UNHCR's Guiding Principles

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UNHCR
The UN Refugee Agency

Table of contents

GUIDING PRINCIPLES FOR UNHCR'S PUBLIC HEALTH AND HIV SECTION

INTRODUCTION

The Office of the United Nations High Commissioner for Refugees (UNHCR) was established on December 14, 1950 by the United Nations General Assembly. The agency is mandated to lead and co-ordinate international action to protect refugees and resolve refugee problems worldwide. Its primary purpose is to safeguard the rights and well-being of refugees. It strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another State, with the option to return home voluntarily, integrate locally or to resettle in a third country.

UNHCR is an impartial organisation, offering protection and assistance to refugees and other persons of concern (PoCs; see below for explanation) on the basis of their needs and irrespective of their race, religion, political opinion or gender. In all of its activities, UNHCR pays particular attention to the needs of children and seeks to promote the equal rights of women and girls.

The 1951 Refugee Convention and its 1967 Protocol are the cornerstones of modern refugee protection, and the legal principles they enshrine have permeated into countless other international, regional and national laws and practices governing the way refugees are treated. In its efforts to protect refugees and to promote solutions to their problems, UNHCR works in partnership with governments, regional organizations, international and non-governmental organizations (NGOs). UNHCR is committed to the principle of participation, believing that refugees and others who benefit from the organisation's activities should be consulted over decisions which affect their lives.

Public health is the science and practice of protecting and improving the health of a community. Public health and HIV are inextricably interlinked with protection and human rights. The public health of refugees and other displaced persons is a priority for UNHCR.

In 2007, the Public Health and HIV Section was created in the Division of Operational Services. Public health is used in the broad sense to include health, reproductive health, child health, nutrition, food security, water and sanitation. The section's objectives are to reduce morbidity and mortality and to enhance the quality of life among refugees, asylum seekers, internally displaced persons (IDPs), returnees and other PoCs to UNHCR.

PERSONS OF CONCERN TO UNHCR

1) **Refugee:** The 1951 Refugee Convention describes refugees as people who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion. People fleeing conflicts or generalized violence are also generally considered as refugees, although sometimes under legal mechanisms other than the 1951 Convention.

2) **Asylum Seeker:** Someone who has made a claim that he or she is a refugee, and is waiting for that claim to be accepted or rejected. The term contains no presumption either way - it simply describes the fact that someone has lodged the claim. Some asylum seekers will be judged to be refugees and others will not.

3) **Internally Displaced Person (IDP):** Someone who has been forced to move from his or her home – because of conflict, persecution (i.e. refugee-like reasons); or because of a natural disaster or some other unusual circumstance of this type. Unlike refugees, however, IDPs remain inside their own country. UNHCR is the lead agency for protection, shelter and camp management/coordination under the humanitarian reform process. UNHCR actively participates in all clusters, including the health, nutrition and WASH clusters. UNHCR is the lead technical agency for HIV and AIDS among displaced persons (i.e. refugees and IDPs) according to the UNAIDS division of labour. In this respect, UNHCR takes an active lead role in HIV and AIDS among IDPs.

4) **Returnee:** A person who was a refugee, but who has recently returned to his/her country of origin. When a refugee decides to go home, it is usually because the threat or danger that had caused him/her to leave his/her place of habitual abode has significantly diminished or the danger in the place of refuge has become greater than the risk of returning home. The term "returnee" is a descriptive term that acknowledges the fact that returning refugees are in need of certain assistance, and sometimes protection, during an interim period until they have re-integrated into their communities. When refugees re-enter their country, as returnees, they are no longer entitled to the full protection afforded by international law to refugees. However, elements of that law, and of the mandate of the UNHCR, focus on achieving "durable solutions" and a return in "safety and dignity". Defining the period of time in which a person can continue to be identified as a returnee is difficult and will be different according to each specific situation.

