

Negotiating Improved Health Governance in Fragile States: UNHCR's Perspective

**Global Health Governance in Fragile States
4th High-Level Symposium on Global Health Diplomacy
29 November 2010**

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United Nations High Commissioner for Refugees (UNHCR)

- Est. in 1950 by UN General Assembly
- Mandated to lead and coordinate international action to protect refugees and resolve refugee problems
- Also mandate to help asylum seekers, stateless people, IDPs and returnees
- Public health is a fundamental protection issue inextricably linked to human rights



Data for Public Health Diplomacy

“Refugees have a high HIV prevalence due to war and spread HIV.”

“Refugees are too unstable a population to be given anti-retroviral therapy.”



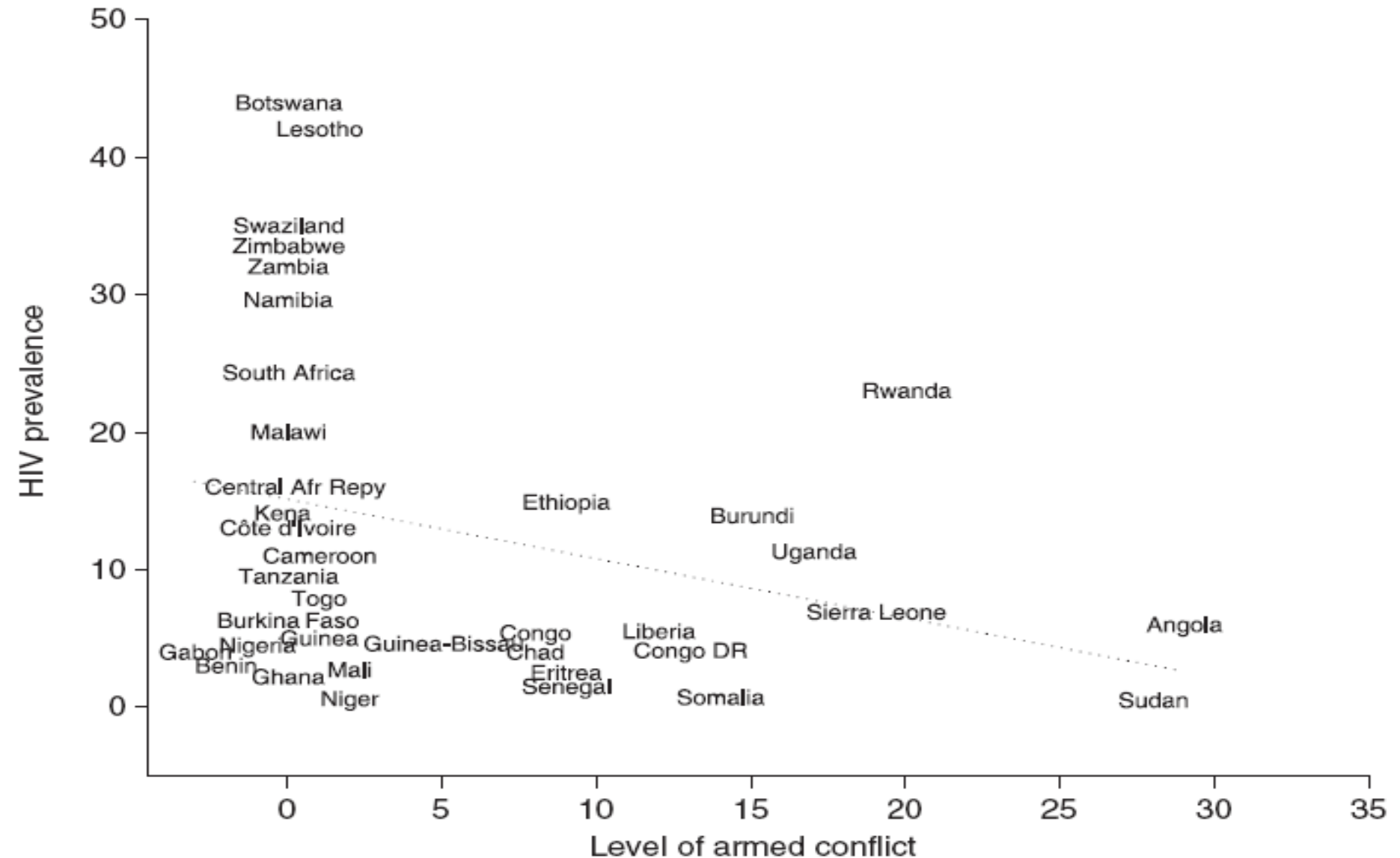


Figure 1 Relation of armed conflict (AC) and HIV seropositivity in sub-Saharan Africa. Spearman rank correlation $r = -0.41$, $P = 0.012$. Sources, see Table 1

