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Health Implications of the Global Refugee and Migrant Crisis

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Overview²

This paper explores the global health implications of the refugee and migrant crisis, highlighting what U.S. government agencies are doing in four key areas: maternal health, reproductive health, nutrition, and immunizations. It reviews the funding mechanisms available to address the needs of displaced populations and specific initiatives related to global health. It also highlights the work of United Nations agencies that are key multilateral partners the United States invests in to address this global challenge, with examples of how U.S. policies and programs can better meet the needs of women and adolescent girls in crisis. Lastly, the paper provides recommendations to the U.S. government about ways to leverage U.S. leadership on humanitarian crisis to increase women's access to family planning and reproductive health services.

Executive Summary

The crisis in Syria has led to the largest increases in refugees and displaced populations the world has seen since World War II. At the end of the Obama administration's tenure, solutions for stemming the flow of people from Syria and other failed states in the Middle East and Africa are limited, as active conflict continues to drive people from their homes. Women make up 50 percent of the world's displaced population, yet addressing their specific health needs requires concerted effort by a range of UN agencies and nongovernmental organizations (NGOs) in the face of record funding shortfalls.

Gender-based violence (GBV) is a significant problem in all crisis interventions, and comes in many forms, including rape, sexual harassment, intimate partner violence, forced marriage, early marriage, infanticide, and forced sterilization. While the United Nations Fund for Population Activities (UNFPA) plays a leadership role in preventing and responding to GBV in humanitarian settings, the resulting impact of sexual violence on health services for women and girls is not given adequate resources or attention. These services include emergency contraception, postexposure prophylaxis (PEP) to prevent HIV infection, preserving forensic evidence, and providing psychosocial support. The International Rescue Committee (IRC) has pointed out that when a woman is raped, she has 72 hours to prevent the transmission of

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² This paper was commissioned by the CSIS Task Force on Women's and Family Health. Research and analysis were conducted in the summer of 2016, prior to the November elections.

HIV, 120 hours to prevent unwanted pregnancy, and only a few hours to ensure that life-threatening injuries do not become fatal.³

While progress has been made in documenting the need for family planning services and maternal and reproductive health in emergency settings, the Inter-Agency Working Group on Reproductive Health in Crisis has pointed out that gaps remain in understanding the needs of and providing services to adolescent girls. Yet, there is evidence that an alarming number of adolescent girls are giving birth in refugee settings. In Jordan, UNFPA estimates that girls under the age of 18 accounted for 5 percent of all new births in Zaatari Camp, and that 30 percent of new marriages registered in Jordan were with girls between the age of 15–17. Displaced families are using early marriage as a protection tool to ensure that girls are not raped or abused by other men in camp settings. Some families have cited that they are using early marriage as a tool to increase the size of the family, so they are eligible for more humanitarian assistance.⁴ Displacement interrupts the normal social patterns of family life, bringing with it negative coping mechanisms that can result in violence against women. Early marriage is a form of GBV that severely restricts the education and employment opportunities of girls. Providing better protection and health services to adolescent girls displaced by the Syria crisis will require a holistic approach that includes keeping girls in school and ensuring that families have other means available for achieving social and financial security.

In spite of increases in awareness about the need to prevent and respond to GBV in humanitarian settings, protection sector programming receives only 3 percent of all funding appeals.⁵ Health sector programs receive considerably more, between 12–22 percent.⁶ This highlights the need to better integrate GBV services into all health interventions. Improvements in data collection and information sharing could also help agencies plan more targeted interventions. However, even large agencies such as the UN High Commissioner for Refugees (UNHCR) maintains separate systems for tracking GBV program data and the provision of health services in the aftermath of rape, making it difficult to understand the full scale of the problem in any given context. Organizations that track survivor data through a GBV Information Management System (GBV-IMS) do not share the results of this data with other agencies out of concerns for survivor confidentiality. Yet, agencies can look to best practices in the collection of information about HIV/AIDS to determine how to protect patient identity and share data that improves interventions at the same time. Agencies should work together to unlock the potential of shared data to inform and strengthen GBV programs in high-risk areas, such as the Democratic Republic of Congo (DRC), South Sudan, and Somalia.

³ International Rescue Committee, "Are We There Yet? Progress and Challenges in Ensuring Life-saving Services and Reducing Risks to Violence for Women and Girls in Emergencies," September 1, 2015, <https://www.rescue.org/report/are-we-there-yet-progress-and-challenges-ensuring-life-saving-services-and-reducing-risks>.

⁴ Sarah Williamson, "Syrian Women in Crisis: Obstacles and Opportunities," Georgetown Institute for Women, Peace and Security Occasional Paper Series, January 2016.

⁵ United Nations Financial Tracking System (FTS) Global Humanitarian Aid Flows, "Trends per sector, 2014–2016," <https://fts.unocha.org>.

⁶ Ibid.

The U.S. government will have to build on current efforts to address the Syria crisis and multiple protracted crises in Africa; to manage mixed flows of migrants and refugees to Europe and the southern borders of the United States; and to understand that refugees are settling in urban contexts and are highly connected to technology. UN agencies and NGOs are working to adapt to a changing humanitarian landscape while the Sustainable Development Goals promise to “leave no one behind.” Now more than ever, the humanitarian and development community has an opportunity to work together to reduce the vulnerability of people affected by crisis in a way that builds resilience. The global health community can make a unique contribution by ensuring that women and girls are not left behind by working toward comprehensive approaches that incorporate family planning into girls’ education; advocating for access to care through local health institutions and insurance plans; and providing comprehensive clinical and psychosocial care to women and girls who are survivors of violence.

Recommendations to the U.S. Government

- Engage in humanitarian diplomacy with United Nations agencies, encouraging member states to follow through on commitments made to refugees and displaced people.
- Encourage receiving countries to offer work permits and education for refugees.
- Strengthen national health systems to provide maternal and family health services to refugees, displaced people, and migrants.
- Adopt a holistic approach to health services for adolescent girls that includes access to education and protection from early marriage.
- Invest in improvements in health data collection as it relates to the needs of adolescent girls and clinical response to gender-based violence (GBV).
- Expand refugee and migrant access to global health programs funded by the U.S. government, such as the President’s Malaria Initiative and Gavi, the Vaccine Alliance.

Addressing Humanitarian Crisis

As a result of the Syrian conflict and destabilization in the Middle East, the world is facing a surge in the number of displaced people. In addition, there are major refugee populations outside of the Near East—South Sudanese, Eritreans, Congolese, and others. Europe has been directly impacted by receiving unprecedented levels of migrants from Syria, Afghanistan, and Iraq, as well as Africa.⁷ In 2016, the UNHCR reported that more than 65 million people are uprooted, with 21.3 million people living as refugees outside their home country, 40.8 million people living as internally displaced people (IDPs), and 3.2 million

⁷ International Organization for Migration, “Mixed Migration Flows in the Mediterranean and Beyond, Compilation of Available Data and Information,” Reporting Period 2015, <http://doe.iom.int/docs/Flows%20Compilation%202015%20Overview.pdf>.

people waiting for decisions on asylum applications.⁸ Anti-immigrant sentiment and fear of terrorism is affecting migration policies globally, with states imposing greater restrictions on the movement of people.

The total number of displaced people is greater than the population of several European countries including the United Kingdom, France, and Italy.⁹ When the number of people seeking assistance is greater than the population of an entire country, we have to ask ourselves, what makes their health needs different than any other population? Refugees and migrants are vulnerable because they are on the move. A large number of refugees are in protracted situations in camps and cities and may lack the financial resources and networks to go elsewhere. Or they may not be able to move because of age, disability, or some other reason. Methods of providing social protection for displaced populations vary depending on the ability and willingness of governments to address the needs of their population and to provide some measure of coverage for foreign populations within their territory. Social protection is “all interventions for public, private and voluntary organizations and informal networks to support communities, households and individuals in their efforts to prevent, manage and overcome risks and vulnerabilities and enhance the social status and rights of the marginalized.”¹⁰ In crisis situations, international UN agencies and NGOs work to fill gaps in the state provision of protection and assistance.