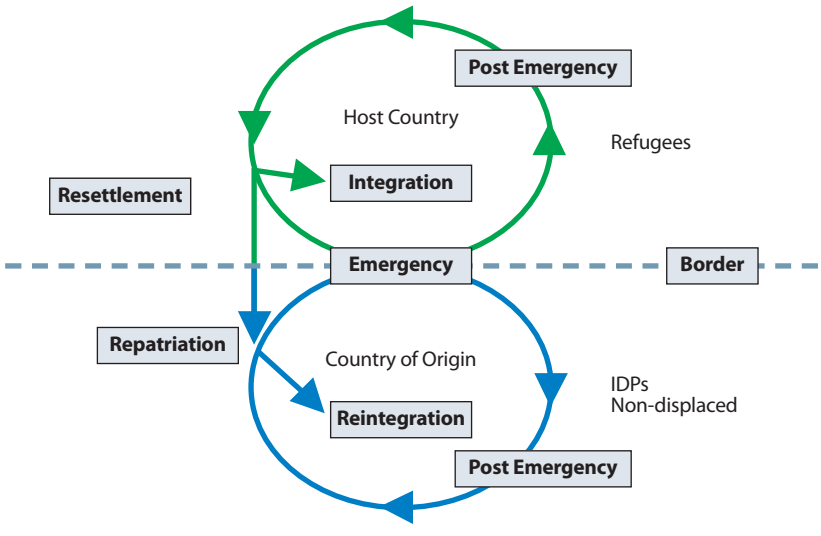
5) **Stateless Person:** Someone who is not considered as a national by any State under its domestic law. Although stateless people may sometimes also be refugees, the two categories are distinct and both groups are of concern to UNHCR.

6) **Surrounding host populations:** Although not officially considered PoCs to UNHCR, surrounding host populations are also directly and indirectly affected by the presence of refugees and IDPs. Thus, when making policy and implementing programmes, this community must also be considered in all of the settings and scenarios discussed below.

SCENARIOS

The influx of refugees into the country of asylum impacts not only their lives but also the lives of the host community (as do IDPs). Refugees and IDPs typically arrive in their host communities after fleeing their homes at the start of conflict or natural disaster. This begins a period often fraught with instability and sometimes frequent movement which is commonly referred to as the cycle of displacement (see figure below). The cycle has been simplied to include three main stages of transition, though additional movement may occur during this period and subgroups among the population may be in different phases of transition. Displacement scenarios are often not linear in nature (e.g. acute emergency followed by post-emergency followed by voluntary repatriation) and may vary even within one country; the humanitarian community generally divides displacement scenarios into phases. Each phase has different public health and HIV priorities.

DISPLACED PERSONS' CYCLE OF DISPLACEMENT:[1]



1 UNHCR and UNAIDS. Strategies to support the HIV-related needs of refugees and host populations. UNAIDS Best Practice Collection. Geneva. October 2005

1) **Acute Emergencies:** There are numerous definitions of the acute phase of an emergency using number of persons displaced, time from onset of emergency and increased mortality (often a doubling of the pre-emergency baseline). This scenario may be marked by extreme hardships, including deprivation of housing, food, and security not to mention public health and HIV services. The main objective in this scenario is to provide the basic lifesaving interventions to prevent excess mortality and morbidity.

2) **Post-Emergency/Stable settings:** This scenario is more stable and can last for months to many years and even decades (prolonged or protracted situations). In this situation, mortality rates should have decreased and basic needs (e.g. food, water, shelter) should have been met. During this period infectious diseases can be contained and additional, more comprehensive interventions should be provided. These may include psychosocial services, comprehensive reproductive health and HIV services, and projects to improve food security, among many others.

3) **Durable Solutions: Repatriation, Local Integration and Resettlement:** In the third and final scenario, refugees prepare to: 1) voluntary repatriate to their country of origin; 2) locally integrate in their host country; or 3) resettle to a third country; preparations for the scenario of durable solutions must begin long in advance and require strong coordination with Governments, other UN agencies and NGOs. Advocacy, integration with existing systems, continuity of care, capacity building and numerous other factors need to be undertaken in these situations.

SETTINGS

1) **Camp:** These settings are the traditional situations in which UNHCR has worked in the past. It is *relatively* easier to provide public health and HIV services to displaced persons in camps than in non-camp settings because they are usually in circumscribed areas where persons can be registered and provided with services. Refugees in camp settings are often wholly dependent on UNHCR and its partners for all services. UNHCR's implementing and operational partners[2] often find it easier to work in camp-like settings than non-camp settings for some of the reasons listed above. However, over the last decade, displaced persons are increasingly found in non-camp settings.