	Prevalence (95% CI)	Year	Host population	Prevalence (95% CI)	Year
Burundian refugees in Tanzania					
Mtabila and Muyovosi camps	1.7%	2001	Kigoma region*	2.0%	2003
	4.5%	2003			
Nduta and Mtendeli camps	1.3%	2001			
	1.6%	2002			
	1.7%	2003			
Lukole Camp	4.8%	2001	Kagera region*	3.7%	2003
	3.1%	2002			
	1.6%	2003			
DRC refugees in Tanzania					
Lugufu and Nyaragusu camps	1.0%	2001	Kagera region*	3.7%	2003
	2.5%	2002			
	1.8%	2003			
DRC refugees in Rwanda					
Gihembe camp	1.5% (0.4–3.8)	2002	Byumba site	6.7% (4.7–9.4)	2002
DRC refugees in Zambia					
Mwange camp	1.2%	2005	Nchelenge site	18.9%	2002
Kala camp	3.4%	2005			
Eritrean refugees in Sudan					
Several camps in eastern Sudan	4.1%	2002	El Gadarif site	4.0%	1998
Sudanese refugees in Uganda					
Palorinya settlement	1.0% (0.3–1.8)	2004	Immediate surrounding population	5.9% (1.7–10.1)	2004
			Moyo site	4.3%	2002
Kyangwali settlement	2.7% (1.3–4.0)	2004	Immediate surrounding population	2.8% (1.0–6.6)	2004
			Hoima site	4.6%	2002
Sudanese refugees in Kenya					
Kakuma camp	5.0% (3.5–7.0)	2002	Lodwar site	18.0%	2002
Somali refugees in Kenya					
Dadaab camps	0.6% (0.01–1.1)	2003	Garissa site	26.0%	2002
	1.4% (0.5–2.2)	2005			
*Population-based data.					

Table 2: Prevalence of HIV infection in refugees and host communities in selected sites, 1998–2005

Spiegel PB, Bennedsen AR, Claass J, et al. Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: systematic review. *Lancet* 2007;369(9580):2187-95.

Antiretroviral Therapy (ART) for Conflict-affected persons

- Average refugee stays a refugee for over 10 yrs
- Does not make public health sense to treat part of a pop. living in same area

