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Introductory Remarks of Steven Corliss
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Refugee public health, including HIV/AIDS (EC/66/SC/CRP.16)
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Thank you, Mr. Chairman.

Distinguished delegates, Ladies and Gentlemen,

I am pleased to introduce Conference Room Paper 16 on refugee public health, including HIV and AIDS, together with Dr. Paul Spiegel, who is UNHCR's senior public health expert.

UNHCR's five-year *Global Strategy for Public Health* – which we issued in March last year – provides the overall roadmap for our work in this critical area. The vision of the *Global Strategy* is to ensure that all refugees are able to fulfil their rights in accessing life-saving and essential health care; HIV prevention, protection and treatment; reproductive health services; food security and nutrition; and water, sanitation and hygiene services (WASH).

During the March session of the Standing Committee, we presented the *2014 Global Strategy Implementation Report* that outlined some of our key achievements and challenges so far. For 2015, we are driving forward the key strategic objectives in UNHCR's field operations, with a focus on improving quality and ensuring that health programming is cost-effective and evidence-based.

Given the broad scope of the *Global Strategy* and UNHCR's programmes for public health and HIV and AIDS, I will only be able to highlight some of the key developments during this presentation.

Let me begin with the critical public health challenges posed by refugee emergencies. Since our last briefing to the Committee, thousands of refugee children – weakened by acute malnutrition and exposed to unnecessary risk by poor sanitation – have died. Many of these deaths could have been avoided. They resulted from preventable or curable diseases, such as measles and cholera.

At the same time, rapid response by UNHCR and its partners have prevented real catastrophes from occurring. The recent outbreak of cholera among Burundian refugees in Tanzania demonstrated how strong emergency preparedness and response capacities – supported by effective outbreak monitoring systems, the development of standard protocols and training – can save lives.

Tens of thousands of refugees were massed on an isolated peninsula in Lake Tanganyika, without access to clean water or sanitation. The risk of cholera was evident well before the first cases were reported. Working closely with the Tanzanian authorities and our partners, including MSF, Oxfam, WHO and UNICEF, UNHCR deployed public health and WASH specialists and mobilised the comprehensive response. This included the rapid provision of safe water and sanitation and the treatment of cholera in multiple locations in order to bring the outbreak under control before more lives were lost.

Emergency response will continue to be a defining priority this year, but UNHCR is also engaged with governments in efforts to bring refugees within national service delivery and health care financing mechanisms. This is a key strategic objective of the *Global Strategy* and also important line of action for the implementation of UNHCR's *Policy on Alternatives to Camps*.

Let me provide a few concrete examples. In Ghana, UNHCR and the Government have advanced with efforts to give refugees access to the national health insurance programme, and we expect to complete enrolment by the end of the year. Our plan is to discontinue costly parallel health care services in the camps and fully mainstream refugees into the National Health Service's programmes.

We are also able to report important progress in the Islamic Republic of Iran, where UNHCR recently signed an agreement that will provide all registered Afghan refugees – over 1 million people – with health insurance coverage through the Government programme that will replace the private health insurance offered previously. We hope that other countries will follow the Islamic Republic of Iran's extraordinary example in the future.

UNHCR seeks to ensure that refugees have access to more specialised treatment, but referral care can place tremendous strains on limited resources. Managing referrals and monitoring the care received can also be complex in urban and non-camp settings, where refugees are living dispersed in the community. We have developed a simple, innovative tool that allows field operations to track and analyse trends in such parameters as the conditions treated, days of hospitalisation and subsequent costs for higher levels of care.

We have also developed the Health Access and Utilisation Survey – or HAUS – to identify the factors that may prevent refugees from accessing health care services. The HAUS analysis combines data on basic health indicators – such as immunisation coverage for children under five, rates of skilled birth attendance at delivery and the use of antenatal care – with an assessment of the practical obstacles they face. These can include a lack of information, the overt denial of service, transportation costs or the availability of childcare. Following successful pilots in Lebanon and Jordan, UNHCR has produced a HAUS manual and will expand its use in other operations.

Together with UNFPA, we have developed another tool to guide field operations through an assessment of reproductive health needs of women and girls in urban areas and other non-camp settings and create an action plan for programming. UNHCR and UNFPA are jointly piloting the tool in Nairobi. All of these new tools and approaches support UNHCR's efforts to take forward implementation of the *Policy on Alternatives to Camps* and UNHCR's 2009 Urban Refugee Policy.

The *Global Strategy* emphasises the importance of evidenced-based decision-making as a way to ensure we are achieving results. Through the data captured in *Twine* (twine.unhcr.org), our health information system, UNHCR can detect disease outbreaks early and monitor trends in key indicators, such as malnutrition and anaemia rates. This allows us to respond quickly, make targeted interventions and shift our focus and investments. Most recently, health data on the newly-arrived Burundian refugees in Rwanda and Tanzania led us to strengthen community-based malaria prevention efforts.

UNHCR has moved forward with efforts to introduce the "balanced score card" approach to provide the evidence needed to improve the quality of health care services for refugees. The balanced score card assesses health care facilities from different angles, including the services provided, staffing and coverage, equipment and supplies, quality of care and health worker and patient satisfaction. Based on the results, we are able to focus and prioritise our support for a specific health care facility.

Repeating the balance score card exercise over time allows us to be sure that problems are being solved. We have seen progress in camp settings in South Sudan and in Ethiopia, where minimum standards and the availability of basic supplies and equipment have improved. In Rwanda and Thailand, we have also expanded use of the balanced score card approach from primary care to reproductive health care.

