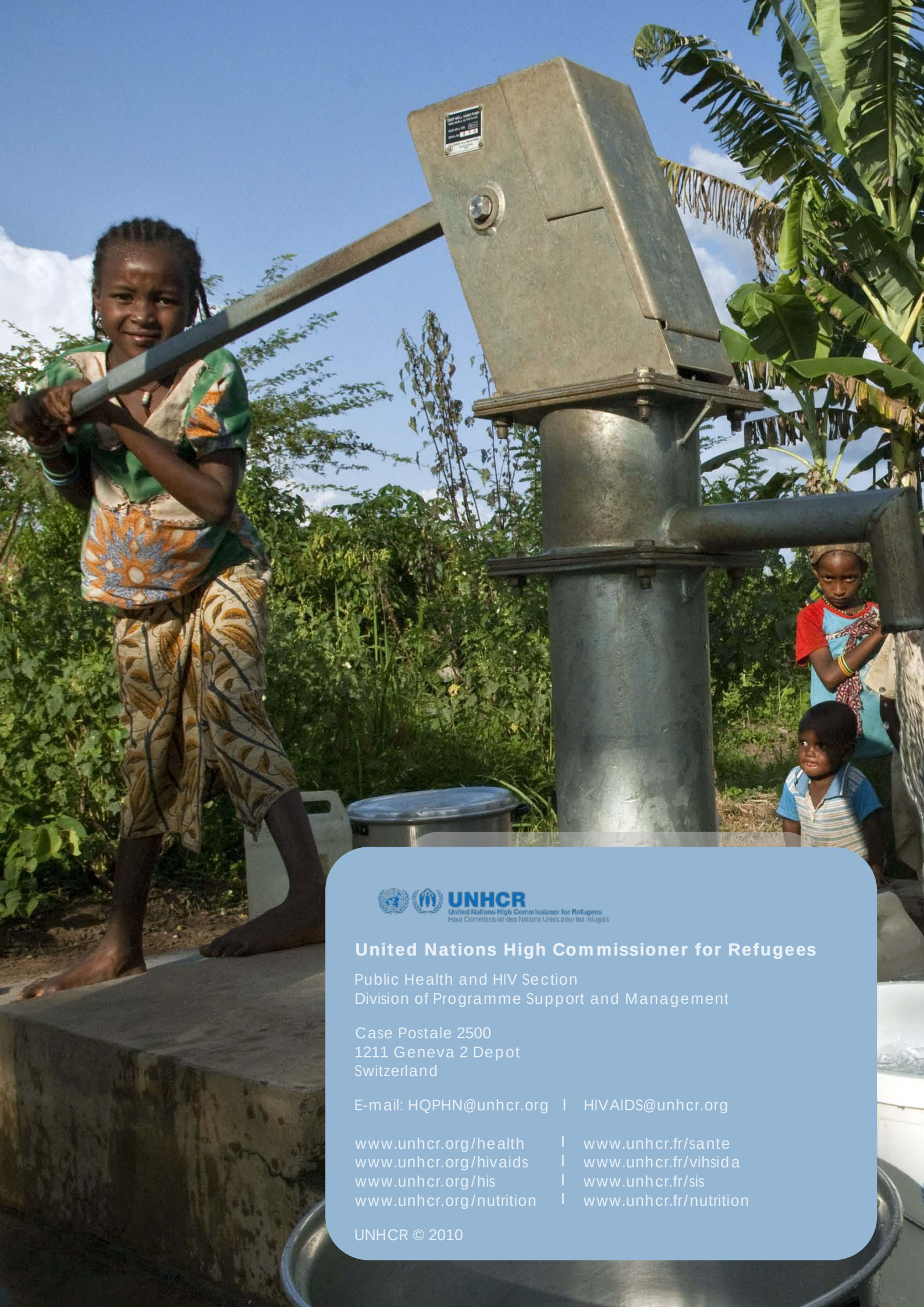
HIV

HIV programmes in the Americas continued to focus on HIV awareness and prevention, sexual and reproductive health, SGBV and related protection issues. HIV prevention and sexual and reproductive health awareness campaigns were embedded into national initiatives and campaigns for young people in countries in the region. UNHCR contributed to the translation of materials and organised events with young refugees and IDPs. In Costa Rica, UNHCR and partners established a protection network involving key institutions, and supported HIV prevention and response for sex workers where refugees and migrant women often turn to survival sex. UNHCR and UNFPA continued to promote actions on sexual reproductive health including HIV/AIDS and gender-based violence along the northern border. The study on dynamics of sex work, in collaboration with Network of Sex Workers of Ecuador, was completed. In Panama, workshops were conducted on HIV/AIDS and gender-based violence for sex workers, partners, Government actors, the UN Country Team, and PoCs such as at-risk women and sex workers in the border regions.

Europe

HIV

In Europe, UNHCR programmes continued to focus on the protection and access to national HIV treatment and care programmes. UNHCR offices undertook a strong role in monitoring human rights of PoCs living with HIV, and advocated for changes in legislation related to mandatory testing of PoCs as well as to ensure that all HIV testing is conducted with informed consent and mandatory pre- and post-test counselling.



UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

United Nations High Commissioner for Refugees

Public Health and HIV Section
Division of Programme Support and Management

Case Postale 2500
1211 Geneva 2 Depot
Switzerland

E-mail: HQPHN@unhcr.org | HIVAIDS@unhcr.org

www.unhcr.org/health | www.unhcr.fr/sante
www.unhcr.org/hivaids | www.unhcr.fr/vihsida
www.unhcr.org/his | www.unhcr.fr/sis
www.unhcr.org/nutrition | www.unhcr.fr/nutrition