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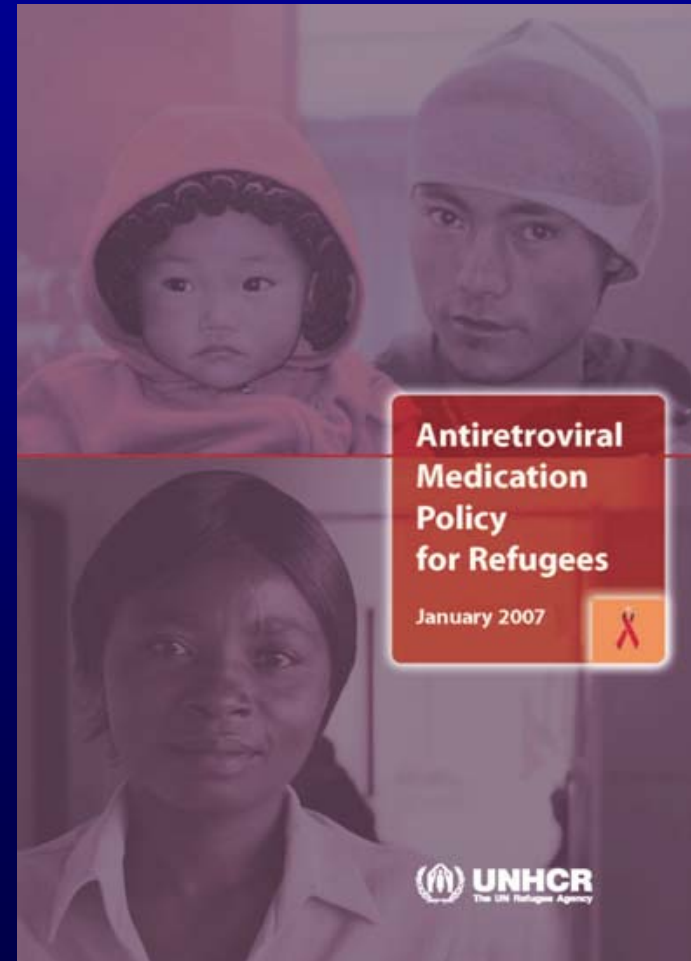
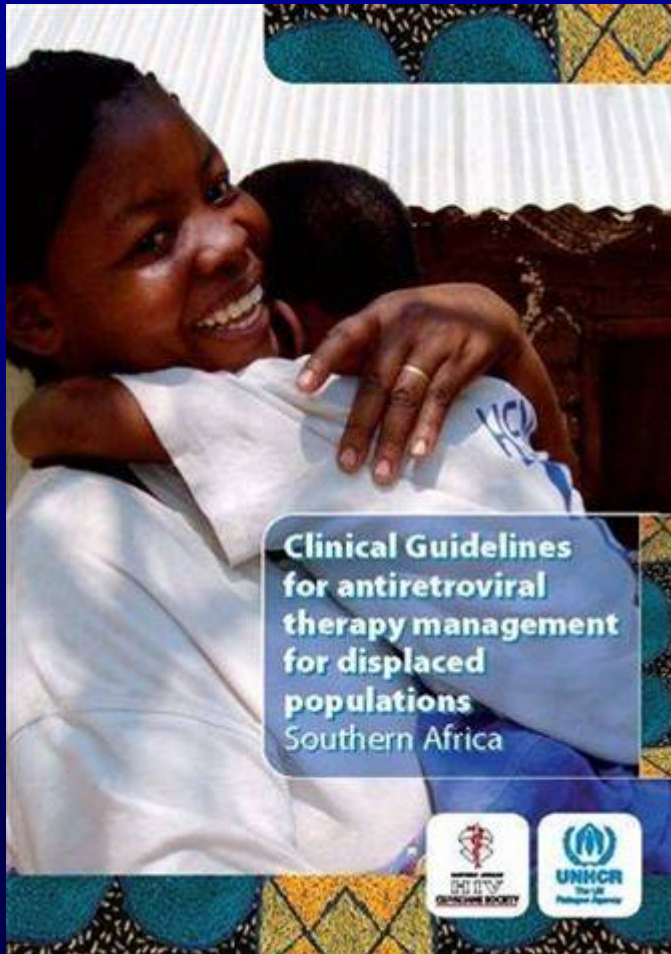
Health in Action

HIV Treatment in a Conflict Setting: Outcomes and Experiences from Bukavu, Democratic Republic of the Congo

Heather Culbert, David Tu, Daniel P. O'Brien*, Tom Ellman, Clair Mills, Nathan Ford, Tina Amisi, Keith Chan, Sarah Venis,
Médecins Sans Frontières

- Provision of comprehensive HIV care including ART in chronic conflict settings is feasible and effective, with early treatment outcomes similar to those in HIV projects in non-conflict settings

ART for Refugees



HIV and Refugees Today

- UNHCR became UNAIDS cosponsor 2002
- Reduced stigma and discrimination; increased acceptance of refugees by host governments
- Refugee and IDPs are slowly now being incl. in HIV National Strategic Plans and donor proposals (except Global Fund)
- Part of HIV sentinel sites in Kenya and Uganda
- 87% of refugees have access to ART and 75% of pregnant refugee women have access to PMTCT when available to surrounding host populations.