UNHCR has also invested significantly in improving Infant and Young Child Feeding (IYCF) practices, based on the evidence. In Chad, we responded to persistent high levels of acute malnutrition, stunting and anaemia with new programming approaches. Vulnerable children between six months and two years of age received a highly nutritious product, based on peanuts, and pregnant and lactating women were provided with enhanced care and counselling. This has led to significant reductions in malnutrition levels among refugee children.

The *Global Strategy* promotes the integrated prevention and control of non-communicable diseases as a strategic objective. Cardiovascular diseases, cancers, chronic respiratory diseases and diabetes place an enormous burden on health facilities serving refugees. Such illnesses account for more than 240,000 consultations last year. Through the development of clinical protocols and training, UNHCR has raised the profile of non-communicable disease with ministries of health and our partners. We've seen improvements in treatment at the primary health care level for Somali refugees in Dadaab camp and Syrian refugees in Jordan.

UNHCR's focus on non-communicable disease includes efforts to improve the availability and quality of mental health services for refugees. The trauma of war, persecution and flight are compounded by the stresses and risks of an uprooted, uncertain and tenuous existence as a refugee, where daily survival may be a struggle. Through the Mental Health Gap action programme or MHGap, UNHCR and WHO are working together to build capacity for mental health services. The first two MHGap training events will take place in Cameroon and Chad this year.

Through the *Global Strategy*, UNHCR is also working to ensure that our interventions are cost-effective and sustainable. Providing refugees with safe water is crucial to their health and well-being, but meeting this basic need can be very expensive. Together with the IRC International Water and Sanitation Centre in the Netherlands we are developing a decision-making tool for managing water supplies in camps and settlements based on the total life-cycle cost approach.

In Kaya camp in South Sudan, UNHCR reduced fuel consumption by 50 percent by converting boreholes operated with diesel-powered pumps into hybrid systems that also use solar power. With support from DFID, UNHCR plans to make the same conversion to solar-hybrid technology in Kenya. This is will yield significant cost-savings through reduced fuel consumption. Solar power solutions are also being considered in Chad.

UNHCR is actively progressing with operational research on various "waste-to-value" solutions in refugee settings. We are testing approaches for processing human waste and domestic waste produced by refugee camps and converting them into 'biogas' or 'biochar' for domestic cooking, or fertilizer for crops. UNHCR has installed a number of waste-to-value latrine prototypes in Ethiopia, and we are seeing positive results from these pilot studies.

Let me now turn to UNHCR's ongoing support for efforts to achieve universal access for HIV protection, prevention, treatments and care. Global targets in these areas cannot be met without adequate programming for refugees and other people affected by emergencies due to conflict and natural disasters. The problem is not insignificant. In 2013, some 1.6 million people living with HIV were impacted by humanitarian emergencies. They represent nearly five percent of people living with HIV globally.

More than a million of these people did not have access to life-saving anti-retroviral therapy. With the world moving to invest more in programming for population that have high levels of HIV prevalence, UNHCR is making the case that strengthening the HIV response in emergencies must be a priority. This will be our key message for the thematic day on HIV in emergencies during the UNAIDS Programme Coordinating Board session next week.

Together with WFP, we are co-convenors of the Inter-Agency Task Team on HIV in Emergencies which has focused on ensuring the minimum essential HIV response at the onset of humanitarian emergencies. The Task Team has also focused on bringing refugees and internally-displaced persons within national HIV programmes, including in the Central African Republic, Democratic Republic of Congo and South Sudan.

We will also continue to advocate strongly that HIV testing should be voluntary for refugees and all other people. Subjecting refugees to mandatory HIV testing – sometimes as condition for renewing their identity documents – is wrong as a matter of principle and human rights. It is also not justified from a public health perspective. Refugees typically have HIV prevalence rates that are lower or comparable to the host communities and similar levels of adherence to anti-retroviral therapy.

What refugees do need is access to integrated, comprehensive national HIV services at all stages of displacement for both prevention and treatment. Voluntary counselling and testing can ensure that refugees know their HIV status and can seek and receive the treatment they need, which reduces the risk of AIDS spreading.

Finally, sustained advocacy by UNHCR and its partners with the Global Fund to Fight AIDS, Tuberculosis and Malaria led to the launch of a new Emergency Fund in 2014. The Fund will provide USD 300 million over three years to agencies responding to emergency needs related to the three diseases. One of the first grants will help to strengthen the response to tuberculosis among Syrian Refugees in Lebanon and Jordan.

Before concluding, I would like to draw attention to the critical funding shortages facing our key strategic partner, WFP. Reductions in food assistance, including through cash and voucher programmes, when they continue over time, inevitably begin to impact on the health and nutrition of refugees. Children pay the heaviest price through high rates of malnutrition, anaemia and stunting, which will have lifelong impacts on their physical and intellectual development.

UNHCR and WFP are working closely together on strategies for targeting food assistance, so that those who need the most support receive it. We are also collaborating on initiatives to build refugee self-reliance. Many refugees today, however, are only receiving a portion of the minimum they need to survive, and large numbers do not have the means or the possibilities to close the gap in assistance. They will continue to depend fundamentally on the food assistance provided by WFP.

We have made significant progress since last year when I presented the first Conference Room Paper on refugee public health, including HIV and AIDS. I am particularly pleased to be able to report progress and concrete results in an area of UNHCR's work where lives are truly at stake.

Having said this, we have much work ahead to make the vision of UNHCR's *Global Strategy for Public Health* a reality. We can only do this with the full support and engagement of governments and the solidarity shown by the international community.

Let me conclude here. I now look forward to receiving the Committee's views and advice and, together with Dr. Spiegel, answering your questions.

Thank you.