NATIONAL LAW SCHOOL OF INDIA UNIVERSITY, BANGALORE


# IMPLEMENTATION OF REFUGEE HEALTH POLICY IN INDIA: A STUDY

Dissertation submitted in the partial fulfilment of the requirements for the Degree in Master of Law (LL.M.)

UNDER THE SUPERVISION OF: Prof (Dr.) V. VijayaKumar

By

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## CERTIFICATE

This is to certify that the work contained in this dissertation entitled **"IMPLEMENTATION OF REFUGEES HEALTH POLICY IN INDIA: A STUDY"** submitted by Satyanand Khillare (I.D. No. 545) for the Degree of Master of Law (LL.M.) for the session 2012-14, of NLSIU is the product of bonafide research carried out under my guidance and supervision. The dissertation or any part thereof has not been submitted elsewhere for any other degree

Place: NLSIU, Bangalore

Date: 8/6/14

Prof. (Dr.) V. VijayaKumar

## DECLARATION

I, Satyanand Khillare, do hereby declare that this Dissertation titled **"IMPLEMENTATION OF REFUGEES HEALTH POLICY IN INDIA: A STUDY"** is a result of bona-fide research undertaken by me in partial fulfilments of LL.M. programme at NLSIU, Bangalore. This dissertation has been prepared by me under the guidance and supervision of Prof. (Dr.) V. VijayaKumar.

I hereby declare that this dissertation is my original work and the relevant material taken from other sources have been properly cited at appropriate places and which are duly acknowledge.

I further declare that this work has not been submitted either in part or whole for any degree or any other University or like Institution.

Place: NLSIU, Bangalore
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## CHAPTER – I

## INTRODUCTION

Refugee crises are not a new problem, but rather one that dates back to the earliest days of humanity. However, the term 'refugee' seems to have first been coined in 1573, when it was used to describe Calvinists fleeing political repression in the Spanish-controlled Netherlands to seek refuge with their co-religionists in France. But refugees were not only defined as victims of persecution, they were also seen as individuals with political, religious, economic or other affiliations that aroused solidarity among those supporting similar interests in other countries and a corresponding sense of responsibility towards them.

This tendency continued into the beginning of the 20th century, but by the end of the First World War and the foundation of the League of Nations, a transition was taking place and the previously selective responses to refugees by interested sections of the community began to be institutionalized. Now, it is seen as the collective duty of the 'international community' to provide aid and protection to refugees, defined by the League of nation as groups of people whose lives would be at risk if they returned to their home countries.[1] In 1921, the League appointed Fridtjof Nansen to the newly created post of High Commissioner for Russian Refugees in response to the waves of refugees fleeing the Russian Revolution and the subsequent civil war.

Since World War II, up to one hundred million civilians have been forced to flee persecution or the violence of war to seek refuge either in neighboring

[1]Erika Feller, 'The Evolution of the International Refugee Protection Regime', *Washington University Journal of Law and Policy*, vol. 5 (2001): pp. 129-139.

countries or in different areas of their own country.[2] The terms 'refugee' have wide implications for the people concerned, particularly regarding their rights to protection and assistance, which are embedded in international law. Refugees have crossed an international border. The United Nation's High Commissioner for Refugees (UNHCR) is mandated by the international community to protect and assist refugees only; due to considerations of state sovereignty, the internally displaced have not been included within UNHCR's mandate. Only on an ad hoc basis has UNHCR been involved in the protection and assistance of the internally displaced, i.e. at the request of the state concerned or of the Secretary General of the United Nations. However, both groups have been forced to leave their homes and undergo physical or mental shock before their departure or during their flight. They are then often forced to settle in an unhealthy environment, where they are unlikely to be in a position to take responsibility for their own welfare.

Armed conflicts have increasingly affected civilian populations, resulting in high casualty rates, widespread human rights abuses, forced migration, famine. The major determinants of high death rates among affected populations and the major priorities for action have also been identified. The provision of adequate food, clean water, sanitation, and shelter have been established to be more effective interventions than most medical programs. The focus of health programs has shifted to community based disease prevention, health promotion, nutritional rehabilitation, and epidemic preparedness, surveillance and control. Refugee health has developed into a specialized field of public health with its own particular technical policies, methods, and procedures.

The researcher deals with Refugees health problems as specific health problems from the physical and mental after effects of displacement and

[2]Simmonds, S. and Vaughan P., Refugee community health care. Oxford:Oxford University Press, 1983.

social isolation, war, and sometimes torture, and communicable diseases, of which tuberculosis is the most important. However, poor knowledge of the system and language barriers limit their access to services. Interpreters are often unavailable, and even when they are present it can be impossible for refugees to explain complex health and social problems during a brief consultation.

The League of Nations was outdated by the United Nations (UN) at the end of the Second World War, and in 1946 the UN created the International Refugee Organization (IRO). In addition to the refugees which the international community had already taken responsibility for between the two World Wars, the IRO was mandated to take care of a further 20 million people scattered throughout Europe as a result of World War II. At first, the IRO's main focus was on repatriation, but Soviet repression of certain groups of repatriated refugees and the increased tensions at the beginning of the Cold War brought about a different approach and its efforts were redirected towards resettlement in a third country. This covered all those who had a 'valid reason' not to return to their countries of origin because of 'persecution, or fear of persecution, for reasons of race, nationality or political opinion'.

In 1951, the IRO was replaced by the United Nations' High Commissioner for Refugees (UNHCR), mandated by a UN General Assembly resolution in December 1950 to encourage countries to receive refugees, prevent them from being forcibly returned, provide assistance and protection, and seek lasting solutions to the problem. The Convention Relating to the Status of Refugees was also drawn up in 1951 and this was a decisive step towards institutionalizing the refugee question. The Convention, which has the force of law and has been ratified by almost 120 countries.[3]

[3]UNHCR. *Handbook on procedures and criteria for determining refugee status*. Geneva: UNHCR, 1992.

The United Nations High Commission for Refugees (UNHCR) was established in 1950 with the short-term mission of assisting European refugees from the Second World War. However, conflicts in post-colonial Africa in the 1960s quickly occupied the organization and UNHCR has been fully engaged ever since with a mandate of providing refugee protection and assistance the world over[4]. Early on, UNHCR recognized that many refugee situations in Africa and other places would not be quickly resolved and that there was need for refugees to become 'self-reliant' in order to avoid long-term dependence on the international community. Many refugee situations today are of an extended nature. there have been considerable changes in' refugees' needs, which neither UNHCR nor the host country has been able to address in a meaningful manner, thus leaving refugees in a state of material dependency and often without adequate access to basic rights even after many years spent in the host country.As long as there are conflicts in the world and as long as the divide between the rich and poor countries exists, people will continue to flee persecution and poverty.

Human rights are based on respect for the dignity and worth of all human beings and seek to ensure freedom from fear and want. Rooted in ethical principles, human rights are essential to the wellbeing of every man, woman and child. Premised on fundamental and inviolable standards, they are universal and inalienable. The traditional view of Human Rights limits them to civil and political rights. Included among these are the right to life, liberty and security. The right not to be discriminated against the person on the basis of race, color, sex, language, religion, social class or political opinion[5]. Gradually, this traditional view is being challenged. Some say that it is too

[4] Betts, A. 'International Cooperation and the Targeting of Development Assistance for Refugee Solutions: Lessons from the 1980s', *New Issues in Refugee Research*, Working Paper No. 107. September 2004. UNHCR Evaluation and Policy Analysis Unit. Geneva: UNHCR.

[5]Michelle Foster. International Refugee Law and Socio-Economic Rights: *Refuge from Deprivation*, Cambridge University press, 2007.

limited in scope and that a more multidimensional and holistic approach must be taken. Thus to basic civil and political rights are added crucial social, economic and cultural rights, including the right to an adequate standard of living, the right to education, the right to work. The United Nations (UN) has adopted this holistic approach in determining what human rights are, and the international community has repeatedly affirmed the interdependence of both sets of rights.