2) **Non-camp**
   i) **Urban settings:** Refugees residing in urban areas are of diverse origins and background. They frequently include a high proportion of displaced persons from rural areas who have moved to cities in preference to other locations because education and employment opportunities may be better. Many urban refugees are unskilled, and live in precarious situations. In many settings, only the most vulnerable persons are registered with UNHCR; it is complex and resource

2 The implementation of UNHCR's assistance and protection projects is often entrusted to an implementing partner who receives funds from UNHCR. These are usually specialised government departments or agencies, other members of the United Nations system, non governmental and intergovernmental organizations. An organisation that works in co-ordination with UNHCR but does not receive funding is referred to as an "operational partner".

intensive to manage such large numbers of individual cases. Assistance to urban refugees varies according to context and funds. Whenever possible, UNHCR and its partners should support Governments and refugees to integrate into existing public health and HIV services (this is also a guiding principle for all displaced persons' situation).

ii) **Non-urban settings:** In some situations, refugees are located in non-urban and non-camp settings (e.g. Uganda). In these settings, refugees live among host populations in village-like settings in an integrated fashion. UNHCR favours such settings but they are, unfortunately, rare due to host Government restrictions.

DURABLE SOLUTIONS

1) **Voluntary Repatriation:** This remains the durable solution sought by the largest number of refugees. Its realization is, however, complex and challenging. Core components for return include physical safety, legal safety, material safety and reconciliation. These are often not yet in place and delay voluntary repatriation. Ensuring sustainable return is possible and is first and foremost the responsibility of the countries of origin towards their own people. It also requires coherent and sustained action and support by the international community. UNHCR's overriding priorities when it comes to return are to promote the enabling conditions for voluntary repatriation, to ensure the exercise of a free and informed choice, and to mobilize support to underpin return.

2) **Local Integration:** Local integration is a legal process whereby refugees are granted a progressively wider range of rights and entitlements by the host State that are broadly commensurate with those enjoyed by its citizens. These include freedom of movement, access to education and the labour market, access to public relief and assistance including health facilities, the possibility of acquiring and disposing of property, and the capacity to travel with valid travel and identity documents. Over time the process should lead to permanent residence rights and in some cases the acquisition, in due course, of citizenship in the country of asylum. It is also an economic process whereby refugees become progressively less reliant on State aid or humanitarian assistance, attaining a growing degree of self-reliance and becoming able to pursue sustainable livelihoods, thus contributing to the economic life of the host country. Finally, it is also a social and cultural process of acclimatization by the refugees and accommodation by the local communities, that enables refugees to live amongst or alongside the host population without discrimination or exploitation, and contribute actively to the social life of their country of asylum.

3) **Resettlement:** A fundamental objective of resettlement policy is to provide a durable solution for refugees unable to voluntarily return home or to remain in their country of refuge. A decision to use the resettlement option should be based on what difference, if any, this option would make in addressing the immediate and long term problems and needs of the individual refugee or groups of refugees. States are encouraged to ensure that resettlement runs in tandem with a more vigorous integration policy aimed at enabling refugees having durable residence status to

enjoy equality of rights and opportunities in the social, economic and cultural life of the country. Resettlement countries generally require certain medical tests for some infectious diseases including tuberculosis. Some countries require test for HIV, this has protection and human rights implications that must be addressed.[3] UNHCR clearly states that HIV status should not adversely affect resettlement claims. The resettlement of persons with medical needs is challenging and resettlement opportunities are limited. Specific criteria for medical resettlement exist and must be carefully followed.[4]

GUIDING PRINCIPLES

1) **Human rights:** Refugees should enjoy access to public health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). 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); this includes a right to be free from hunger and mal-nutrition and to adequate food, nutrition and clean, safe drinking water including in emergency situations. UNHCR has a specific note for HIV and AIDS.[5] Refugees, like all persons, should be adequately informed, actively make their own decisions and provide their consent to the services provided to them. Respect for confidentiality and privacy must be ensured.

2) **Uniqueness:** Refugees and other PoCs to UNHCR are unique groups which often have special needs due to their circumstances (e.g. trauma and violence including sexual violence, different languages and cultures, issues related to durable solutions, dependency upon external support and limited economic opportunities). Existing policies, guidelines and protocols for persons in resource-poor settings may need to be modified accordingly and in some cases specifically developed.[6,7]

3) **Age, Gender and Diversity:** All policies and programmes must respect gender equality and the rights of all refugees and other PoCs of all ages and backgrounds. Particular attention must be paid to those who have traditionally been excluded and the most disenfranchised, that is, women, children, older persons, persons with disabilities and minority groups. An emphasis should be placed on women and children.