Refugee influxes are largely a result of failed states. The countries of Somalia, Afghanistan, and Syria were responsible for 54 percent of all displacement worldwide in 2015.¹¹ The war in Syria has galvanized the world’s attention on the refugee crisis, with 4.9 million Syrians living outside the country. Beginning in 2015, nearly a million of those Syrian refugees migrated to Europe in search of a more stable life than what regional host countries, such as Turkey, Jordan, and Lebanon, could offer. Thousands of migrants have lost their lives at sea trying to reach Europe, and many remain trapped at border points across the continent.

Galvanizing the World to Action

The international humanitarian system has struggled to cope with the influx of refugees caused by the Syria crisis, while also providing for the needs of refugees in Africa and elsewhere. Now more than ever, governments and UN agencies are working together to coordinate needs that no one agency is able to meet by itself. Acknowledging that on one hand, the humanitarian system is struggling to manage the scale of need, and that on the other, refugee flows stretch the economic, social, and political systems of host countries, the international community has acknowledged that humanitarian action alone cannot meet the needs of uprooted people. States must fulfill their obligation to resolve conflict and uphold international human rights law, which recognize the right to seek asylum.

⁸ UNHCR, “Global Trends: Forced Displacement in 2015,” 2015, <http://www.unhcr.org/en-us/statistics/unhcrstats/576408cd7/unhcr-global-trends-2015.html>.

⁹ Ibid.

¹⁰ Mpho Makhena, “Social Protection for Refugees and Asylum Seekers in the Southern Africa Development Community,” Paper 0906, Social Protection and Labor, World Bank, 2009, <http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-papers/Labor-Market-DP/0906.pdf>.

¹¹ UNHCR, “Global Trends.”

In 2016, the United Nations convened the first World Humanitarian Summit in Turkey to identify new ways of working to address today's challenges. The summit resulted in numerous recommendations for improving humanitarian action. Several of the recommendations addressed the security of health care workers in conflict settings, improving access to reproductive health care services and reducing GBV.¹² The summit also called for more livelihood opportunities for refugees, and education for refugee children.¹³ The United Nations General Assembly held a High Level Meeting on Addressing Large Movements of Refugees with state actors about increasing their commitments to refugees in September 2016. The short-term outcome of these forums was a renewed commitment among state actors to provide for the legal and social protection of displaced people. However, the long-term outcome of these gatherings depends on the extent to which states implement the commitments by adjudicating asylum claims and providing access to basic services to displaced people regardless of their location.

Ensuring that the next secretary general continues to pursue the reforms envisioned by the World Humanitarian Summit will be important to the effectiveness of that meeting and the ability of the United Nations to galvanize states to action. At the same time as the U.S. presidential transition, the leadership of the United Nations is also changing with a new secretary general replacing Ban Ki Moon by the end of 2016. In December 2016, former Prime Minister Antonio Guterres was sworn in as the new secretary general of the United Nations. Guterres previously served as the UN high commissioner for refugees (UNHCR), and is well aware of the pressures facing world leaders, particularly in Europe, who are receiving large numbers of Syrians. The new secretary general faces several immediate political challenges, including the United Nations role in Syria peace talks, the role of Russia in ending the conflict, and elections in the United States and Europe that have resulted in new leaders with a skeptical outlook about the benefit and utility of international institutions. President-elect Trump and Secretary General Guterres had an introductory call in early January 2017, stating their intentions to work together.¹⁴

U.S. Funding for Multilateral Agencies

Funding for the United Nations and international women's health programs have been a contentious issue for numerous Republican administrations and conservative lawmakers. However, many U.S. government agencies have longstanding, historical partnerships with international agencies that support the health of refugees and displaced populations. For the most part, meeting urgent needs in humanitarian crisis has been a bipartisan issue that Republicans and Democrats largely agree is part of U.S. leadership in the world.

However, disagreements ensue about what constitutes an "urgent need," what should be paid for by the U.S. government, and what programs should be paid by other donors or

¹² "Chair's Summary by the United Nations Secretary General: Standing Up for Humanity: Committing to Action," World Humanitarian Summit (Istanbul: May 23–24, 2016), <http://reliefweb.int/sites/reliefweb.int/files/resources/Chairs%20Summary.pdf>.

¹³ Ibid.

¹⁴ "After disparaging United Nations, Trump and new U.N. Chief talk," Reuters, January 4, 2017, <http://www.reuters.com/article/us-usa-trump-un-idUSKBN14O1ZA>.

affected communities themselves. For example, the Office of Foreign Disaster Assistance (OFDA) within U.S. Agency for International Development (USAID) does not consider education for displaced children to be an urgent, life-saving need, while the UN Fund for Children (UNICEF) does consider education an essential pillar of emergency relief for children.¹⁵ In some countries, the United Nations High Commissioner for Refugees (UNHCR) has introduced different levels of health insurance based on individual refugees' ability to pay.¹⁶ These types of public-private partnerships that allow refugees to access national health care institutions or local private facilities, with the support of a humanitarian agency to ensure access, are promising models that should be further explored.¹⁷ Over the past decade, the private sector has also come to play a significant role in funding global health emergencies, particularly as it relates to public health, including Ebola and Zika. Therefore, the U.S. government has choices about how to strategically position its funding for international programs vis-à-vis the contributions of other donors, and options for using its diplomatic influence to encourage other donors to give more. For example, the Gulf states have played a minimal role thus far in the Syria refugee crisis; giving considerable funding to humanitarian programs, but not opening their doors to offer resettlement or other temporary solutions such as short-term work opportunities for refugees.¹⁸

The chart below provides an overview of the partnerships essential to health services.

U.S.-UN and Intergovernmental Stakeholders for Refugee Health

U.S. Agency	Sub-Organization	UN Agency	Area Emphasis
State Department	Bureau of Population, Refugees and Migration (PRM)	UNHCR	Refugee Protection, Assistance, and Resettlement
		IOM	Migrant Health; Health Screenings
		ICRC	Health services in conflict zones
	Bureau of International Organizations (IO)	UNICEF	Child Health; Nutrition
		UNFPA	Maternal Health; Reproductive Health
Agency for International Development (USAID)	Food for Peace (FFP)	WFP	Food and Nutrition
	Office of Foreign Disaster Assistance (OFDA)		Emergency food assistance

¹⁵ Discussion with U.S. Fund for UNICEF, July 2016.

¹⁶ Interview with UNHCR Public Health Officer, July 2016.

¹⁷ Discussion with director of Johns Hopkins Center for Humanitarian Health, August 2016.

¹⁸ Author discussions with Gulf State representatives, Dubai International Humanitarian Aid and Development Conference (DIHAD), March 2016.