The effective application of law, statute, regulations, and policies is as essential as investigation, evaluation and strategic communication to protecting and promoting the public's health. Public health practice works to change behaviors at the individual, institutional and community levels, using programs, services and health education to cause those changes. These efforts are important, but require continual re-enforcement or the changes will revert. Law presents opportunities to align incentives and penalties to support behaviors and environments that make it easier and even normal for people to make the healthy choice. The sustaining power of law makes it a powerful tool to improve health, and, we believe, one that should be central to public health practice. Laws and regulations can give public health efforts the teeth they need to speed up wide scale adoption and to create societal norms. Law enables public health to reach more people, improve the environment, and realize broad social change in a relatively short time.

## RESEARCH PROBLEM

There are various difficulties and workings involved in the implementation of refugee policy and, being so, it is a knotty task to determine an appropriate, realistic and viable implementation of refugees' health policy. Therefore, the research problem involved in this dissertation is to envisage the above mentioned model.

## AIMS AND OBJECTIVE

The present research is being done to bring out the need of refugees` health care and the possible means to achieve the same. The researcher will focus on the existing framework to deal with the health rights issues of refugees, and moreover what are the obligation on the state who have ratified the refugee convention relating to the rights and status of refugees. The researcher will also focus on the irregularities, deficiencies and gaps present in the convention, the barriers in the path of implementation of refugees health policy. Finally the researcher will do a brief overview of the efforts undertaken by UNHCR in this direction, etc. In order to better achieve the above mentioned objectives, researcher will make a reference to the relevant international and regional instruments.

## RESEARCH QUESTION

1. Who are the refugees?
2. What are the laws and convention for the protection of refugees?
3. What are the rights of refugee?
4. What is UNHCR and its role relating to refugees health?
5. What should be the emergency phase for refugees` health?
6. What are the strategies for refugees` health?
7. What are the barriers and challenges in implementation of refugees` health care?

## RESEARCH HYPOTESIS

Better implementation of existing conventions and policies regarding the health of refugees will improve the health standards of refugee.

## RESEARCH METHODOLOGY

The research methodology adopted for this research is 'descriptive' and 'analytical' in nature.

## MODE OF CITATION

A uniform mode of citation will be followed throughout in the dissertation.

## WHO IS A REFUGEE?

The 1951 Geneva Convention is the main international instrument of refugee law. The Convention clearly spells out who is a refugee and the kind of legal protection, other assistance and social rights he or she should receive from the countries who have signed the document. The Convention also defines a refugee's obligations to host governments and certain categories or people, such as war criminals, who do not qualify for refugee status. The Convention was limited to protecting mainly European refugees in the aftermath of World War II, but another document, the 1967 Protocol, expanded the scope of the Convention as the problem of displacement spread around the world.

The 1951 United Nations Convention Relating to the Status of Refugees has adopted the following definition of a refugee

"Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country".

It means a refugee is someone who has been forced to flee his or her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries.

A determination of the refugee status is necessary in order for a refugee to avail himself of the right and protection granted to refugee. The legal basis for determination of refugee status in the context of a given legal instrument is the definition of a refugee in that instrument. So any person is refugee within the framework of the given instrument if he meets the criteria of the refugee definition. Again the competent authority for determining the refugee status will depend on the instrument under which the process of determination is conducted. The definition of a refugee, basically focusing on individual cases of persecution. Moreover, the Convention stresses the basic principle of non-refoulement, according to which refugees may not be forcibly returned to a country where they have reason to fear persecution.

This wider UNHCR definition was formalized to a certain extent in 1969 by the Organization of African Unity which convened to discuss the problems of refugees in Africa. The 'Convention Governing the Specific Aspects of Refugee Problems in Africa', which was adopted at its meeting, included in its refugee definition those refugees who are forced to leave their native countries, not only because of persecution, but also due to 'aggression, occupation by an outside force, foreign domination or events seriously disturbing the peace in a part or all of the country of origin'. In 1984, Latin American countries adopted the Cartagena Declaration which extended the OAU definition to include victims of 'massive human rights violations'. This enlarged definition acknowledges that any person fleeing war and insecurity qualifies for refugee status and thus enables many people who would not

have been covered by the 1951 Convention to benefit from international protection. This has proved invaluable in situations of large-scale exodus where it is impossible to examine every individual request for refugee status. In such situations, this so-called prima facie procedure enables groups of refugees to be recognized collectively and to receive aid and protection from the host state, UNHCR and the international community at large[6].

[6]UNHCR. *The state of the world's refugees - in search of solutions.* Oxford: Oxford UniversityPress, 1995.

## CHAPTER – II

## THE LEGAL FRAMEWORK OF THE INTERNATIONALREFUGEE PROTECTION SYSTEM

Every States have the responsibility to protect their citizens. When governments are opposed or unable to protect their citizens, individuals may suffer such serious violations of their rights that they are forced to leave their homes, and often even their families, to seek safety in another country. Since, by definition, the governments of their home countries no longer protect the basic rights of refugees, the international community then steps in to ensure that those basic rights are respected.[7]After the World War II, the United Nations General Assembly created the Office of the United Nations High Commissioner for Refugees.

The Statute of the Office of the United Nations High Commissioner for Refugees was adopted by the General Assembly on 14 December1950 as Annex to Resolution 428 (V). In this Resolution, the Assembly also called upon the Governments tocooperate with the High Commissioner in the performance of his orher functions concerning refugees falling under the competence ofthe Office. In accordance with the Statute, the work of the HighCommissioner is humanitarian and social and of an entirely nonpoliticalcharacter.[8]

UNHCR is mandated to protect and find durable solutions for refugees. Its activities are based on a framework of international law and standards that includes the 1948 Universal Declaration of Human Rights and the four Geneva Conventions 1949 on international humanitarian law, as well as an

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[7] Ms. Kate J. and Ms. Achiron M, Refugee Protection: *A Guide to International Refugee Law,* UNHCR. December 2001. (http://www.refworld.org/docid/3cd6a8444.html) *accessed on,* 3 may2014.

[8] *Statute* of the Office ofthe United Nations High CommissionerFor Refugees. <www.unhcr.org/4d944e589.pdf> (*accessed on 03 may 2014).*

array of international and regional treaties and declarations, both binding and nonbinding, that specifically address the needs of refugees.

Internally displaced persons, or IDPs, are among the world's most vulnerable people. Unlike refugees, IDPs have not crossed an international border to find sanctuary but have remained inside their home countries. Even if they have fled for similar reasons as refugees, IDPs legally remain under the protection of their own government – even though that government might be the cause of their flight. As citizens, they retain all of their rights and protection under both human rights and international humanitarian law.

UNHCR's original mandate does not specifically cover IDPs, but because of the agency's expertise on displacement, it has for many years been protecting and assisting millions of them. Under this, UNHCR has the lead role in overseeing the protection and shelter needs of IDPs as well as coordination and management of camps.

In case of Canada, on 4th June 1969 Canada signed the convention relating to the status of refugee. In fact, there has been good and bad in Canadian responses to refugees, both before and after signing the Refugee Convention.The Canadian immigration and refugee system can be complex, confusing and intimidating for newcomers, especially when they are not sure how their HIV status may affect their chances of becoming Canadian citizens.The Canadian immigration and refugee system and how it affects people with HIV from other countries. It describes mandatory HIV testing for immigrants, services for people going through the immigration process, and information on how some communities have dealt with the challenges that immigrant, refugee and non-status people with HIV face.

Immigrants and refugees represent an increasing proportion of people living with HIV in Canada. This points to the need for equitable services in prevention education, treatment and support for immigrants and refugees infected and affected by HIV.

Immigrants and refugees with HIV face complex demands, the trauma and challenges of the migration journey, the complex and confusing Canadian immigration and refugee system, the challenges of adapting to a new culture and lifestyle, difficulties with access to housing and employment and stigma, and discrimination in their own ethno-racial communities and in larger society. They also face barriers in accessing HIV-related information, treatment and support related to language and culture, health literacy and systemic discrimination. All these demands and barriers have a significant impact on their health, well-being and ability to participate as equal members of society.[9]The Canadian immigration system is not only complex and confusing, it is very intimidating for newcomers to deal with. People with HIV have tremendous fear and concerns about possible exclusion because HIV testing is a mandatory part of all newcomer applications.