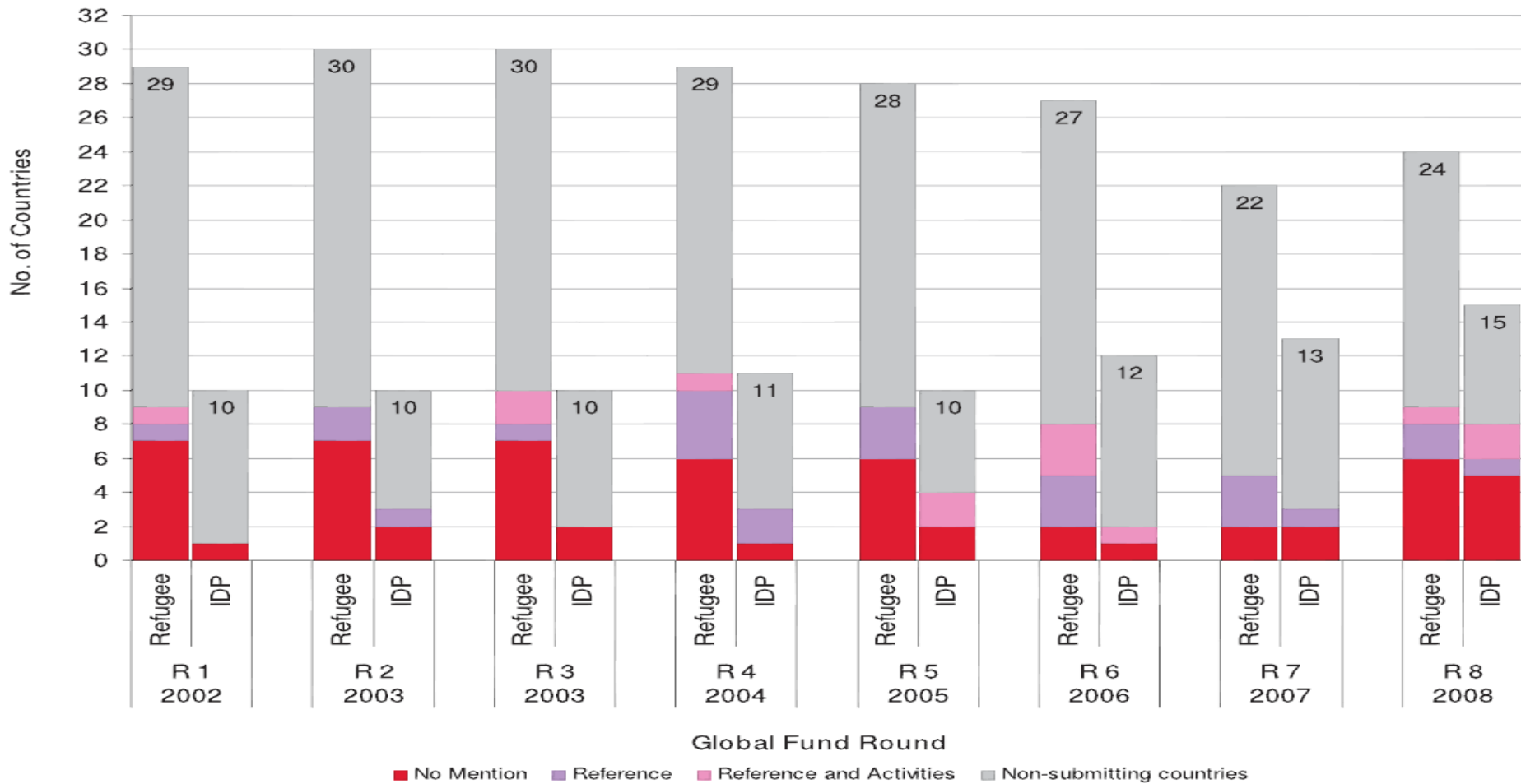


Figure 1 Inclusion of refugees and/or IDPs in accepted Global Fund proposals with HIV component in African countries with $\geq 10,000$ refugees and/or $\geq 10,000$ IDPs. Rounds 1-8 (2002-2008).