Health and Human Services (HHS)	Centers for Disease Control and Prevention (CDC)	Various partners	Preventing disease and mortality among immigrants, refugees, and travelers, through immunizations and other interventions
	Office of Refugee Resettlement (ORR)	Various partners	State/PRM supports reception and placement of refugees for 3 months, then responsibility for local integration shifts over to ORR and partners

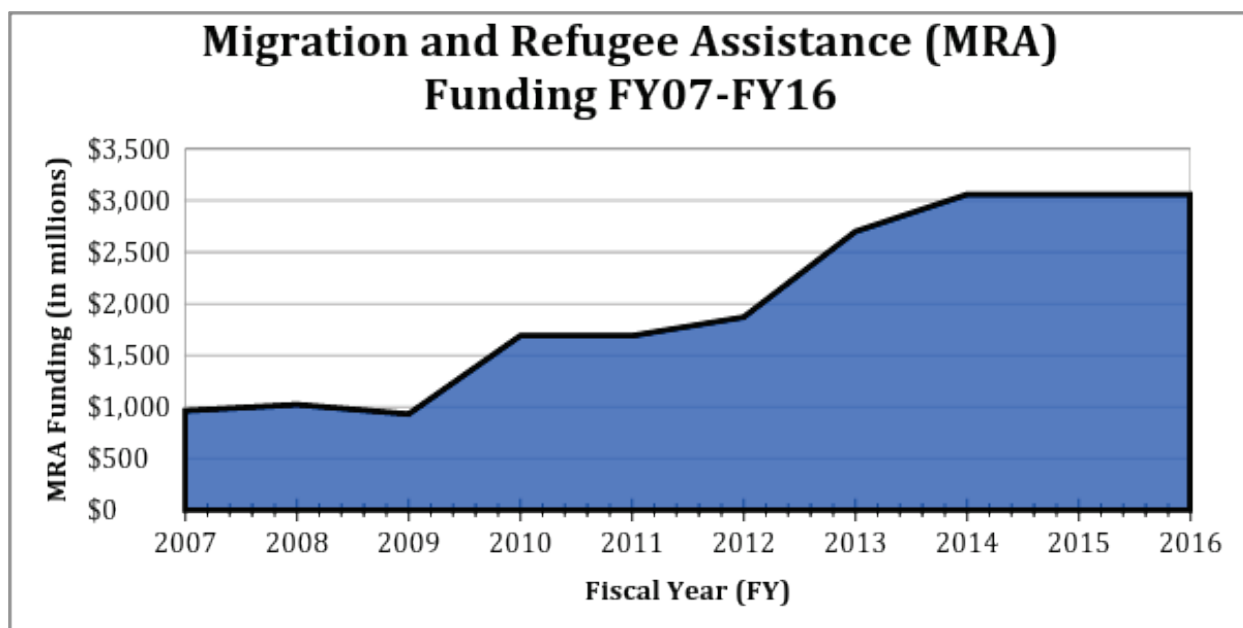
U.S. Government Commitment to Displaced Populations

U.S. foreign policy depends on the coordinated work of development, diplomacy, and defense institutions, all of which play an important role in meeting the needs of people affected by humanitarian crisis. The Refugee Act of 1980 created the State Department Bureau for Population, Refugees, and Migration (PRM) to administer U.S. contributions to international agencies and the U.S. refugee resettlement program in conjunction with other federal agencies.¹⁹ Today, U.S. commitments for refugees are manifested in the following ways:

- Donor support for the UNHCR and other multilateral agencies that protect and assist refugees, internally displaced, and stateless populations, such as the United Nations Relief and Works Agency (UNRWA)
- Resettlement of refugees to the United States as determined by an annual Presidential Determination on U.S. Refugee Admissions
- Humanitarian assistance toward refugees, internally displaced persons (IDPs), and migrants through U.S. and international NGOs, as well as limited direct support to local NGOs
- Humanitarian diplomacy urging states to uphold similar commitments to the protection of displaced populations

The Bureau of Population, Refugees, and Migration (PRM) leads the way in providing resources to UN agencies and NGOs that support refugees. PRM is funded through the Migration and Refugee Assistance (MRA) and the Emergency Refugee and Migration

¹⁹ Office of the Historian, "Assistant Secretaries of State for Population, Refugees and Migration," U.S. State Department, <https://history.state.gov/departmenthistory/people/principalofficers/assistant-secretary-for-population-refugees-migration>.



Source: Data in chart was compiled from annual publications from the Congressional Research Service: Susan B. Epstein, Marian L. Lawson, and Alex Tiersky, "State, Foreign Operations, and Related Programs: FY2016 Budget and Appropriations," Congressional Research Service, November 5, 2015, <https://fas.org/sgp/crs/row/R43901.pdf>; Susan B. Epstein, Marian L. Lawson, and Alex Tiersky, "State, Foreign Operations, and Related Programs: FY2015 Budget and Appropriations," Congressional Research Service, December 8, 2014, <https://fas.org/sgp/crs/row/R43569.pdf>; Susan B. Epstein, Marian L. Lawson, and Alex Tiersky, "State, Foreign Operations, and Related Programs: FY2014 Budget and Appropriations," Congressional Research Service, January 16, 2014, <https://fas.org/sgp/crs/row/R43043.pdf>; Susan B. Epstein, Marian L. Lawson, and Alex Tiersky, "State, Foreign Operations, and Related Programs: FY2013 Budget and Appropriations," Congressional Research Service, July 23, 2012, <https://fas.org/sgp/crs/row/R42621.pdf>; Susan B. Epstein and Marian L. Lawson, "State, Foreign Operations, and Related Programs: FY2012 Budget and Appropriations," Congressional Research Service, January 6, 2012, <https://fas.org/sgp/crs/row/R41905.pdf>; Susan B. Epstein, Marian L. Lawson, and Tamara J. Resler, "State, Foreign Operations, and Related Programs: FY2011 Budget and Appropriations," Congressional Research Service, April 22, 2011, <https://fas.org/sgp/crs/row/R41228.pdf>; Susan B. Epstein, Marian L. Lawson, and Kennon H. Nakamura, "State, Foreign Operations, and Related Programs: FY2010 Budget and Appropriations," Congressional Research Service, December 29, 2009, <https://fas.org/sgp/crs/row/R40693.pdf>; Susan B. Epstein and Kennon H. Nakamura, "State, Foreign Operations, and Related Programs: FY2009 Appropriations," Congressional Research Service, April 3, 2009, <https://fas.org/sgp/crs/row/RL34552.pdf>; and Susan B. Epstein and Connie Veillette, "State, Foreign Operations, and Related Programs: FY2008 Appropriations," Congressional Research Service, December 14, 2007, <https://fas.org/sgp/crs/row/RL34023.pdf>.

Assistance (ERMA) account in the Foreign Operations Appropriations bill. This account provides annual contributions to several international agencies that support refugees, internally displaced people (IDPs), vulnerable migrants, and stateless populations, including the UNHCR, International Organization for Migration (IOM), and the International Committee of the Red Cross (ICRC).

Given increasing demand on the international humanitarian system, funding for the MRA account has been robust over the last decade. Since FY12, the Obama administration has distinguished between enduring costs and Overseas Contingency Operations (OCO) funds,

which are not subject to the budget caps established by the Budget Control Act of 2011.²⁰ The majority of MRA funding comes from OCO funds, a trend that began during the Bush administration, which relied on supplemental funding from the war in Iraq and Afghanistan for funding humanitarian emergencies. Funding for the MRA account has increased significantly since large numbers of Syrian refugees entered Turkey, Lebanon, and Jordan in 2011 and 2012.²¹

PRM signs an annual agreement with UNHCR, which lays out areas of cooperation between the U.S. government and the agency. PRM also works closely with UNHCR in support of its Global Strategic Priorities (GSPs), which includes public health and preventing and responding to GBV. PRM has a health officer who monitors progress on the humanitarian health efforts of its multilateral and NGO partners in consultation with other agencies such as the Centers for Disease Control and Prevention (CDC) and Office of Foreign Disaster Assistance (OFDA) within the U.S. Agency for International Development (USAID), which has a leadership role in protecting and assisting IDPs and other disaster-affected populations who have not crossed an international border.

The United States is the world's largest donor to UNHCR, providing over \$1 billion to its annual \$5 billion budget.²² The United States is also the largest donor to the UNRWA, which assists Palestinian refugees in the Near East, providing over \$100 million to their annual budget.

U.S. support for UNHCR has increased proportionally with increases to MRA funding over time. In FY07, PRM contributed \$252 million toward UNHCR, which only had a \$1 billion annual budget at that time. In FY15, the United States contributed over \$1.6 billion to the agency. These funds are not earmarked, which allows UNHCR to allocate U.S. contributions where it sees the greatest need. See chart below on U.S. contributions to UNHCR:

Within UNHCR headquarters, there is a Public Health and HIV Section under the Assistant High Commissioner for Operations, Division of Programme Support and Management. Expenditure for the public health division at UNHCR headquarters was \$2.8 million in 2014, and UNHCR's 2015 budget anticipated higher spending levels for global health up to \$3.9 million.²³ These figures do not reflect spending on health programs at the country level, which are discussed in the following section of the paper.