## 2.1INTERNATIONAL LAWS AND STANDARDS

### 2.1.1 1951 CONVENTION RELATING TO STATUS OF REFUGEE

The Convention relating to the Status of Refugeesof 1951 sets out the principles upon which the regime of international protection for refugees is built. It established the main rights and obligations of refugees as well as the treatment to which they are entitled by the country of asylum.

The Convention is both a status and rights-based instrument and is supported by a number of fundamental principles, most notably non-discrimination, non-penalization and *non-refoulement*. Developments in international human rights law also reinforce the principle that the Convention be applied without discrimination as to sex, age, disability, sexuality, or other prohibited grounds of discrimination. The Convention further stipulates that, subject to specific exceptions, refugees should not be penalized for their

[9]http://www.catie.ca/en/practical-guides/managing-your-health/17. (accessed on 3rd June 2014)

illegal entry or stay. This recognizes that the seeking of asylum can require refugees to breach immigration rules. Prohibited penalties might include being charged with immigration or criminal offences relating to the seeking of asylum, or being arbitrarily detained purely on the basis of seeking asylum. Importantly, the Convention contains various safeguards against the expulsion of refugees.[10] The principle of nonrefoulement is so fundamental that no reservations or derogations may be made to it. It provides that no one shall expel or return a refugee against his or her will, in any manner whatsoever, to a territory where he or she fears threats to life or freedom. The Convention lays down basic minimum standards for the treatment of refugees, without prejudice to States granting more favourable treatment. Such rights include access to the medical care, primary education and to work.The 1951 Convention contains a number of rights and also highlights the obligationsof refugees towards their host country.

### 2.1.2 1967 Protocol Relating to the Status of Refugees

The 1967 Refugee Protocol is independent of the 1951 convention even though it is integrally related to the1951 Convention. The Protocol lifts the time and geographic limits found in theConvention's refugee definition. Apart from expanding the definition of a refugee, the Protocol obliges States to comply with the substantive provisions of the 1951 Convention to all persons covered by the refugee definition in Article 1, without any limitation of date. Although related to the Convention in this way, the Protocol is an independent instrument, accession to which is not limited to States parties to the Convention.

[10]http://www.unhcr.org/pages/49da0e466.html. *(Accessed on 04th may 2014).*

The fundamental importance and enduring relevance of the Convention and the Protocol is widely recognized. In 2001, States parties issued a Declaration reaffirming their commitment to the 1951 Convention and the 1967 Protocol, and they recognized in particular that the core principle of *non-refoulement* is embedded in customary international law.

### 2.1.3. INTERNATIONAL HUMANITARIAN LAW

International humanitarian law is part of international law, which is the body of rules governing relations between States and international law. International law is contained in agreements between States and treaties or conventions, in customary rules,[11] which consist of State practice considered by them as legally binding, and in general principles. International humanitarian law provides that victims of armed conflict, whether displaced or not, should be respected, protected against the effects of war, and provided with impartial assistance. Because many refugees find themselves in the midst of international or internal armed conflict, refugee law is often closely linked to humanitarian law. The Fourth Geneva Convention Relative to the Protection of Civilian Persons in Time of War 1949 contains an article, A.44 that deals specifically with refugees and displaced persons.[12]

International refugee law is part of a larger variety of international human rights law and international humanitarian law. Human rights law constitutes the broad framework within which refugee law provisions should be seen. Refugees are entitled to two partially overlapping sets of rights: those rights accorded to them as individuals and guaranteed under international human

[11]ICRC. Advisory Service on international humanitarian law, *available at:* <www.icrc.org/eng/assets/files/other/what_is_ihl.pdf>
[12]Refugee protection, AGuide to International Refugee law, *available at:* <www.ipu.org/pdf/publications/refugee_en.pdf>

rights standards and national law, and specific rights related to their status as refugees.

## 2.2REFUGEES ARRIVING IN LARGE NUMBERS

When large numbers of refugees cross the border at once, their arrival may overcome the local capacity to protect and assist them. The international community needs to share the responsibility of assisting the country of asylum. UNHCR makes every effort to assist asylum States to keep borders open, and to mobilize international support. The right response to a large-scale influx of refugees will save lives, promote regional stability and encourage international cooperation. When refugees are pouring across a border, it is impractical if not impossible to examine individual asylum requests, even when there may be a doubt that the people should be recognized as refugees. When the circumstances under which large numbers of people flee indicate that members of the group could be considered individually as refugees, it makes sense for the country of asylum to use "prima facie" or group status determination. This allows for basic protection and assistance to be extended to those in need, pending arrangements for a durable solution, without initially addressing the question of their status under the Refugee Convention and Protocol.

In the situations of large-scale influx, asylum seekers should be admitted to the State inwhich they first seek refuge and if that State is unable to admit them on a durable basis, itshould always admit them at least on a temporary basis and provide them with Protection. Temporary protection is an immediate, short-term response when large numbers of people arrive after fleeing armed conflict, massive violations of human rights or other forms of persecution. The purpose of temporary protection is to ensure protection in the frontline countries of asylum as well as to provide a coherent regional

response. Temporary protection is based on the principles of the international refugee protection regime, since all those displaced are refugees within UNHCR's mandate and many fulfil the Refugee Convention definition. UNHCR's Executive Committee has recommended minimum standards oftreatment for refugees arriving in large numbers such that their status cannotbe quickly determined.

ISSUES OF HEALTH POLICY IN SYRIA: DUE TO MASS INFLUX OF REFUGEES.

The Conflict in Syria has caused the worst humanitarian crisis and the entire region is securing under its impact. The scale and pace of displacement within the country and the flight of refugees across borders have mirrored the patterns and rising intensity of the violence.

The impact of the refugee influx upon the societies, economies and communities of the host countries is immense. It further compounds already dire economic consequences created by the conflict consequences including a loss of foreign investment, reduced trade flows and cross-border economic and commercial exchanges, as well as drastically diminished tourism revenues not to mention the security risk of a war across the border. The pressure on local authorities and host communities is felt heavily in all areas of everyday life from education and health to housing, water and electricity supply. Across the region, employment opportunities, salaries and price levels have been affected, leaving refugees and local families.

International experience proves that large scale displacement often results in protracted refugee situations. Some refugees may therefore remain in Lebanon for many years. The magnitude of their presence in Lebanon already has had a considerable impact on the economic and social welfare of local populations. What makes Lebanon's situation exceptional is the considerable macro-economic impact of the Syrian conflict, and the

associated costs of absorbing such a proportionately large refugee population among local communities.

Within the health area, there has been a rise in communicable and other diseases and infections following the influx of refugees, spiking a surge in demand for health care services and revealing weaknesses in the health system, including inadequate capacity in primary health care, in numbers of sufficient health workers and shortages of medicines. Economically disadvantaged Lebanese have encountered problems in accessing health care services due to over-crowding in both public and private facilities and higher costs.The economic and social impact of the Syrian conflict and refugee crisis upon Lebanon has been huge. The assessment of the impact of the conflict and the refugee influx, it is evident that the enormous economic and social costs to Lebanon and its people cannot be addressed by conventional emergency relief measures. The stress and pressures are all too evident, and the need for remedies has become more urgent. The negative macro-economic and fiscal impact on growth and on government expenditure is expected to increase. Human and social development indicators and the rapidly growing demands on under-capacitated service delivery are of great concern. Pressures on critical infrastructure are rising. In sum, the essential stability of the country and social cohesion between the Lebanese and Syrian communities is increasingly coming under question; their protection requires an altogether more comprehensive response combining humanitarian and development approaches.