Spiegel P, Hering H, Paik E, Schilperoord M. Conflict-affected displaced persons need to benefit more from HIV and malaria national strategic plans and Global Fund grants. *Conflict and Health* 2010, 4:2 Jan 2010

- Persons affected by HEs are not adequately included in approved Global Fund grants for HIV

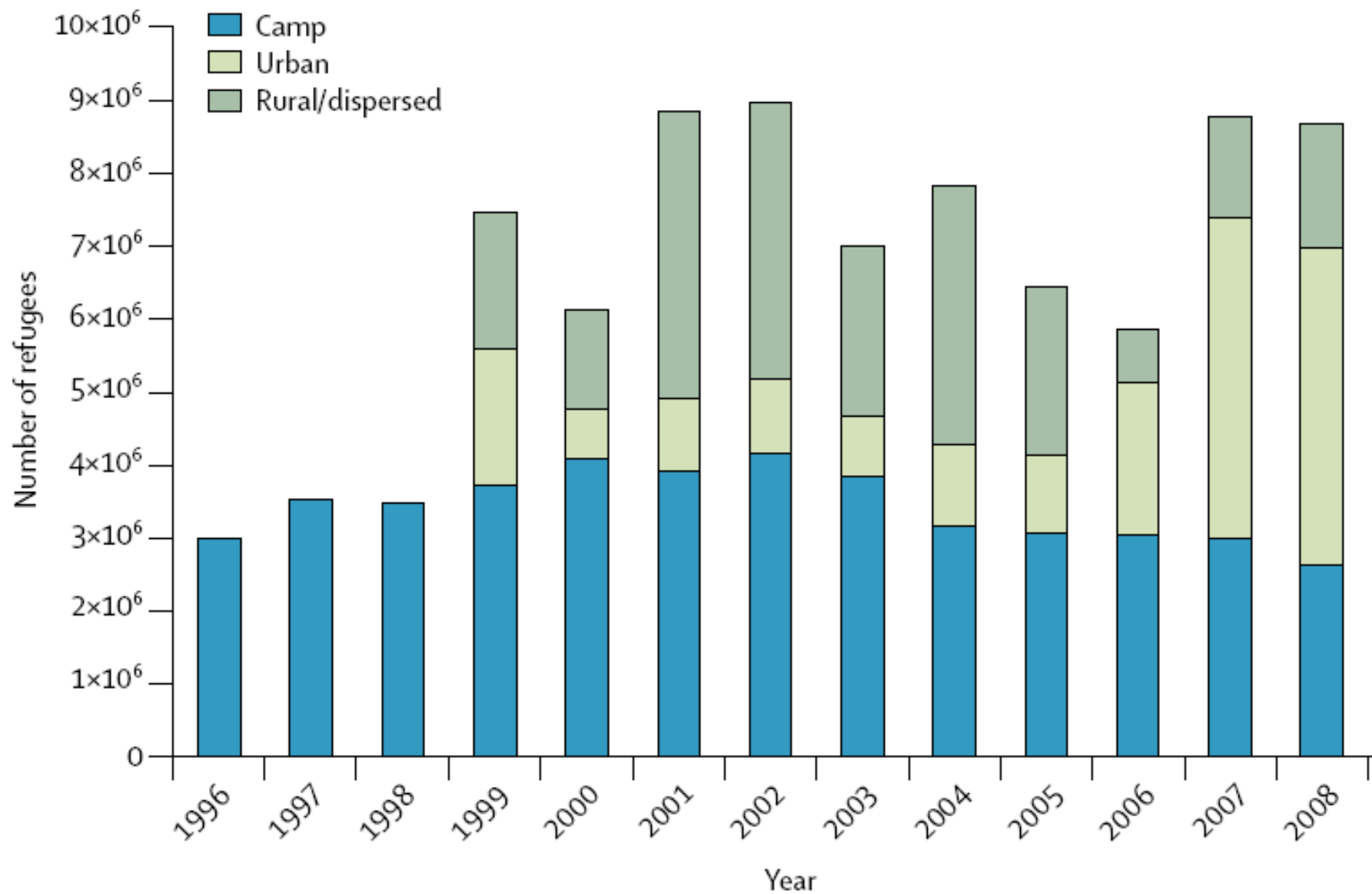


Figure 2: Number of refugees living in camp-like, urban, or rural and dispersed settings, 1996–2008*

Spiegel, P, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. *Lancet* 2010; 375: 341–45