PRM also provides funding to the IOM, which is the lead agency for Camp Coordination and Camp Management (CCCM) in natural disaster. IOM also conducts health screening for migrants and coordinates the transportation of refugees resettling to the United States.

²⁰ Susan B. Epstein, Marian L. Lawson, and Alex Tiersky, "FY2017 State, Foreign Operations and Related Programs Budget Request: In Brief," Congressional Research Service, February 19, 2016.

²¹ Migration Policy Centre, "Timeline: Syrian Refugees, A Snapshot of the Crisis in the Middle East and Europe," European University Institute, <http://syrianrefugees.eu/timeline/>.

²² UNHCR, "Biennial programme budget 2016–2017 of the Office of the United Nations High Commissioner for Refugees," August 25, 2015, <http://www.unhcr.org/en-us/excom/icm/55dc778d9/biennial-programme-budget-2016-2017-office-united-nations-high-commissioner.html>.

²³ Ibid.

Other U.S. government agencies may contribute funds to UNHCR through PRM. For example, the President's Emergency Plan for AIDS Relief (PEPFAR) has provided funding to UNHCR HIV prevention and treatment programs in Botswana, Kenya, Zambia, Ethiopia, Tanzania, and Uganda.²⁴

The State Department Bureau for International Organizations (IO) contributes to funds to UNICEF and UNFPA, both of which play a critical role in child and maternal health.

Funding for UNICEF provides support for emergency nutrition and immunization of children, including refugee children. U.S. support for UNICEF has more than doubled since the start of the Syrian refugee crisis, with contributions going from \$334 million in 2012 to \$867 million in 2015.²⁵ UNICEF's priority for the global refugee crisis is to increase refugee children's access to education. UNICEF has developed a new initiative, Education Can't Wait, to provide education to children in conflict zones. "One in 4, some 462 million school-aged children, live in countries in crisis. This program addresses the 75 million that are unable to obtain the education required to rebuild their country after the crisis ends."²⁶ UNICEF has been working with U.S. donors on considering education as a life-saving need.²⁷

The UN Population Fund (UNFPA) provides family planning, maternal health, and reproductive health services in some but not all humanitarian settings. UNFPA works to implement a Minimum Initial Services Package (MISP) for reproductive health in emergency settings and provides more comprehensive maternal health services to local clinics in developing country contexts.

The George W. Bush administration withheld U.S. funding for UNFPA due to policy differences over family planning and abortion assistance. However, during the Obama administration this funding has been restored. Funding levels for UNFPA peaked in FY10 at \$55 million and have leveled off to between \$33–35 million in FY12–FY17.²⁸ Continued support for UNFPA by the U.S. government will be critical to ensuring that maternal and reproductive health services are available to refugees and other populations in crisis. It remains in the strategic interest of the United States to maintain a relationship with UNFPA. The United States should ensure that global health programs include maternal and newborn care in emergency contexts, to preserve the life and well-being of women and families where there are gaps in state capacity to provide for public health.

²⁴ PEPFAR, "Report on Refugees and Internally Displaced Persons," February 2006, <http://www.pepfar.gov/reports/progress/76860.htm>.

²⁵ USA for UNICEF, "U.S. Contributions," e-mail message to author.

²⁶ UNICEF, "Education Cannot Wait: A Fund for Education in Emergencies," 2016, http://www.unicef.org.uk/Documents/Publication-pdfs/UnicefEducationCan%20notWaitBriefing_2016_s.pdf.

²⁷ Interview with USA for UNICEF representative, June 2016.

²⁸ Kaiser Family Foundation, "U.S. Global Health Funding (Enacted): United Nations Population Fund (UNFPA), FY 2001–FY2017 Request," May 27, 2016, <http://kff.org/global-health-policy/slide/u-s-global-health-funding-for-the-united-nations-population-fund-unfpa-enacted/>.

U.S. Agency for International Development (USAID)

USAID's OFDA is responsible for leading and coordinating the U.S. government's response to disasters overseas. It also holds the primary responsibility for meeting the needs of IDPs. The OFDA policy on IDPs requires all USAID missions to include IDPs in the planning, implementation, and reporting of assistance.²⁹ OFDA strives to provide assistance based on need. OFDA ensures that people who are more vulnerable to disasters due to age, gender, disability, or other factors can equally benefit from assistance.

OFDA provided \$303 million in humanitarian assistance to Syria in FY15. This funding included support for 100 hospitals inside Syria and helped more than 180,000 Syrians get life-saving medical surgery.³⁰ OFDA funding comes from the International Disaster Assistance (IDA) account in the Foreign Operations Appropriations bill.

The United States is also the leading donor to the World Food Programme (WFP). The Food for Peace (FFP) Bureau, USAID, as well as food aid programs at the U.S. Department of Agriculture (USDA), provide support to WFP and implementing NGOs through programs such as Title II, which provides in-kind food aid, and the Emergency Food Security Program (EFSP), which allows for the local purchase of commodities and cash transfers, within the Bureau for Democracy, Conflict, and Humanitarian Assistance (DCHA/FFP). The FFP program has played a critical role in providing food assistance to people in Syria. From FY12–15, FFP has provided \$1.8 billion in funding to the Syria crisis.³¹

In addition to providing emergency food assistance, WFP is the global lead for humanitarian logistics, providing support for the transportation and delivery of assistance to all UN agencies and affiliated NGOs. Thus far in FY16, WFP has received over \$100 million from FFP.³² This included support for aerial food drops and bringing convoys of food supplies to besieged areas inside Syria. Funding also includes other logistics, such as common transport for NGOs and relief supplies. In 2015, the U.S. government provided \$2 billion in funding for WFP.

U.S. Department of Health and Human Services

Each year, the president of the United States signs a Presidential Determination (PD) on Refugee Admissions, which authorizes a certain number of refugees to be resettled in the United States that fiscal year. Since 1975, over 3 million refugees have resettled in the United States.³³

²⁹ "USAID Assistance to Internally Displaced Persons (IDP) Policy Implementation Guidelines," <https://www.usaid.gov/sites/default/files/documents/1868/200mbd.pdf>.

³⁰ Office of Foreign Disaster Assistance, "Annual Report for Fiscal Year 2015," https://scms.usaid.gov/sites/default/files/documents/1866/USAIDOFDA_AnnualReportFY15.pdf.

³¹ USAID, "Syria Complex Emergency Fact Sheet #4, Fiscal Year (FY) 2016," July 13, 2016, <https://www.usaid.gov/sites/default/files/documents/1866/07.13.16-USGSyriaComplexEmergencyFactSheet04.pdf>.

³² Ibid.

³³ U.S. Committee for Refugees and Immigrants (USCRI), Presentation Slides on History of the U.S. Refugee Program, 2016.

In FY16, the president allowed for up to 85,000 refugee admissions, up from 70,000 in FY15. The U.S. Department of Health and Human Services (HHS) plays an essential role in the U.S. refugee resettlement program, through the Office of Refugee Resettlement (ORR) within the administration for Children and Families (ACF), which provides assistance to refugees after three months of arrival in the United States. The State Department provides support to refugees for the first three months. ORR facilitates the reception and placement of refugees approved by the Department of Homeland Security (DHS) and State Department for entry into the United States. The IOM provides support for the transportation of refugees to the United States, and NGOs and faith-based agencies support the integration of refugees into local communities throughout the country.

The CDC also ensures that all refugees resettled into the United States have medical screenings and are vaccinated prior to entry. The Division of Global Migration and Quarantine (DGMQ) provides vaccinations to tens of thousands of refugees on an annual basis. In FY16, funding for DGMQ was \$31.5 million.³⁴ In addition, the CDC's Emergency Response and Recovery branch coordinates the agency's technical assistance to international organizations, NGOs, and partner governments responding to humanitarian emergencies. CDC's technical assistance has been invaluable in numerous emergencies, including the Ebola response, unprecedented inflows of Somali refugees into Kenya and Ethiopia during the 2011 famine, the Pakistan flood response, and the Haiti earthquake in 2010.

