EXECUTIVE COMMITTEE OF THE
HIGH COMMISSIONER'S PROGRAMME

Dist.
RESTRICTED

EC/58/SC/CRP.15
4 June 2007

STANDING COMMITTEE
39th meeting

Original: ENGLISH

HEALTH, NUTRITION AND HIV/AIDS – NEW STRATEGIES

I. OBJECTIVES

1. This paper provides a strategy for the newly established Public Health and HIV Section[1] as well as an update on its key programmes.

II. PUBLIC HEALTH AND HIV SECTION STRATEGIES

2. The overall aim of the Public Health and HIV Section is to achieve UNHCR's Global Strategic Objectives on health, nutrition, food security and HIV, as well as to establish policy priorities on these issues in the context of the Office's protection mandate. This includes:

i) *Link to protection*: Strong linkages of health, nutrition, food security and HIV with protection and human rights will be ensured. This includes resettlement (medical conditions as well as HIV testing), voluntary repatriation, right to health and proper nutrition, human rights, sexual exploitation and violence, gender equality and child rights.

ii) *Technical support***:** Specific countries will be targeted according to established criteria (to be developed) for additional technical support, monitoring and evaluation.

iii) *Strategies and policies:* All existing and draft strategies and policies on health, reproductive health, child survival, nutrition and food security will be catalogued, reviewed and updated if necessary.

iv) *Emergency response*: The Section will maintain a close relationship with the Emergency Preparedness and Response Section to ensure that health, nutrition and HIV are a part of emergency response when required. Regional health/HIV and nutrition coordinators must work closely with the authorities and relevant actors in their respective countries to ensure adequate and timely response. The Section will actively participate in the humanitarian reform process/cluster approach, ensuring that UNHCR has a lead technical response in HIV among displaced persons, as outlined in the UNAIDS division of labour.

[1] Sectors covered include health, nutrition, food security, child survival, reproductive health and HIV/AIDS

v) *Synergy among sectors within UNHCR*: the Section will examine the 2007 and 2008-2009 plans and proposals to ensure complementarity. It will identify cross-cutting issues and synergies with other sectors (e.g. protection, water/sanitation, education, community services, and age, gender and diversity mainstreaming).

vi) *Staffing*: The overall strategy should follow that established by the previous HIV Unit. A core group of regional health/nutrition and HIV coordinators will be developed to support a network of in-country public health officers. The group will be composed of a mix of professional staff, national officers, international and national United Nations Volunteers, depending on the size, budget and complexity of the operation. Secondments from other organizations will be pursued as a strategy to overcome limited funding and posts for technical sectors. Depending upon identified gaps, consultants will be recruited when needed. In addition, standby agreements and rosters for emergency response and technical support will be reinforced.

vii) *Improved coordination and training*: Within UNHCR, the Section will prepare pre-deployment packages and encourage staff to receive thorough briefings at Headquarters. Annual meetings for all public health and HIV professionals at UNHCR will continue to be organized, and the Section will promote at least one regional meeting for technical professionals from UNHCR and non-governmental organizations (NGOs) to encourage the sharing of information and ensure standardization and a common approach. The Section is seeking to enhance thematic training on nutrition and food security and to ensure adequate missions to the Field by regional technical coordinators and headquarters staff. On the external front, effective collaboration and coordination with the inter-agency cluster approach is required and the Office will continue to work closely with United Nations agencies and others, including UNAIDS, UNFPA, UNICEF, WFP, WHO, the Standing Committee on Nutrition and the Centers for Disease Control and Prevention (CDC), as well as key implementing and operational partners and host Governments.

viii) *Communications strategy***:** The Public Health and HIV Section will institute internal global and regional strategies for technical, policy and programme updates and feedback. It is developing an external strategy to share new publications and reports to target managers and policy makers who can advocate for inclusion and integration of refugees, internally displaced persons (IDPs) and other persons of concern to UNHCR in national programmes. Health and HIV websites will be kept updated and a nutrition website is in the process of being set up. In collaboration with UNHCR's public information officers, the Section works closely with national and international media to ensure that UNHCR's health messages are conveyed accurately. It will continue to contribute to scientific debates and analysis of refugee health issues by submitting articles to professional journals.

ix) *Evidence-based decision making***:** UNHCR's camp-based health information system (HIS) will be expanded throughout Africa and Asia (see paragraph 6 below), through other United Nations centralized databases, including UNHCR's own standards and indicators data collection, as well as United Nations

information sources on nutrition in crisis situations. All countries with more than 5,000 refugees and IDPs will be examined to compare data with internationally accepted standards and indicators. The above data will be used to make evidence-based decisions on all aspects of public health and HIV at UNHCR.

x) *Donors***:** The Section is meeting with traditional and non-traditional donors to discuss its role and to explore options, including possible joint health, nutrition and HIV proposals, for additional funding.

III. UPDATE ON PUBLIC HEALTH AND HIV SECTION PROGRAMMES

A. Special projects for health, nutrition and sexual and gender-based violence (SGBV)

3. In February 2007, the High Commissioner allocated USD 15 million to health, nutrition and SGBV projects in 13 countries where UNHCR had previously lacked sufficient resources. Health and nutrition interventions (USD 11.25 million) focused on seven operations in Africa (Djibouti, Ethiopia, Kenya, and eastern Sudan) and in Asia (Bangladesh, Myanmar and Nepal). The projects include the provision of supplemental food and micronutrients; malaria prevention and treatment; reproductive health; child survival; water and sanitation improving infrastructure; provision of medicines and related materials/equipment; non-food items; human resources; capacity building; and improving monitoring and evaluation. A concerted effort has been, and will continue to be, made to improve the health and nutrition status of these refugees, who live primarily in camps, in protracted situations. A similar level of funds will be provided to these operations in 2008 to ensure the sustainability of the projects.