## CHAPTER – III

## RIGHTS OF REFUGEES

All refugees have the same human rights afforded to the any other person. Like all other persons, refugees are entitled to an adequate standard of living, adequate food and housing, as well as physical and mental health. However, refugees' primary need is for physical safety that they are unable to obtain in their country of origin. Thus the primary obligation of states under the refugee conventions is not to return refugees to countries where they will be in danger of "persecution."[13] The grant of refugee status is thus often described as being an international substitute for the protection that should come from a person's state of nationality or habitual residence. The vast majority of the world's estimated refugees are in developing countries. The Middle East hosted the largest number of refugees, followed by Africa. Women and children make up more than 80 percent of the refugees.[14]

### 3.1 1951 CONVENTION

Article 23 of the 1951 Convention seeks to ensure that refugees lawfully staying in the host country are entitled to benefit from the national social assistance and welfare schemes enjoyed by nationals, even if they do not meet any of the conditions of local residence or affiliation which may be required of nationals.[15] Thus, refugees without sufficient resources are equally entitled to social and medical assistance on the same conditions as nationals. As the Convention does not contain a definition of public relief and

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[13]UNHCR, *The State of the World's Refugees* (Oxford: Oxford University Press, 1997), p.62-67.
[14] US Committee on Refugees, *World Refugee Survey,* Washington 2000.
[15] Robinson, Convention Relating To The Status Of Refugees: *Its History, Contents and Interpretation*, 1953, re-published by UNHCR, Geneva, 1997, p.142,

assistance, the level of assistance that refugees, and indeed all beneficiaries, receive will depend on the situation of each Contracting State.

The high standard of treatment granted to refugees with regard to public relief and social security in the 1951 Convention, this should remain the basic instrument of reference in these fields. However international and regional human rights instruments also provide for these rights, and continue to be relevant to the extent that they apply even to countries that have not ratified the 1951 Convention, and in some cases benefit from enforcement mechanisms not available under the 1951 Convention. Moreover, these human rights instruments can be used to protect, support and further define these rights, both in general as well as in relation to particular groups, such as refugee women or children.

### 3.2 INTERNATIONAL HUMAN RIGHTS INSTRUMENT

Article 25 of the Universal Declaration provides that everyone has the right to a standard of living adequate for health and well-being, including basic medical care and social services, in the event of unemployment, sickness, disability, widowhood, old age, or other circumstances causing a loss of livelihood. Similarly, the ICESCR obliges States to provide assistance to persons who are unable to be self-sufficient, and stipulates the right of everyone to an adequate standard of living, mentioning adequate food, clothing and housing in particular.[16] No definition for measuring what constitutes an "adequate standard of living" is provided, and standards will of course differ between host States depending on their available resources, but the State concerned must show that they have delivered basic assistance to the best of its abilities.

[16]Article 4.International Covenant on Civil and Political Rights, adopted by UNGA Resolution 2200 A (XXI) of 16December 1966 (*entered into force 23 March 1976*).

More specifically with regard to health, article 12 of this Covenant recognizes the right of everyone to the highest attainable standard of physical and mental health, which includes medical service and attention. The right to life contained in article 6 of the ICCPR has also been interpreted by the HRC as imposing an obligation on States to take positive measures, such as to eliminate malnutrition and reduce infant mortality.[17]

The scope of the above human rights instruments extends to everyone and is not limited to nationals, these instruments also include a non-discrimination provision.[18] Given this non-discrimination principle and the minimum core rights of the ICESCR, any differential treatment of non-nationals is only acceptable if it is based on reasonable grounds and is not endangering the health of that person. While these are important guarantees, with regard to refugees the 1951 Convention continues to provide the highest and most definitive standard of treatment i.e. the same as granted nationals, a standard which Contracting States are deemed to apply and which does not allow for any differentiation between refugees and nationals. Other relevant international instruments also include CEDAW and the CRC. CEDAW, which applies to women without any distinctions and therefore benefits refugee women, grants them both substantive rights and the right against discrimination in the area of social assistance, adequate living conditions, and equality in access to health facilities. The CRC, which applies to all children without distinction, requires that the State ensure the child's survival and development, and in a separate provision provides for the right of the child to an adequate standard of living, including the mental, spiritual, moral and social aspects of his or her development.[19] While, according to article 27, parents have the primary responsibility for the child's development, States

[17] Dent, J.A., *Research Paper on the Social and Economic Rights of Non-Nationals in Europe*, prepared for the European Council on Refugees and Exiles (ECRE), November 1998, p. 82
[18] *Ibid*, p.63 and 80
[19] See, Articles 6(2) and 27 of the Convention on the Rights of the Child.

Parties are to take appropriate measures to assist parents in this task and in case of need, are required to provide material assistance, especially with respect to such basic needs as housing, food and clothing. The child's right to health is elaborated in article 24 of the same Convention, which due to its broad approach to health and specific requirements is considered to be a particularly progressive provision in international law, and exceeds the protection provided in the ICESCR. Particularly important is its guarantee of access to healthcare services for the treatment of illness and for rehabilitation, its emphasis on the development of primary health care, information and preventive health services, the combat of disease and malnutrition, and measures to abolish traditional practices which are prejudicial to the health of children, such as female genital mutilation.

## CHAPTER – IV

## ROLE OF UNHCR RELATING TO REFUGEES' HEALTH

### 4.1 UNHCR AND REFUGEE CONVENTION

Since 1951, The Office of the United Nations High Commissioner for Refugees has been responsible for protecting refugees and promoting lasting solutions to their problems. The Convention relating to the Status of Refugees has been the governing legal standard under which the legal status, rights, and obligations of refugees traditionally have been defined and enforced[20]. Originally, the Refugee Convention applied only to refugee situations known to exist at the time of its adoption.

The Refugee Convention is founded on the principles set forth in the Universal Declaration of Human Rights that "human beings shall enjoy fundamental rights and freedom without discrimination.[21]

Under the Refugee Convention, UNHCR is compelled to protect any person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

However, while application of this highly individualized definition of refugee still forms the core of UNHCR's work, its mandate has evolved to accommodate the evolving nature of refugee flows. Thus, although many

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[20]Convention on the Status of Refugees, 189 U.N.T.S. 137 (entered into force Apr. 22, 1954).

[21]Protocol Relating to the Status of Refugees, Jan. 31, 1967, 606 U.N.T.S. 267 (entered into force Oct. 4, 1967).

States in the developed world continue to apply the narrow definition of refugee found in the Refugee Convention, States in Africa and Latin America apply a broader definition, committing themselves to the principle of non-refoulement of individuals fleeing generalized violence. Similarly, UNHCR has, in practice, adopted this broader definition of refugee, basing its own intervention on an assessment of conditions in the refugee-producing country rather than on an analysis of each individual's claim.[22]

UNHCR seeks to ensure that those who qualify for refugee status are granted asylum and a legal status that takes account of their particular situation and needs.[23] UNHCR seeks to ensure that refugees are treated in accordance with recognized international standards and receive an appropriate legal status, including, where possible, the same economic and social rights as nationals of the country in which they have been granted asylum. The Refugee Convention ensures to those who fall within the refugee definition a broad range of civil, political, economic, social, and cultural rights. Although the rights of refugees are not always coextensive with the rights of nationals, the Convention creates in those refugees lawfully in the country of asylum a privileged class of non-nationals In addition to guaranteeing them certain civil and political rights , it entitles them to the same economic, social, and cultural rights as nationals in a number of key areas, including the right to public relief, the right to elementary education, participation in rationing systems, freedom of religion, and generally, rights under labor and social security legislation, including maternity, sickness, and

[22]STATE OF THE WORLD'S REFUGEES: *The Challenge of Protection 166 (1993)*, At 170. In 1969, the Organization of African Unity adopted a broader definition of refugee, which includes "every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality." OAU Convention Governing the Specific Aspects of Refugee Problems in Africa, adopted Sept. 10, 1969, Art. (I) (2), 1001 U.N.T.S. 14691 (entered into force June 20, 1974).

[23]UNHCR, THE STATE OF THE WORLD'S REFUGEES: *The Challenge of Protection 166* (1993), at 171.

disability . Together, the Refugee Convention, the 1967 Protocol, and the practice of UNHCR have created a framework to provide for the protection and assistance needs of refugees. Nonetheless, the narrow definition of refugee has, in many contexts, limited the access of most asylum seekers to the same social services as nationals of the host country.