Humanitarian Funding Shortfalls

In spite of significant U.S. government funding for refugee and other forcibly displaced populations, UN agencies have been experiencing budget shortfalls with dire humanitarian consequences. These shortfalls have considerable human costs:

In 2015, the UN requested approximately \$20 billion to provide life-saving aid, only \$11 billion of which was funded. [In 2016], the \$21 billion that the UN is seeking is less than one-quarter funded. . . . The World Food Program had to cut back significantly rations to . . . Syrian refugees, and half a million refugees from Somalia and South Sudan in Kenya. In Jordan, in July 2015, approximately 250,000 Syrian refugees received news—often on their phone—that the UN aid they were receiving would be halved to the equivalent of 50 cents' worth of aid a day. In Iraq, the shortfall forced the World Health Organization to shutter 184 health clinics in areas with high levels of displacement, resulting in three million people losing access to basic health care.³⁵

Given the significant increase in resources that U.S. government agencies have contributed to refugee and migrant crisis, meeting these shortfalls will depend on the extent to which other donor countries increase their contributions, and the extent to which host countries

³⁴ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, "Justification of Estimates for Appropriations Committees Fiscal Year 2016," <https://www.cdc.gov/budget/fy2016/congressional-justification.html>.

³⁵ Power, Remarks on "The Global Refugee Crisis: Overcoming Fears and Spurring Action."

allow for refugees to work so they can meet their own needs for shelter, food, and health care.

Global Health Challenges

Given the large number of refugees, migrants, and IDPs around the world, understanding the short- and long-term implications of displacement on public health can be difficult to generalize given the different contexts that vary by region and country.

The following section of the paper provides an overview of global refugee health indicators and provides examples in two specific contexts, Somali refugees in Kenya and Syrian refugees in Jordan, to show trends in both an emergency context and a protracted crisis. UNHCR defines protracted refugee situations as “one in which refugees find themselves in a long-standing and intractable state of limbo.”³⁶ Today, one in three refugees are caught in a protracted crisis.³⁷ Given that UNHCR generally considers five years of displacement to be a protracted situation, the Syrian refugee crisis should no longer be seen as just an emergency response, but as a long-term protracted crisis.

While humanitarian appeals for Syria have been underfunded, refugee crises in other parts of the world are also suffering from funding shortfalls. The UNHCR Kenya Comprehensive Refugee Programme Plan for 2016 notes that “In light of increasing competition globally over funds it is envisaged that the Kenya refugee operation will receive less humanitarian funding in the coming years, which has been the trend for the past three years.”³⁸

Both the Syria crisis and protracted refugee crisis in Kenya have consequences on local health systems. In Jordan, hospitals are short on beds and essential medicines to serve the increasing population. In Kenya, local health services face constraints such as a lack of funding and skilled health care workers. That having been said, humanitarian programming can also bolster local health care systems especially when working in conjunction with development actors. The host community around Dadaab Camp in Kenya can and does access local health care facilities. In urban settings, UNHCR can reinforce staffing and training for local facilities.

Refugee Health Trends

Globally, UNHCR tracks progress on refugee health through a Health Information System (HIS) called Twine, which collects health indicators from 80 out of 120 UNHCR country offices. The Public Health Section in UNHCR headquarters prioritizes interventions where there are at least 10,000 refugees. Most of these locations have a public health officer who

³⁶ James Milner, “Towards solutions for protracted refugee situations: The role of resettlement,” Annual Tripartite Consultations on Resettlement Geneva, June 29, 2007, www.unhcr.org/46934d4f2.pdf.

³⁷ Power, Remarks on “The Global Refugee Crisis: Overcoming Fears and Spurring Action.”

³⁸ UNHCR, “Kenya Comprehensive Refugee Programme 2016: Programming for Solutions,” April 2016, <http://reliefweb.int/sites/reliefweb.int/files/resources/2016-KCRP5.13fv.pdf>.

oversees primary care interventions. Once a location has a refugee population over 50,000 refugees, health interventions include cooperative agreements with local NGO partners.³⁹

A major challenge for UNHCR is meeting the basic primary health care needs of refugees. The HIS tracks causes of refugee morbidity in camp settings and has found that the most common causes of refugee death are upper respiratory track infection, malaria, lower respiratory track infection, intestinal worms, and watery diarrhea.⁴⁰ These infections and diseases are related to gaps in the provision of primary care. UNHCR believes that strengthening national health systems is the best method of ensuring that refugees can access basic health care services. This provides, as one public health officer put it, a “rudimentary social protection floor” for refugees and other populations of concern to UNHCR.⁴¹ In 2015, UNHCR made considerable gains in the following refugee health indicators: 90 percent of refugee children under five were vaccinated for measles, 90 percent of refugee women were able to access safe deliveries for maternal health, and 100 percent of refugees had access to antiretroviral treatment for HIV/AIDS.⁴²

The UNHCR-HIS tends to record health data in large refugee camps, since health data for urban refugee populations comes from local ministries of health, which does not segregate refugee from national patient data.⁴³ Thus, understanding and documenting the health needs of urban refugee populations and other populations of concern to UNHCR is a gap in the system. UNHCR’s Global Health Strategy lays out key priorities for refugee health: decrease morbidity from communicable diseases and epidemics; improve childhood survival; improve access to prevention and noncommunicable diseases, including mental health services; and improve access to specialist care and national health systems.⁴⁴

Integrating refugees into local and national health care services is a major priority for UNHCR. A public health officer explained that UNHCR “has done the math” and “can prove that there are considerable cost savings” when the agency switches from providing health services to refugees through NGO contracts to supporting the provision of services at the local or national level.⁴⁵

In general, the more remote or isolated refugees are from major population centers, the more likely it is that UNHCR will have to set up a camp or parallel system of care. Unfortunately, these parallel systems often provide refugees with better health care services in the camp than what the local host population uses outside the camp.⁴⁶ UNHCR is moving away from policies of encampment of refugees in order to ensure that refugees live dignified lives where they integrate into communities by having work and educational opportunities, in addition to accessing local health care services. This is reflected in UNHCR’s Alternative to

³⁹ Interview with Heiko Hering, senior public health officer, UNHCR, July 27, 2016.

⁴⁰ UNHCR, “Global Strategy for Public Health: Public Health—HIV and Reproductive Health—Food Security and Nutrition Water, Sanitation and Hygiene (WASH),” 2014, <http://www.unhcr.org/530f12d26.pdf>.

⁴¹ Interview with Hering.

⁴² UNHCR, “Public Health 2015 Annual Global Overview,” <http://twine.unhcr.org/ar2015/>.

⁴³ Interview with Hering.

⁴⁴ UNHCR, “Global Strategy for Public Health.”

⁴⁵ Interview with Hering.

⁴⁶ Ibid.

Camps Policy, which was released in 2014.⁴⁷ While some host governments prefer to isolate refugee populations in camp settings, UNHCR is working to develop the evidence and tools with which to engage and persuade host governments to consider alternatives.

One of the most promising practices for health service integration is the enrollment of refugees into community and national health care insurance plans. UNHCR has been able to enroll refugees into local community insurance schemes in West Africa including in Senegal, Burkina Faso, and Togo.⁴⁸ Refugees have also been enrolled in national health insurance plans in Ghana and Iran.⁴⁹ UNHCR has tried to work through commercial health insurance providers, and has yet to find a successful model for commercial integration.⁵⁰

Country Snapshot: Kenya

In Kenya, the largest refugee settlements are Dadaab camp, which held 345,491 people at the end of 2015, to the northeast of the country, and Kakuma, which held 187,333 people in the northwest.⁵¹ An increasing number of urban refugees are also settled in Nairobi and major towns around the country. In 2013, UNHCR registered 56,000 urban refugees.⁵²

The government of Kenya maintains a policy of not allowing refugees to work.