B. UNHCR's Strategic Plan for Malaria Control (2005-2007)

4. Malaria remains a primary cause of illness and death among displaced populations, even though malaria is preventable and treatable. Many refugee and IDP settlements are in highly endemic countries: approximately 68 per cent of persons of concern to UNHCR live in malaria-endemic areas. Refugee populations are particularly vulnerable to malaria because of poor housing, malnourishment and having to live in locations which are often particularly affected by malaria-transmitting mosquitoes. To improve malaria control in refugee settings, CDC provided technical support for UNHCR to develop a Strategic Plan for Malaria Control (2005-2007). The plan for camp-based refugee populations targets 13 African countries located in malaria-endemic areas, with populations of more than 5,000 persons (Chad, Côte d'Ivoire, the Democratic Republic of the Congo, Ethiopia, Ghana, Guinea, Kenya, the Republic of the Congo, Sierra Leone, Sudan, the United Republic of Tanzania, Uganda and Zambia), representing 1.6 million refugees living in 80 camps at the end of 2004. Most of the refugees in these countries now have access to the Artemesin-based anti-malaria combination therapy which is recommended by the respective Ministries of Health and UNHCR. Long-lasting treated mosquito nets for vulnerable individuals (children below the age of five and pregnant women) have been provided in the majority of the selected countries. Unfortunately, the plan to implement malaria testing, treatment and prophylaxis for pregnant women during antenatal visits has not yet been widely adopted, although progress has been made in Zambia and eastern Sudan with special funds provided by a donor Government. Further improvements should be achieved through the special project mentioned in the previous paragraph.

C. Avian and human influenza (AHI)

5. UNHCR has a humanitarian responsibility to ensure preparedness and mitigate the risks for refugees and other persons of concern, in particular those in camps, in case of an AHI pandemic. The majority of camps are in countries where managing and responding to an AHI pandemic for the national population would already pose enormous challenges for the Government. While UNHCR will continue to advocate for all refugees to be included in national AHI plans, it will work with Governments, United Nations and other agencies and NGOs to ensure timely and efficient management of any AHI outbreak. Thanks to generous contribution from two major donor Governments, UNHCR has hired six Epidemic Preparedness and Response Officers in Asia, Africa and the Middle East and North Africa for 2007. They will advocate for host Governments to include refugees in their National AHI plans; aid NGOs in refugee camps to prepare AHI plans; improve general epidemic preparedness and response in refugee situations; ameliorate essential medication supply and management systems; and provide AHI education and training programmes to UNHCR staff and partners, as well as to refugees and other persons of concern.

D. Health Information System (HIS)

6. The HIS comprises a data management application supported by data collection tools, guidelines and training materials that have been successfully implemented in refugee operations in Ethiopia, Kenya and the United Republic of Tanzania. It will be rolled out in approximately eight countries in Africa and Asia in 2007. A training-of-trainers' workshop was recently held in Nairobi for UNHCR and NGOs; similar workshops will be organized in West Africa and Asia. In March 2007, UNHCR convened an HIS partners' conference with participation from NGOs, United Nations agencies and donors. The HIS was broadly endorsed as a simple yet powerful tool for collecting, analysing and reporting data on camp-based populations. Adaptation of the tool for non-camp situations was strongly recommended.

E. Nutrition

7. Since the report presented to the 36th meeting of the Standing Committee (EC/57/SC/CRP.17) in June 2006 and the update provided on global programmes and partnerships at the 38th meeting of the Standing Committee in March 2007, UNHCR, in partnership with WFP, has taken a number of strategic steps towards reaching acceptable standards in nutrition and related sectors. The Office has included nutrition (and health) as part of its Global Strategic Objectives for 2007 and for 2008-2009, giving priority to reducing malnutrition and major risks to the health of populations of concern. The limited technical capacity for nutrition management at UNHCR has been enhanced by the part-time secondment of one nutritionist from the United Nations Standing Committee on Nutrition; joint assessments and training with WFP; and technical workshops for UNHCR staff at the country level. The appointment of a Junior Professional Officer to the Nutrition Unit, and short-term consultancies in the special project countries, will bring further support in 2007. However, UNHCR still lacks sufficient nutrition/food security regional coordinators in some regions. To monitor the situation better, improved nutrition indicators were finalized and included in the current HIS (see previous paragraph), and quality nutrition surveys are being undertaken in collaboration with CDC and other organizations.

F. HIV and AIDS

8. For an update on HIV and AIDS developments, please refer to the conference room paper entitled “HIV/AIDS and Refugees/IDPs” (EC/58/SC/CRP.16).

IV. CONCLUSIONS

9. The creation of a new Public Health and HIV Section will provide an opportunity for health, nutrition, food security and HIV to be integrated better into UNHCR’s operations in a more synergistic way.

10. The implementation of the proposed strategies has begun and benefits can already be seen. The provision of technical support in a more coordinated and integrated fashion has improved public health and HIV services to refugees. In part, this has led to increased funding, allowing for more technical support at regional and country levels and intensified efforts in targeted countries to improve the health, nutrition and HIV situation of the affected populations.

11. However, much more still needs to be done by UNHCR and its partners in the public health and HIV sectors to pursue these goals. Insufficient attention has been paid to these sectors in protracted refugee situations. A concerted and coordinated effort over many years will be needed to improve the overall health and nutrition status of persons of concern to UNHCR and to reduce HIV transmission while providing quality care and treatment.