The health of refugees and other forcibly displaced people is a key component of protection and a priority for UNHCR. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population, while everyone has the right under international law to the highest standards of physical and mental health. The refugee agency plans its health care interventions based on needs, risks and vulnerabilities, which are determined as part of an inter-agency assessment by a competent health and nutrition partner and/or UNHCR staff.

## 4.2 PUBLIC HEALTH GUIDELINES

### 4.2.1 UNHCR'S ESSENTIAL MEDICINES AND MEDICAL SUPPLIES POLICY

UNHCR's health programmes are based on the concept of Primary Health Care through which essential health care is made accessible to individuals, families and the community. Health services are provided to refugees and other persons of concern at national health centers or through health centers supported by UNHCR's implementing and operational health partners. Provision of medicines, supplies and equipment necessary for preventive and curative health services is primarily carried out through two mechanisms: centrally by UNHCR or nationally through Ministry of Health central pharmacies. This policy contains a chapter presenting selected technical guidelines for UNHCR and partners' public health staff and pharmacists.

Those technical guidelines provide detailed step by step guidance on managing procurement, storage, rational use and monitoring of medicines and medical supplies.

This policy contains selected technical guidelines for UNHCR and partners' public health staff and pharmacists. Those technical guidelines provide detailed step by step guidance on managing procurement, storage, rational use and monitoring of medicines and medical supplies. Essential medicines play a crucial role in the prevention and control of diseases. UNHCR has therefore developed an EML, based on World Health Organization's essential medicine list.[24]

During the emergency phase of a refugee influx medicine procurement is streamlined by the immediate provision of Emergency Health Kits. Even if kits are used, normal non-emergency lines of procurement must be planned and set up from the beginning of an emergency situation so that a smooth and timely transition can take place. The supplementary unit contains medicines and medical devices for a population of 10,000 persons and is to be used only by professional health workers or physicians. The supplementary unit does not contain any medicines or medical devices from the basic units. The supplementary unit should only be used together with one or more of the basic units at the field hospital level.

Reproductive Health Kits for Crisis Situations[25] have been designed by members of the Inter-Agency Working Group on Reproductive Health to complement the Inter-agency Emergency Health Kits. In an emergency, delivery of the reproductive health kits will take between 2–7 days after

[24]WHO Model List of Essential Medicines, March 2010.*Available at*, <http://www.who.int/medicines/publications/essentialmedicines/Updated_sixteenth_adult_list_en.pdf> (accessed on, 6th may 2014)

[25]Inter-agency reproductive health kits for use in crisis situations, *5th edition*, 2011.*Available at*, <http://www.unfpa.org/webdav/site/global/shared/procurement/06_for_customers/02_gccperhkits/RH%20its%20Manual%202011.pdf>*accessed on*,6th may 2014

finalization of the budget allocation. Vaccine and nutritional emergency kits are available. However, in almost all instances, vaccines are provided locally through Ministry of Health with support from UNICEF and WHO. For continued access to antiretroviral treatment in the first phase of an emergency, it is important to ensure that refugees and other persons of concern to UNHCR are included into national HIV treatment programmes.[26] Where this is not feasible, appropriate discussion with the Senior HIV Officer and the relevant bureau in headquarters is required before UNHCR procures antiretroviral medication.

The choice of medicines available depends on the staff's capacity to use them effectively. Consequently, it is important to know the extent of staff training and the availability of support facilities for each level of the health care system before deciding where individual medicines will be made available. Every programme should have an Essential Medical List, but this does not mean that all medicines should be made available at every level of care. Under normal conditions, the number of medicines available at a health facility increases with the level of health services provided. In many settings, health facilities are operating beyond their capacity due to lack of resources, need, and poor geographical planning. In this case, a pragmatic approach based on the staff's capacity and expertise should be used to ensure sufficient access to essential medicines.

Consideration should be given before including medicines that are sensitive to heat, light or humidity in a setting where these factors are difficult or impossible to control. Choosing the most stable dosage form for a particular setting is part of the overall medicine quality assurance system. Choosing tablets rather than capsules, ointments rather than creams, powder for reconstitution rather than injectable solutions and avoiding syrups is a

[26]UNHCR Antiretroviral medication policy for refugees, 2007, *available at,* <http://www.unhcr.org/45b479642.html>*accessed on,* 6th may 2014.

lowcost, high impact intervention in maximizing the therapeutic lifespan of medicines in extreme climatic conditions.

Vaccines, antiretroviral medications and second line anttuberculosis medications are considered essential medicines, and refugees and other persons of concern to UNHCR should have access to these under all circumstances. These medicines can be ordered, but only after appropriate discussion and approval from the Regional or Global Senior Public Health Officer and the relevant bureau at headquarters.

## DEVELOPING A NATIONAL ESSENTIAL MEDICINES LIST

The Essential Medical List developed for a UNHCR Primary Health Care programme should be based on UNHCR's Essential Medical List adapted to national standards. National standards are those established by the respective Ministry of Health. A national standardized EML may have been established. Some countries do not allow importation of medicines that are not included in the national EML, thus it is important to obtain this list. The national medicines list has legal status, whereas UNHCR or WHO EMLs only remain a guideline until a country's health authorities officially adopt it. Any deviation from the national EML should be discussed with the local health authorities.

The UNHCR Country Public Health Officer together with the public health staff of partner agencies and Ministry of Health should take the lead in the development or review of the Essential Medicine List, essential medical supplies and standard treatment guidelines in coordination with relevant local authorities and other agencies. Where there is no country-based UNHCR Public Health Officer, the UNHCR Programme Officer should assume this responsibility in coordination with the Regional or Headquarters Public Health Section.

### 4.2.2. DEVELOPING LOCAL STANDARD TREATMENT GUIDELINES

The standard treatment guidelines used in conjunction with standard symptom or disease definitions, is compulsory in all refugee health programmes.[27] This is particularly necessary given the often large number of agencies and personnel providing refugee health services, the rapid turnover of staff, and the wide range of health workers involved. These treatment guidelines should cover the most common diseases and complaints, be differentiated for the different levels of health care, and be adapted to the competence of the health workers.

UNHCR's medicine and medical supplies procurement chapter does not replace UNHCR's general procurement guidance as specified in UNHCR Manual, on Supply Chain Management[28] as well as UNHCR's Procurement Guidelines for Implementing Partners[29]. The specific medicine procurement guidance outlined below needs to be used as a supplement to the general UNHCR procurement regulations to comply with UNHCR's accounting and auditing procedures and standards.

### 4.2.3 HEALTH INSURANCE SCHEME FOR REFUGEE

The health of refugees is a key component of protection and a priority for the United Nations High Commissioner for Refugees. The Refugee Agency works closely with governments and partner organizations who implement health programmes in a range of challenging settings. Health and nutrition programmes are delivered within a public health and community

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[27]Standard Treatment Guidelines, *Ministry of Health,* Republic of Ghana, sixth edition, 2010.
[28]UNHCR Manual, Chapter 8 on Supply Chain Management: available at, <https://intranet.unhcr.org/intranet/unhcr/en/home/executive_direction/official_policies/unhcr_manual/cha er_8__supply.html.>*accessed on, 10th may 2014*
[29]UNHCR Procurement Guidelines for Implementing Partners, 2004: *available at,* <http://www.unhcr.org/pages/49c3646c4a6.html.>*accessed on,* 10th may 2014

development framework, with an emphasis on primary health care and support for secondary and sometimes tertiary hospital care. The objective of these programmes is to minimise mortality and morbidity among refugees and other persons of concern to UNHCR.[30]

UNHCR advocates that essential PHC and emergency services be provided free of charge to refugees during an emergency. Furthermore, certain essential services such as childhood vaccinations, antenatal and delivery care, and communicable disease control should be provided free to all refugees during the post-emergency phase. Fees for all others services depend upon the context, but UNHCR advocates that they should not be higher than those prices charged to nationals. Furthermore, vulnerable refugees should be identified and a suitable safety net provided for them to ensure access to preventative and curative health services. The agency advocates that government services are accessible to and used by refugees whenever possible. In most countries where insurance schemes are available, there will also be several co-existing health financing mechanisms. Resources for health services come from many sources including but not limited to: taxation, general budgetary support, the private sector, individual out-of-pocket payments, grants, and payments by civil society organisations and international agencies. Individuals and communities may also make non-financial contributions by freely giving their labour in the construction of a health facility. A full understanding of the health financing mechanisms relevant to the health services accessed by refugees needs to be assessed and understood according to the specific context where refugees live. Any health financing schemes, including insurance schemes, need to be combined with a way of financially protecting the poor and other potentially vulnerable persons and groups in order to enable them to access health services as readily as people who are better off or less vulnerable. Clear and

[30] www.unhcr.org/4f7d4cb1342.pdf. (accessed on 15th may 2014)

objective eligibility criteria need to be designed to identify these persons and groups.