This policy, coupled with the dry and arid climate of the land given for the refugee settlements, means that refugees are mostly unable to purchase or cultivate food to meet their basic needs. In early 2016, the government of Kenya announced its plan to close Dadaab Camp, encouraging refugees to repatriate to Somalia.

UNHCR Kenya has been experiencing reductions in its health budget over the last several years, from \$6 million in 2014, then \$4.6 million in 2015, down to \$3.7 million in 2016.⁵³ This, coupled with the reduction of food rations due to shortfalls in WFP funding, has had negative consequences on the protection and nutritional status of refugees.

Together with UNHCR, the World Food Programme (WFP) plays a major role in monitoring the health and nutrition of the refugee population. In the annual WFP Report for Kenya (2015), WFP highlighted that while it continued to provide general food distributions (GFD)

Refugee Integration

UNHCR has successfully advocated for the inclusion of refugees in health insurance programs in Cambodia, Costa Rica, Ghana, the Democratic Republic of the Congo (DRC), and Iran. In Iran, over 350,000 refugees are enrolled in a voluntary health insurance program. UNHCR and the government analyzed three private and government health insurance organizations and chose one scheme that was believed to most benefit the refugees. UNHCR is exploring how to integrate refugees into national plans and programs in other host countries such as Cameroon.

Source: UNHCR, "Public Health 2015."

⁴⁷ UNHCR, "Policy on Alternatives to Camps," July 22, 2014, <http://www.unhcr.org/en-us/protection/statelessness/5422b8f09/unhcr-policy-alternatives-camps.html>.

⁴⁸ Interview with Hering.

⁴⁹ Ibid.

⁵⁰ Ibid.

⁵¹ UNHCR, "Kenya Comprehensive Refugee Programme 2016."

⁵² Urban-Refugees.org, 2015, urban-refugees.org.

⁵³ UNHCR, "Kenya Comprehensive Refugee Programme 2016."

for all refugees in camps, malnutrition remained a concern. The nutrition trend in Dadaab remained stable with prevalence global acute malnutrition (GAM) at 8.1 percent (slightly down from 8.8 in 2014). However, results for Kakuma revealed a significant increase in GAM from 7.4 percent in 2014 to 11.4 percent in 2015.⁵⁴ Due to funding shortfalls, WFP had to cut food rations in the camps by 30 percent for a six-month period, which had a negative impact on the population. In order to address vulnerable populations, WFP implemented supplementary feeding programs for women and children.⁵⁵

UNHCR and its partners have worked on several innovations in Dadaab Camp to improve health conditions for refugees. Some of these innovations include:

- Cash distributions to purchase local food that improves diet variety.
- Developing nighttime taxis for pregnant women to get to the hospital.⁵⁶
- Implementation of solar-powered water boreholes to reduce the cost of fuel for pumping water for better sanitation.

In spite of UNHCR's efforts to introduce cost-savings mechanisms and improve infrastructure for better health outcomes in Dadaab camp, the future of public health interventions for refugees in Kenya will largely depend on the urban refugee context. When and if Dadaab closes, larger numbers of refugees may settle in urban areas. This will require additional outreach to identify vulnerable populations in need of services and a continued emphasis on integration with national and communal health care providers.

Country Snapshot: Jordan

Health activities for Syrian refugees in Jordan are robust, with many agencies providing services to those inside and outside of camp settings. The Health Sector Working Group in Jordan has made considerable efforts to track the needs of Syrian refugees both inside and outside of camps. The largest refugee settlement in Jordan is Zaatari camp, with a population of 79,264 refugees. It is estimated that half a million Syrians are living outside of camps as urban refugees in Jordan.

UNHCR has prioritized efforts to ensure that the Syrian population can access the local health care system. However, Jordan's Ministry of Health (MoH) imposed limitations on refugees' access to free services:

Until the end of November 2014, MoH maintained a policy of free access to primary and secondary care in their facilities for registered Syrians living outside of camps. Following a decision made by the Cabinet in November 2014 registered Syrian

⁵⁴ World Food Programme, "Standard Project Report 2015, World Food Programme in Kenya, Republic of (KE), Food Assistance to Refugees," 2015, http://documents.wfp.org/stellent/groups/public/documents/projects/wfp283299.pdf?_ga=1.237598976.1877429486.1468884596.

⁵⁵ Ibid.

⁵⁶ UNHCR, "Improving Maternal Health in Dadaab Refugee Camp," June 2010, <http://www.unhcr.org/4c247d969.pdf>.

refugees outside of camps now have to pay the uninsured Jordanian rates at MoH facilities. This heavily subsidized rate (around 35–60 percent of what other non-Jordanians pay), while manageable for most refugees, will nevertheless pose a problem for the most vulnerable.

UNHCR issued a temporary policy to mitigate its immediate effects. Services are targeted towards the most vulnerable but SGBV [sexual and gender-based violence], mental health, malnutrition in children; neonatal complications and obstetric emergencies will be supported for all.⁵⁷

For refugees living outside of camps, access to care was more precarious. In a survey by Oxfam, refugees said they would like more information about what services are available to them and which services they need to pay for themselves. The main reasons mentioned for inability to get care were costs (44.7 percent), long wait at the clinic (16.3 percent), and not knowing where to go (14.7 percent).⁵⁸

While malnutrition rates among Syrian refugees in Jordan is low with a GAM of 1.2 percent for children under five living in Zaatari and 0.8 percent for refugees living out of camps.⁵⁹ Anemia in children and women of reproductive age is high and of concern, affecting 48.7 percent in Zaatari camp and 44.7 percent of those outside of camps.⁶⁰ This data indicates that refugees living outside of the camp have better nutrition than those living in the camps, which may be due to additional income related to informal work activities.

Immunization efforts among Syrian refugees in Jordan focused on addressing a measles and polio outbreak in 2013 in Jordan and 182 diagnosed cases of TB:

The patchy immunization coverage especially of refugees outside of camps is of concern particularly in light of the polio outbreak with 36 confirmed cases in Syria and two confirmed cases in Iraq. The last virologically confirmed polio case in Jordan was reported on 3 March 1992. There is a need to strengthen uptake of routine immunization . . . to maintain the gains achieved during the national and subnational campaigns for both refugee and Jordanian children.⁶¹

In terms of reproductive health, an alarming number of adolescent girls are giving birth in Zaatari camp. In March 2016, UNFPA counted 5,000 babies born in the camp, 5 percent of whom were delivered by girls under the age of 18.⁶² This is largely due to the increase in early marriage occurring among Syrian refugee girls in Jordan, which is well documented by UNICEF. In 2013, 25 percent of all Syrian marriages registered in Jordan were with girls between the ages of 15 and 17, and this number increased to 31.7 percent of all marriages in

⁵⁷ Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP), "Health Sector Humanitarian Response Strategy Jordan 2014–2015," May 2015, <http://www.alnap.org/resource/20586>.

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ Ibid.

⁶¹ Ibid.

⁶² UNFPA News, "5000th baby born at UNFPA-supported clinic for refugees in Jordan," March 8, 2016. <http://www.unfpa.org/news/5000th-baby-born-unfpa-supported-clinic-refugees-jordan>.