3 Note on HIV/AIDS and the Protection of Refugees, IDPS and Other Persons of Concern, UNHCR. Geneva. April 2006.

4 UNHCR. Chapter 4: UNHCR criteria for determining resettlement as the appropriate solution (pg IV/10). Geneva. November 2004.

5 Note on HIV/AIDS and the Protection of Refugees, IDPS and Other Persons of Concern, UNHCR. Geneva. April 2006.

6 UNHCR. Chapter 4: UNHCR criteria for determining resettlement as the appropriate solution (pg IV/10). Geneva. November 2004.

7 UNHCR. Antiretroviral medication policy for refugees. Geneva. January 2007.

4) **Participation:** Refugees and other PoCs should be empowered at all stages to participate in policy making, programme planning, implementation and monitoring and evaluation in order to design acceptable, appropriate, sustainable and culturally sensitive policies and programmes. These must take into consideration beneficiaries' needs, requirements and diversity within the framework of international standards and human rights. Participation of organisations working with the PoCs and Government line ministries/focal points should be ensured.

5) **Multi-Sectoral:** Policies and programmes are operationally interdependent and, thus, must be multi-sectoral in nature linking those sectors within the Public Health and HIV Section as well as outside of the section. This integrated approach is essential towards ensuring complimentary and comprehensive programmes that should help ensure a higher level of sustainability in the long term.

6) **Multi-Partner:** The section must build upon current UNHCR partnerships in delivering its programmes through implementing and operational partners, Governments, sister UN agencies, international agencies and other organisations when appropriate.

7) **Integration:** Public health and HIV policies and programmes should be integrated with other programmes in UNHCR (linked to multi-sectoral principle above) as well as with those surrounding the PoCs (e.g. Government and host community programmes).

8) **Quality of Services:** Refugees and other PoCs to UNHCR should receive services of sufficient quality as listed below. To monitor quality, functioning public health information systems must be in place and used and appropriate feedback provided.
   i) **Availability:** Appropriate services exist for the community.
   ii) **Accessibility:** Those who need existing services should be able to obtain them regardless of status, gender, age, marital status, race, religion, sexual orientation and disability. During the emergency phase, services should be free of charge. During the post-emergency phase, services should be affordable to PoCs. This depends upon the context. In refugee camps, services are generally provided free of charge while in urban settings, refugees generally follow the situation in the host country; however, in all situations, there needs to be a system to ensure that vulnerable populations can access appropriate services regardless of cost. Accessibility also refers to service hours, registration procedures, and location of services including referral hospitals (e.g. ensuring women have access to emergency obstetrical care, including Ceasarean sections in an appropriate timeframe).
   iii) **Equity:** Different populations or segments of populations in a geographical area who need services can obtain them in a similar manner. In most circumstances, host communities should have access to services provided to refugees in camps, and refugees should have access to government services available to host communities in non-camp settings. Systems to examine the equity of services for women and children should be available.

iv) **Appropriateness:** Prevention, care and treatment services are provided according to context while unnecessary or harmful services are not provided. This includes minimum essential services in the emergency scenario and different levels of comprehensive services in the post-emergency scenario according to context. Continuity of services in the durable solution scenario is essential. Overall, services should be similar to those provided in the country of origin and host country. However, minimum essential services must be provided in all situations regardless of availability in host communities. If not available in the latter, UNHCR must advocate for their provision and provide such services to the host community within its means to do so. In developed country displaced settings, sophisticated secondary and even tertiary care may need to be provided depending on context and funds. Prioritisation is essential in these circumstances, and wide scale availability of primary health care, including obstetric care and prevention services must be prioritised.

v) **Acceptability:** Services provided meet the expectations of the community accessing them. This includes but is not limited to confidentiality, informed consent and choice of services.

vi) **Effectiveness:** Services bring about positive change in public health status of people. This requires trained and competent staff among UNHCR and its partners. Algorithms, protocols, policies and guidelines should follow host country protocols unless shown to be ineffective or they do not meet international standards. If the latter occurs, internationally accepted algorithms, protocols, policies and guidelines should be followed by UNHCR while advocating for a change in national equivalents.

vii) **Efficiency:** Services are provided at lowest possible cost while fulfilling the other components of quality of services in a timely manner.

9) **Sustainability:** Policies and programmes should be created and implemented with sustainability and durable solutions kept in mind as the ultimate goal. Various issues must be considered including appropriate technology, capacity building, and use of local skills and knowledge.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