Health insurance schemes can be national, community or private. They can be mandatory or voluntary. Mandatory schemes are usually national, in which there is a legal obligation for people to pay into them and are based on the principle of social solidarity. Contributions are community-rated i.e. based on an average expected cost of health service. These are usually called Social Health Insurance or, if covering the whole population, National Health Insurance. They are generally collected through payroll deductions. There are also voluntary health insurance schemes. Voluntary or private insurance schemes may be managed on a for profit or not for profit basis. Community-based health insurance schemes are usually run by community based or non-governmental organizations (NGOs), and may also be referred to as mutual health insurance, micro-insurance or community health funds. Insurance schemes often have high administrative and revenue collection costs.

There may be numerous direct and indirect benefits in providing health insurance to refugees. Improved access to health services and financial protection are clearly the two largest benefits[31]. Indirect benefits include an official piece of documentation that may protect refugees from harassment by authorities and provide refugees with a sense of belonging and security. More data about refugees may be provided to UNHCR and its partners to allow for an objective decision as to who is vulnerable as well as data from health insurance companies about who uses which services where and for what reason. The improved protection benefits as well as the provision of

[31]Apoya P & Marriott A., Achieving a shared goal: *Free universal access to health care in Ghana*,Oxfam International March 2011.<http://www.oxfam.org.uk/resources/policy/health/achieving-shared-goal-free healthcareghana.Html.> accessed on 14th may 2014.

data from different sources may allow for improvement in other sectors and programmes.

## GUIDANCE ON INTRODUCING HEALTH INSURANCE SCHEMES FOR REFUGEES

All options must be considered and the conclusions from any available evaluations of these schemes taken into consideration as they are reviewed. While a scheme may potentially increase access to health services and financial protection for refugees, it may not be equitable and may not be available to the poorest or most vulnerable. However, while a scheme may exclude a group of especially vulnerable refugees or those with specific diseases, it may still be cost effective for some or the majority of refugees. UNHCR and its partners can attempt to find alternative arrangements for those who cannot be insured. Other indirect benefits may also occur as discussed previously in the section why consider health insurance for refugees.

UNHCR can contribute financially to insurance schemes in several ways that include complete or partial payment of premiums and funding to pay the co-payment for the costs of the service generally for vulnerable refugees; however, when refugees incur a catastrophic event with very high costs, a relatively well-off refugee can suddenly become financially vulnerable[32]. In other circumstances, UNHCR may be able to provide expertise, funds and equipment to those health centres and hospitals used by the health insurance scheme that would allow for a more favourable deal for the refugees.

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[32]MacIntyre D, Learning from experience: *health care financing in low and middle-income countries*. Global Forum for Health Research June 2007, <http://whqlibdoc.who.int/publications/2007/2940286531_eng.pdf.>*accessed on 14th may 2014.*

Vulnerable refugees should be included in insurance schemes with UNHCR covering some or all of the premium and the insurance co-payments for services. Clear criteria designating who is vulnerable must exist. UNHCR should advocate that needs of vulnerable refugees should be covered by the host government when feasible. It is important to identify the possibility for refugees to benefit from government provided welfare support whenever possible. This is not social insurance but rather payments to vulnerable people with government resources that comes from direct taxation. Refugees with disabilities are eligible to apply for disability grants. This includes some categories of people with chronic illness who are unable to work and the terminally ill. But in practice very few refugees will be able to benefit from such government welfare programmes, and UNHCR should work with other agencies to attempt to provide such assistance in proportion to the amount that would be received under the government scheme[33] when feasible.Presentation is difficult to calculate all the costs involved in any insurance scheme in advance. Only by piloting a scheme in a region with a certain number of refugees can the real costs, benefits and disadvantages of a scheme become apparent. Generally, schemes should be piloted before being rolled out to a very large number of refugees.A pilot will also give an indication of the extra administrative and technical burden thatan insurance scheme might encumber UNHCR staff with.

GUIDANCE ON IMPLEMENTING HEALTH INSURANCE SCHEME

UNHCR should plan with the government and partners effective communication strategies for implementing insurance schemes in order to fully inform refugees about the existence of the scheme, its advantages and disadvantages, the documentation process when applying, and seeking

[33]Meny Q. et al, Expanding health insurance coverage in vulnerable groups:a systematic review of options. *Health policy and planning 2011;* pp 26 &93-104. <http://heapol.oxfordjournals.org/content/early/2010/09/02/heapol.czq038.abstractOxfam.>*accessed on* 15th may 2014.

treatment and reimbursement. Refugees will also need to be made aware of their rights within the scheme and their obligations.

UNHCR and partners should monitor the scheme closely and regularly to ensure that the agreement is being followed, refugees are accessing services and receiving reimbursement, and ultimately that the scheme is cost-effective and non-discriminatory according to what has been agreed upon. A further socio-economic survey may be undertaken in countries in which very large numbers of refugees have enrolled to measure the impact of the insurance scheme on the household economy and levels of poverty amongst refugees. UNHCR and partners should continue to monitoring the public health status of both enrolled and non-enrolled refugees to compare the impact of the scheme. Such monitoring will require a clear plan and require financial and human resources.

UNHCR and partners should continue to negotiate with the insurance company to ensure that insurance premiums are not unduly raised and that the best deal possible has been obtained for refugees. As numbers of subscribers increase, UNHCR may be able to renegotiate reduced premiums and co-payments by refugees and/or increased ceilings. Analysis of disaggregated data according to services may allow for improved negotiations. Other schemes and alternative financing mechanisms to the current insurance scheme should be assessed to ensure that the best option has been chosen at that moment.

UNHCR and partners should continue to advocate that refugees access quality health services at a level that is similar to nationals. Furthermore, when the care is insufficient, UNHCR and partners should work with the government to improve the services. This may involve ongoing work with governments, partners and a wide range of actors to monitor and support

improvements in government facilities and to strengthen the government's public health system.

### 4.2.4REFUGEE CAMPS SETTING.

The United Nations High Commissioner for Refugees operations and specifically country level Public Health Officers (PHO) and partners with guidance on how to develop and establish outbreak preparedness and response capacities for communicable diseases in refugee camps and settlements. Since 2008, significant amounts of resources have been mobilized worldwide to improve readiness to respond to the threat of pandemic influenza and its potentially high mortality and morbidity. Lessons have been learnt notably in planning different components of pandemic preparedness, which are to some extent applicable to other communicable diseases with outbreak potential.

Communicable disease control is indeed a challenge in most UNHCR operations. During an acute emergency, the living conditions in camp settings present a favourable environment for epidemics of communicable disease. In more protracted refugee camp situations, even if overall living condition of refugees has improved, many emergency standards are often just met. Prevention of communicable diseases is always a priority intervention. However, preparedness to recognize and manage an outbreak of communicable disease is essential. This guidance outlines practical steps to establish and maintain an epidemic/pandemic preparedness and response in refugee camp settings and settlements.

- Coordination with all actors is crucial to ensure that the programme is able to respond quickly and that it is linked to the national outbreak and response programme. Coordination must ensure:
- Consistency with national preparedness and response activities.