2014.⁶³ Syrian families are using early marriage as a way of diversifying sources of income within the family, without considering that early marriage is likely to restrict a woman's earning potential by cutting short her education and her entry into the workforce.⁶⁴

Improvements in health care outcomes for Syrian refugees will continue to depend on the availability of services at local clinics, purchasing power of refugees to pay for medical services, and information campaigns so that urban refugees know what services they can access and how to pay for such services. The continued diversification of funding to support refugee-hosting countries, such as World Bank contributions to Jordan to strengthen its health and education system, will also support the continuation of integrated health services for refugees.⁶⁵

Gender-Based Violence

There are multiple forms of gender-based violence (GBV) that affect refugees, IDPs, vulnerable migrants, and other populations. These include rape, sexual harassment, early and forced marriage, intimate partner violence, domestic violence, trafficking, female genital mutilation (FGM), female infanticide, coerced prostitution, forced labor, social discrimination and exclusion, denial of rights, and other forms of abuse. There is no one system for tracking the prevalence of GBV globally. However, UN Women has stated that 1 in 3 women globally will experience physical or sexual violence in her lifetime.⁶⁶ Leading agencies that work on GBV within the UN system have advised the following:

Obtaining prevalence and/or incidence data on GBV in emergencies is not advisable due to the methodological and contextual challenges related to undertaking population-based research on GBV in emergency settings (e.g., security concerns for survivors and researchers, lack of available or accessible response services, etc.). The majority of information about the nature and scope of GBV in humanitarian contexts is derived from qualitative research, anecdotal reports, humanitarian monitoring tools and service delivery statistics. These data suggest that many forms of GBV are significantly aggravated during humanitarian emergencies.⁶⁷

UNHCR's health system tracks the clinical management of rape in some refugee contexts, focusing on women's access to PEP to prevent HIV infection. The clinical management of

⁶³ UNICEF, "A Study on early marriage in Jordan," 2014, [http://www.unicef.org/mena/UNICEFJordan_EarlyMarriageStudy2014\(1\).pdf](http://www.unicef.org/mena/UNICEFJordan_EarlyMarriageStudy2014(1).pdf).

⁶⁴ Sarah Williamson, "Syrian Women in Crisis: Obstacles and Opportunities," Georgetown Institute for Women, Peace, and Security Occasional Paper Series, January 2016, https://giwps.georgetown.edu/sites/giwps/files/occasional_paper_series_volume_i_-_womens_economic_participation.pdf.

⁶⁵ World Bank, "Emergency Assistance for Jordan to Cope with Impacts of Syrian Crisis," July 18, 2013. <http://www.worldbank.org/en/news/press-release/2013/07/18/emergency-assistance-jordan-cope-impacts-syrian-crisis>.

⁶⁶ UN Women, "Facts and Figures: Ending Violence against Women," <http://www.unwomen.org/en/what-we-do/ending-violence-against-women/facts-and-figures>.

⁶⁷ Inter-Agency Standing Committee (IASC) and Global Protection Cluster, "Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience, and aiding recovery," 2015, http://gbvguidelines.org/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf.

rape also includes documenting and treating injuries, collecting forensic evidence, evaluating risk of pregnancy and prevention, and providing psychosocial support. However, the UNHCR Health Unit does not typically track whether rape survivors receive comprehensive health services. The Division of International Protection (DIPS) within UNHCR tracks overall trends in the reporting of GBV.

Another method of tracking incidents of GBV is the GBV Information Management System (GBVIMS) used by UNFPA and NGO partners in emergency contexts. Data from the GBVIMS is not shared with government health care providers or other NGOs because it includes confidential survivor data. Donors, UN agencies, and NGOs need to continue working together to ensure that women and girls have access to comprehensive GBV prevention and response services.

These different systems of tracking violence against women in humanitarian emergencies do not represent the actual number of women who suffer GBV. It is generally accepted that underreporting is one of the major problems with tracking the number of cases of GBV and rape. Vast numbers of women who do not come forward and do not receive care are not counted. That is why UN agencies working on GBV have issued guidance stating that agencies should assume that violence is happening and put measures in place to prevent and respond to GBV in every emergency situation.⁶⁸

One of the most challenging aspects of addressing GBV is ensuring that humanitarian agencies integrate GBV guidance in every sector of a response. Too often, shelter, water, and food aid interventions do not take risk factors into consideration, such as ensuring that tents, toilets, and food distribution points are safe places for women and girls. The Inter-Agency Standing Committee (IASC) Guidelines on Integrating Gender-Based Violence Interventions in Humanitarian Action address how every sector of a relief response can address the prevention and response to GBV.⁶⁹

In 2013, the State Department and USAID developed a special initiative called Safe from the Start to strengthen efforts to mitigate the risk of GBV at the onset of an emergency response.⁷⁰ When asked what more needs to be done on GBV, a State Department official said, "We still need more agencies to implement what we already know is good practice in the field."⁷¹ The Office of Foreign Disaster Assistance (OFDA) has similarly stated that not enough NGOs have the technical skills to clinically manage rape cases in locations where conflict related sexual violence is an ongoing problem, such as the current fighting in South Sudan.

⁶⁸ Ibid.

⁶⁹ Ibid.

⁷⁰ For more information about the Safe from the Start Initiative, see U.S. Department of State, "Addressing Gender-Based Violence in Emergencies," <http://www.state.gov/j/prm/policyissues/issues/c62377.htm>.

⁷¹ Interview with gender-based violence (GBV) focal point, State Department Bureau for Population, Refugees and Migration (PRM).

Maternal and Reproductive Health

While efforts to reduce maternal mortality have resulted in considerable gains since 1990, with a 2.3 percent annual reduction in maternal deaths, up to 2015, the United Nations Population Fund (UNFPA) points out that critical gaps remain in countries affected by conflict and disaster.⁷² Over 60 percent of all maternal deaths (185,000) in 2015 occurred in countries affected by a humanitarian crisis or fragile settings.⁷³ UNFPA further emphasizes that 500 women a day die from giving birth in humanitarian and fragile settings.

Reproductive Health

During the emergency influx of Burundians in Rwanda and Tanzania in 2015, UNHCR ensured that the minimum initial service package (MISP) for reproductive health was provided at all sites. MISP rapidly scaled up to comprehensive reproductive health services within weeks into the emergency in both countries. With an increase in the number of camps and refugee-hosting sites, logistical support for referral was a key priority, especially during emergencies. To avert a referral crisis, UNHCR supported partners in Tanzania with ambulances. Coordinated work with partners supported 13,939 women (11,368 in Tanzania and 2,571 in Rwanda) with delivering their babies in 2015. Respectively 98 percent and 95 percent of deliveries were assisted by skilled personnel.

Source: UNHCR Public Health 2015 Annual Global Overview.

The Global Strategy for Women's, Children's Health is part of the Sustainable Development Goals (SDGs). The Every Woman, Every Child initiative is part of this larger global strategy. The vision for the initiative is that "by 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping sustainable and prosperous societies."⁷⁴

Approaches to providing reproductive health services to refugees and vulnerable migrants vary from the emergency operations phase, when public health services are generally unavailable, to recovery and development contexts where some services are available. During the emergency phase, UNFPA, UNHCR, and other agencies implement a minimum initial service package (MISP). The core components of the MISP are ensuring that there is a lead agency and reproductive health officer providing maternal health kits and supplies, preventing and managing the consequences of sexual violence, reducing transmission of HIV by making safe blood transfusions and condoms available, and preventing maternal and infant mortality by providing emergency obstetric and newborn care, a 24/7 referral system, and clean delivery kits to skilled birth attendants and visibly pregnant women.

The UNHCR Emergency Guidelines on Refugee Health in Camps lays out the difference between emergency care and longer-term care in humanitarian settings:

⁷² UNFPA, "Maternal Mortality in Humanitarian Crises and Fragile Settings," November 12, 2015, <http://www.unfpa.org/resources/maternal-mortality-humanitarian-crises-and-fragile-settings>.

⁷³ Ibid.

⁷⁴ United Nations, "The Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030)," 2015, <http://globalstrategy.everywomaneverychild.org/>.

0-6 Months into Emergency	+6 Months into Emergency
Where reproductive health services (RH) are not available	Where MISP or RH/HIV components exist
Implement the minimum initial service package (MISP).	Expand to comprehensive RH.
24/7 emergency obstetric neonatal care.	All the MISP, plus: Antenatal care. Postnatal care. Family planning. Postabortion care. Fistula detection and management. Adolescent sexual and reproductive health services (SRH). Comprehensive SGBV response. Comprehensive HIV services.
Prevention of sexual and gender-based violence (SGBV) and clinical management of rape survivors.	
High-impact STI/HIV prevention and continuation of ART / EMTCT.	