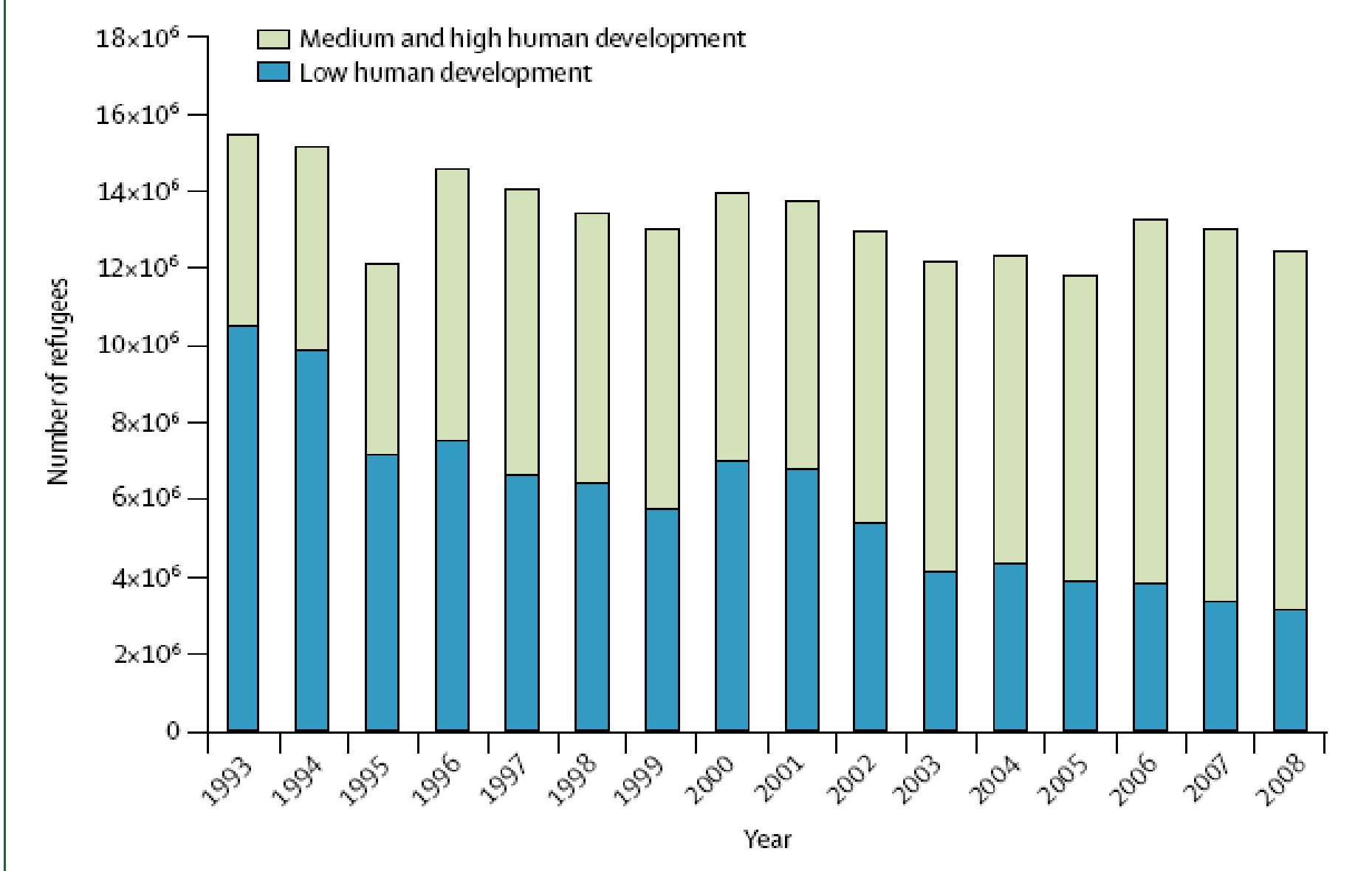
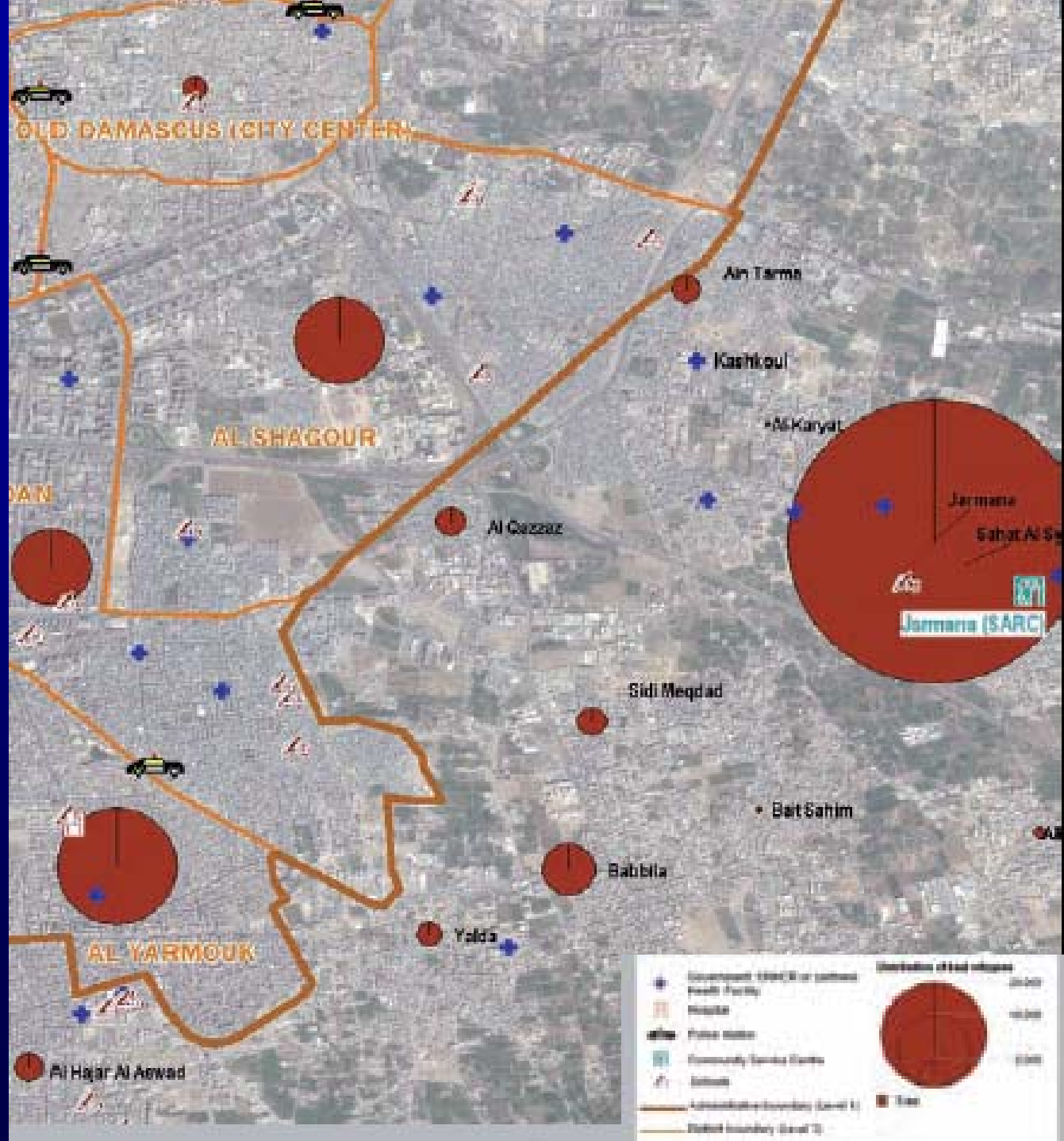


Figure 3: Number of refugees* by human development index category (low versus medium to high) of country of origin†, 1993-2008

Spiegel, P, Checchi F, Colombo S, Paik E. Health-care needs of people affected by conflict: future trends and changing frameworks. *Lancet* 2010; 375: 341-45

Distribution of Registered Iraqi refugees and services in Damascus, Syria Oct 2007



Tertiary Care for Iraqi Refugees in Syria in 2009

HCR spent ~USD 5 million (69% on 4 main categories)

Type	Number	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



Negotiating with Gov'ts to Improve Health Services for Refugees in Urban Areas

- Integrate services into existing nat'l health services
 - Address barriers and help governments
- Ensure primary and emergency health-care services are established before concentrating on secondary and especially tertiary health care
- Negotiate contracts with limited no. of org. and hospitals for lowest prices similar to local pop.; allows for easier monitoring and quality control