- Advocacy for inclusion of refugees into national plans for specific disease outbreak responses.
- Rapid two-way flow of information between relevant authorities, agencies and health facilities.
- Consistency in risk-communication messages being disseminated.
- Transfer of specimens and referral of patients if necessary.
- Overall improved cost-effectiveness of preparedness and response activities

Coordination takes place at three levels: national, district and camp. Coordination at global and regional level is not considered here. Coordination involves all actors including the Ministry of Health (MoH), other essential government services, UNHCR partners in the refugee camp, the World Health Organization (WHO), United Nations Children Fund (UNICEF) and other United Nations (UN) agencies.

Contact can be initially made with MoH, WHO, and UNICEF. National Red Cross and other organizations may produce useful IEC materials. Donor agencies or embassies may provide advocacy support. In UNHCR operations where PHOs are not based in the capital, coordination with agencies at the national level becomes more challenging. In this situation, UNHCR may appoint capital-based staff to attend national level coordination meetings regularly. However, the PHOs in the field should endeavor to attend these meetings every quarter or semester while at the same time strengthening provincial and district level coordination.

The outbreak control team should be active and meet regularly with minutes of meetings documented and shared with all participating agencies and individuals. Therole of the Outbreak Control Team before an epidemic will mainly focus on setting up and maintaining a contingency plan, identifying critical functions and setting up a business continuity plan. During an

epidemic, its role will be broader and include coordination of essential services, implementation of public health measures, management of public health information and limiting social disruption.

The Business Continuity Plan is a global issue; plans should be developed in all sectors and in all organizations. UNHCR has its own internal BCP. Focus in this document is on its public health components. However, in practice many sectors are inter-related. The public health component of the BCP should be developed in full awareness of what other sectors have planned.

One of the important roles of the PHO in the BCP is to identify all critical health functions that will need to continue during a major crisis. Prior training may be necessary for the critical staff to carry out their roles. Non-essential functions that will be temporarily halted also need to be identified as staff currently assigned to these activities can be used to back-up essential functions. Regular updates of the staff list are critical, and should preferably be done by human resource officers of UNHCR and implementing operational partners. UNHCR and partners should ensure animal health surveillance is in place. This includes idenfying the camp focal person, clarifying the information flow channel, identifying the appropriate health/veterinary official and updating contacts. Objective of animal health surveillance is to minimize contact of humans with sick or dead birds and animals. Establishing coordination mechanisms and operational links with national/regional veterinary authorities is important to prevent and respond appropriately to diseases originating from animals, while avoiding over reactions such as inappropriate culling of poultry as soon as a few bird deaths have been rumored. All camp must have active disease surveillance with early warning systems in place including the outbreak prone diseases in the area. Early detection of cases will allow[34]

[34] UNHCR's Health Information System, *available at:*

- Early initiation of control measures to reduce morbidity and mortality.
- Activation of outbreak operational plans: health resources will be organized to receive the expected increase in patients and to continue essential services.

Infection prevention is not specific to an outbreak but represents a major task in epidemic control and mitigation. The principal objectives of infection prevention and control are to protect patients, protect care providers, auxillary staff and reduce spread of the infection. The UNHCR Country PHO in coordination with the health partners is responsible for developing the country specific plans for refugee camps and settlements.

### 4.2.5REPRODUCTIVE HEALTH IN REFUGEE SITUATIONS

UNHCR's sister organization, the World Health Organization, defines reproductive health as a state of complete physical, mental and social well-being - and not merely the absence of disease or infirmity - in all matters relating to the reproductive system and to its functions and processes. People in good reproductive health, including the forcibly displaced, are not only able to have a satisfying and safe sex life but also to have the capability to reproduce and the freedom to decide if, when and how often to do so.

UNHCR supports the organization of comprehensive services for antenatal, delivery and postnatal care, consistent with WHO policies and the Inter-agency Field Manual on Reproductive Health in Refugee Situations.[35] The organization of such services should take into account existing facilities for the local population; the needs of both refugee and local populations should be considered. The services provided should be responsive to obstetric

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<http://www.unhcr.org/4613888c2.html.>

[35]The Inter-agency Field Manual is currently being revised, based on the results of several years of field testing in early 1999.*Available at,* < http://www.unhcr.org/4045aedd4.html.>

emergencies, although, where appropriate, host country services should be used in preference to establishing new, refugee-specific facilities which will not be maintained in the long term.

In order to ensure that the services provided are appropriate, accessible, and of the highest quality, it is essential to:

- Identify skilled care providers involved in childbirth (physicians, midwives, experienced nurses, trained Traditional Birth Attendants
- Provide refresher training and supportive supervision, as needed;
- Ensure the availability of the basic supplies, equipment and drugs; and
- Be aware of and discuss community beliefs and practices, and health seeking behavior relating to delivery – e.g. position for delivery, presence of relatives for support and traditional practices both positive and harmful.

Antenatal and postnatal services should be offered in an appropriate environment, in the same location as family planning, STD services, the "baby clinic" and other related primary health care services. The emphasis for delivery care must be on provision of skilled assistance. In the absence of midwives or nurses, TBAs should be trained in clean and safe delivery practices, early detection of problems, and immediate and safe referral to a health care facility.

The essential interventions for safe motherhood, to which UNHCR agrees, can be summed up as follows[36]

- Information and services for family planning
- STD/HIV prevention and management
- antenatal registration and care

[36]World Health Organization. Mother-Baby Package: *Implementing Safe Motherhood in Countries*.WHO/FHE/MSM/94.11. Geneva, World Health Organization 1994.

- treatment of existing conditions, according to country policy
- advice regarding nutrition and diet
- prevention, early detection and management of complications

Each camp has a compound at which health services are delivered. Most compounds include facilities for both outpatient and inpatient services, including maternity inpatient services. Patients requiring services not available at the camp health compound are referred to a district, regional or tertiary hospital operated by the Ministry of Health. The administration of health services is the responsibility of the designated implementing agency for a particular camp. The agency is responsible for hiring and supervising staff, providing and maintaining infrastructure, ensuring the availability of the necessary supplies, equipment and drugs, and implementing and monitoring the delivery of a range of preventive and curative health services.

Women living in refugee settings require the same services as pregnant women elsewhere. These services include comprehensive antenatal care, including careful assessment, health promotion, screening and treatment for diseases such as syphilis, iron supplementation, malaria treatment; clean and safe delivery care, including the prevention, early detection and management of obstetric emergencies; essential newborn care, including thermal protection, basic newborn resuscitation, and early and exclusive breast feeding; and postnatal care, including comprehensive family planning information and methods. The services for pregnant women must be linked by a functioning referral system which has the capacity to respond to obstetric emergencies, if and when they arise.

In an emergency phase, pregnant refugee women may need additional psychological support and more intensive monitoring of the pregnancy to ensure a safe outcome.

Access to quality reproductive health services, including adequate emergency obstetric care, can drastically reduce the number of women who die during or after child birth and ensure that mothers and their children enjoy a healthy life. Reproductive health education for adults and young people is also important, helping to raise awareness about, among other things, maternal health; family planning; the fall-out from sexual violence; female genital mutilation; sexually transmitted diseases; and HIV.

### 4.2.6MALARIA: STRATEGIES AND POLICY

The UNHCR Malaria prevention and control activities are directed by guiding principles of effective malaria control in complex emergency settings, which applies equally to refugee situations, as for other situations of displacement. These guiding principles, a combination of international humanitarian standards and evidence-based programming, are defined into programmatic activities in UNHCR's Strategic Malaria Plan.

Malaria remains a leading cause of morbidity and mortality among refugees. A majority of refugees live areas in which malaria is endemic or occurs in seasonal epidemics. Many factors may promote susceptibility to malaria morbidity and mortality among refugees[37]. Pregnant women and young children are particularly at risk of severe illness and death. Refugee camps are often sited on marginal lands that promote breeding sites for malaria vectors. Refugees may be malnourished, particularly in the phase immediately following flight. Travel may take refugees through or to areas of higher malaria endemicity than their place of origin. Control programmes may have broken down.