Source: UNHCR, "Emergency Handbook: Health in camps," October 21, 2016, <https://emergency.unhcr.org/entry/54566/health-in-camps>.

In order to strengthen the implementation of the MISP and expand work on RH in complex environments, the International Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) was established in 1995. The IAWG is a coalition of UN agencies, international and national NGOs, government agencies, donors, and academic institutions that work together to improve the reproductive health of communities affected by conflict and disaster. The IAWG recently completed a global evaluation of reproductive health interventions in crisis. The report highlighted areas of progress to date and key gaps, including:

Progress and Gaps in Reproductive Health in Humanitarian Settings

Progress includes:

- Increased number of emergency health and protection proposals to implement reproductive health
- Increased funding for reproductive health to conflict-affected countries
- Reported growth in institutional capacity to address reproductive health in crisis, including organizational policy frameworks and accountability mechanisms
- Progress in the following technical areas:
 - Increased awareness of, funding for, and provision of maternal health services broadly
 - Increased provision of postabortion care
 - Increased funding and attention to gender-based violence (GBV) broadly, including documentation of prevalence of sexual violence in conflict settings

Key gaps include:

- Equitable and adequate reproductive health funding for crisis-affected settings
- Commodity management and security
- Community engagement to increase utilization of services
- Adolescent reproductive health
- High-quality evaluation of reproductive health programming
- Gaps by technical area:
 - Full, systematic MISP implementation
 - Emergency obstetric care
 - Newborn care
 - Comprehensive abortion care, including safe abortion and postabortion care at the primary care level
 - Long-acting and permanent family planning methods
 - Emergency contraception as a family planning method
 - Prevention of sexual violence and comprehensive clinical management of rape
 - Antiretroviral therapy at the primary care level
 - Diagnosis and treatment of sexually transmitted infections
 - Diagnosis and treatment of cervical cancer

Source: Sarah K. Chynoweth, "Advancing reproductive health on the humanitarian agenda: the 2012–2014 global review," *Conflict and Health* 9, suppl. 1 (March 2015): 11, <https://conflictandhealth.biomedcentral.com/articles/10.1186/1752-1505-9-S1-11>.

As part of the IAWG global evaluation, an analysis of reproductive health indicators in the UNHCR-HIS from 2007–2012 was conducted. The analysis noted that while there were measurable increases in the number of births attended by a skilled birth attendant, the mean camp maternal and neonatal mortality rates were lower than the host-country estimates for all countries and years.⁷⁵ Kenya's mean maternal mortality rate was high from 2007 through 2013 with a range across years of 198.5 through 301.5 maternal deaths per 100,000 live births.⁷⁶ More women who had been raped were receiving PPE but some countries were not reporting rape cases at all. Overall, the study concluded that "more information is needed to explain current trends as why or if improvement is lacking."⁷⁷

⁷⁵ Jennifer Whitmill et al., "Retrospective analysis of reproductive health indicators in the United Nations High Commissioner for Refugees post-emergency camps 2007–2013," *Conflict and Health* 10, no. 3 (March 2016), <https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0069-6>.

⁷⁶ Ibid.

⁷⁷ Ibid.

Immunizations

Immunizations are an important preventative measure for refugee health programs. The UNHCR Global Health Strategy emphasizes the challenges of implementing vaccination programs in refugee contexts:

The Expanded Program on Immunization (EPI) is considered to be the most cost-efficient prevention intervention to reduce childhood morbidity and mortality. Refugee children often miss their vaccination in their country of origin due to conflict and disruption of services. In the asylum country, giving full EPI coverage to refugees often takes time, leaving children unprotected for a longer period. UNHCR, along with UNICEF and WHO, is striving to bring children under coverage of the national EPI programme.⁷⁸

A major gap in the provision of EPI for refugees, IDPs, and migrant populations is the extent to which national governments are making progress on achieving their EPI programs. For example, when Doctors without Borders (Médecins Sans Frontières, MSF) began vaccinating refugee children in Yida Camp in South Sudan against pneumonia, it had difficulty working with Gavi, the Vaccine Alliance, which focuses on implementing vaccination programs through national governments. Gavi is currently updating its policy on working in fragile contexts.

One promising development in vaccinating refugee children is that the WHO issued a call to all states receiving refugees and migrants in Europe to vaccinate children regardless of their nationality.⁷⁹ UNHCR has also seen that refugees en route to Europe have been able to access basic health care in all European Union member states without prejudice to their nationality.⁸⁰

Recommendations to the U.S. Government

The executive branch and Congress will need to work together to address the many domestic and foreign policy challenges with having a robust response to the global refugee crisis. Primary among those issues is how to end the Syria conflict while providing a pathway for the 5 million displaced Syrians to live with opportunity and dignity. The U.S. government can address the human needs of people affected by the war and address regional security concerns by ensuring that refugees have access to work and educational opportunities. The Syrian people will need their own capital, both human and financial, to rebuild Syria when the time is right to return.

⁷⁸ UNHCR, "Global Health Strategy 2014–2018."

⁷⁹ World Health Organization, "WHO-UNHCR-UNICEF joint technical guidance: general principles of vaccination of refugees, asylum-seekers and migrants in the WHO European Region," November 23, 2015, <http://www.euro.who.int/en/health-topics/disease-prevention/vaccines-and-immunization/news/news/2015/11/who,-unicef-and-unhcr-call-for-equitable-access-to-vaccines-for-refugees-and-migrants/who-unhcr-unicef-joint-technical-guidance-general-principles-of-vaccination-of-refugees,-asylum-seekers-and-migrants-in-the-who-european-region>.

⁸⁰ Interview with Hering.

The U.S. government also has an opportunity to refine the international humanitarian system created by the United Nations and supported by several U.S. government agencies that hold the system accountable to high standards of achievement. Together with the secretary general of the United Nations, the U.S. government can foster regional alliances that ensure refugees have access to protection under the law, and better access to life-saving care in failed states with limited public health institutions and weak infrastructure. As displaced people settle in urban locations in greater numbers, the world's cities will need to have the capabilities to manage emergencies and provide for the safety of a multi-ethnic society. As migrants move from region to region looking for a place where they can work and send their children to school, receiving states (including the United States) need to assess their capacity to absorb large numbers of people. Meeting this challenge will require international cooperation. Instead of isolating the United States from international institutions, the U.S. government must galvanize the support of development institutions and nontraditional donors, enlisting their support in a mutually beneficial partnership.

Durable solutions that offer refugees the right to work and be educated in a country willing to resettle them or integrate them locally are the best hope for those displaced. Refugees have much to offer receiving countries once they are settled and contributing to the local economy. The president of the World Bank believes that receiving refugees is a smart strategy for global growth, documenting that refugees have registered over 1,000 new businesses in Turkey alone.⁸¹

The United States is a world leader in providing support to refugees, displaced, and migrating populations. U.S. investments in global health have a positive effect on populations in crisis. Women and children, who often bear the brunt of conflict, depend on U.S. commitments to provide life-saving assistance during humanitarian emergencies. Ensuring that family planning, reproductive health, and comprehensive health services reach women and girls in crisis, especially those who are survivors of violence, is the least we can do to address current gaps and meet the needs of future generations.

Providing health services to populations on the move has unique challenges that are hard to address with limited funding. UNHCR has developed promising practices and innovative program models that permit refugees to access national health insurance schemes. Solutions like this, which meet needs and reduce costs, are a win-win for donors and aid agencies alike. Private foundations dedicated to achieving global health outcomes, and private-sector companies investing in innovative global health solutions, can be a resource to the U.S. government in striking the balance between public charity and making smart investments in a better future for all Americans.

⁸¹ Jim Yong Kim, President of the World Bank Group, "Looking for a global growth strategy? Support refugees," Editorial, *Washington Post*, October 1, 2015.