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[37]Allotey and Pascale. The Health of Refugees: *Public Health Perspectives from Conflict to Settlement.* Oxford: Oxford Press 2003.p.34

The WHO position[38] on insecticide-treated nets recommends that malaria control programs purchase only Long Lasting Insecticide-treated Nets, and furthermore recommends full coverage of all people at risk of malaria. Nets have been shown to provide a community protective effect when as little as 60% of the population are using the nets[39]. During scale-up operations of LLIN distribution, certain at-risk populations should be targeted first such as pregnant women and children under five years of age. In general, it is recommended that one LLIN be given to each two persons. Additionally, all UNHCR programs should have LLINs for all inpatient beds in clinics, hospitals, and therapeutic feeding centres.UNHCR aims at achieving universal net coverage for its PoCs by 2010.[40] The distribution of LLINs in favour over conventional ITNs and their consistent use will further improve protection from infection.

Distribution should be accompanied by effective community education strategies, monitoring, and follow up. Net misuse and resale is a problem in refugee settings where adequate community engagement and education is not conducted, and there are competing survival priorities. There are many other insecticide-treated materials which have been used in attempt to prevent spread of malaria such as insecticide treated blankets, clothing, and plastic sheeting. Although many show promising study results, none are currently approved and recommended by WHO or the WHO Pesticide Evaluation Scheme. UNHCR has been working closely with malaria partners, academic institutions, and UN agencies to further improve novel materials and strategies for malaria control and prevention in emergencies.[41]

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[38] Insecticide-treated Mosquito Nets: a WHO Position Statement, 2007.
[39]Killeen GF et al. Preventing childhood malaria in Africa by protecting adults from mosquitoes with insecticide-treated nets. *PLoS Medicine, 2007*,4(7).
[40]*Ibid.*
[41]WHO. Roll Back Malaria consultation on best practices and lessons learnt:*implementing malaria control in complex emergencies in Africa 2000-2004.* Geneva, World Health

The participation of beneficiaries has not only been a strategic objective in all UNHCR programmes but a catalyzing factor in the scale up and improvement of quality of malaria services and service-related commodities. The refugees and other Person of Concerns are encouraged to be engaged in all phases of the strategic plan including the situation assessment, planning, monitoring, and delivery of services.

Malaria in particular, community investment and participation are absolutely essential for a successful prevention and treatment campaign. Efforts such as LLINs and IRS are virtually useless unless understood and accepted by the target population. As well, it is often seen that sick patients will delay seeking care which can be related to poor community education and communication efforts.

When establishing messages and priorities, several key issues should be included: causes of malaria, vulnerable populations, discernment of severity, treatment, accessibility to health facilities, and prevention. Implementation of Information Education Communication should be executed with respect to timing such as being aware of holidays, public gatherings, and other health campaigns. Messages can be strategically interposed into and in conjunction with outpatient clinics, supplementary feeding centers, immunization, and Absolute Neutrophil Count efforts.

UNHCR coordinates and shares malaria control information to governments,[42] UN agencies and other humanitarian organizations. UNHCR is a member of the Network for Malaria Control in Emergencies, coordinated by WHO and liaises with Roll Back Malaria and the Alliance for Malaria Prevention. As part of the humanitarian community and within the protection

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Organization. <www.who.int/malaria/epidemicsandemergencies>.*Accessed on* 13th may 2014.

[42]UNHCR, Malaria in Refugee Camp, *a cycle of death and debilitation.* <http://www.unhcr.org/456ac0d32.pdf>*accessed on 17th may 2014.*

mandate, UNHCR ensures that malaria control policies and programmes for IDPs are coordinated and integrated within the humanitarian reform process.

### 4.2.7MENTAL HEALTH AND PSYCHOLOGICAL SUPPORT GUIDENCE FOR REFUGEE

The guidance on Mental Health and Psychosocial Support provides a practical orientation and tools for UNHCR country operations. It covers specific points of good practice to consider when developing Mental Health and Psychosocial Support programming and offers advice on priority issues and practical difficulties, while also providing some background information and definitions. Since Mental Health and Psychological Support is a cross cutting concept this operational guidance is relevant for programming in various sectors, including health, community based protection, education, shelter, nutrition, food security and livelihoods. Experiences of displacement due to armed conflict, persecution, or disasters put significant psychological and social stress on individuals, families and communities.[43] The ways in which refugees experience and respond to loss, pain, disruption and violence vary significantly and may in various ways affect their mental health and psychosocial wellbeing or increase their vulnerability to develop mental health problems. Often, reactions to troublesome situations are normal and can be overcome with time. Many refugees will be able to cope with these difficult experiences, and even build resilience, if a supportive family and community environment is available.

Some refugees may develop negative coping mechanisms that may be reinforced while they struggle to meet basic needs. Some will newly develop mental disorders while others with pre-existing mental disorders may experience exacerbation of their symptoms. The usual systems for providing

[43] Warrell and Gilles. Essential Malariology. New York City, *Oxford University Press Inc.* 2002

mental health care may be negatively affected, leaving people with mental disorders without adequate treatment.

OPERATIONAL GUIDENCE

UNHCR and partners need to ensure that refugees and other persons of concern, including children, youth, women, older persons, sexual and other minorities,[44] as well as groups with specific needs, are involved in all stages of design and implementation of the Mental Health and Psychological Support activities. All interventions in UNHCR, including those for MHPSS, should prioritize the interests of the refugees, show respect for their decisions, and be guided by principles of confidentiality, safety, security, respect, dignity and non-discrimination. Gender equality and respecting the rights of all refugees of all ages and backgrounds are central to the work of UNHCR. This is reflected in the Age, Gender, and Diversity Mainstreaming Approach[45] that integrates the approaches.

A participatory approach that seeks to link refugee participation to programme design, and feedback.

A community-based approach that recognizes the resilience, capacities, skills and resources of the refugees, and focuses on identifying and building on community capacities for self-protection.

A rights-based approach that requires actively working towards the realization of human rights of refugees, seeking to redress discriminatory practices and unjust distributions of power that impede development progress and ensuring that plans, policies and processes of development are

[44] UNHCR, Age, Gender and Diversity Policy. Geneva: *United Nations High Commissioner for Refugees.*2011 <http://www.unhcr.org/4e7757449.html>*accessed on* 10th may 2014.
[45] UNHCR, *Age, gender and diversity mainstreaming*, 31 May 2010, EC/61/SC/CRP.14, <http://www.unhcr.org/refworld/docid/4cc96e1d2.html> accessed on 10th may 2014.

anchored in a system of rights and corresponding obligations established by international law.

CONSULT THE PEOPLE WITH MENTAL AND PSYCHOLOGICAL PROBLEMS

Use participatory methods for needs assessments, and ensure that the voice of people with mental and psychosocial problems and their families is included. Keep in mind that persons most in need may be the least likely to come forward to make their needs known. Determine how communities cope with disability and psychosocial stress and how the refugee context has perhaps ruptured those coping mechanisms.[46]

Ensuring access to quality health care treatment is becoming increasingly challenging, as preventative services; chronic disease treatment and referral care for a largely dispersed and urban population comes at considerable cost. Mental, neurological, and substance use disorders are common in all regions of the world, affecting every community and age group across all income countries. The budget for Mental Health constitutes 5% of the general health budget. Available resources are mainly allocated for long-stay in-patient costs in mental hospitals and the provision of some psychotropic medications. Outpatient and community based services are the responsibility of the private sector. Mental Health care provided through primary health care is limited and typically restricted to prescription of medication through the general physician without supervision by specialists. A limited number of health centres have social workers or nurses that are trained in mental health. Those mainly seek care from general physicians at clinics, or

[46] Richard and Laura McDonald. "Old Stereotypes, New Realities Refugees and Mental Health." *United Nations Chronicle* 2002- Online Edition (2). <www.un.org/pubs/chronicle/2002/issue2/0202p29_refugees_and_mental_health.html> *Accessed on* 18th may 2014.

polyclinics that are operated by private doctors, or charities, but not by Mental Health professionals.

SYSTEM OF BASIC SERVICES AND SECURITY

Ensure that provision of basic needs and essential services like food, shelter, water, sanitation, basic health care, control of communicable diseases and security is done in a way that does not undermine psychosocial wellbeing or negatively affect mental health. This implies that the actors responsible for providing these essential services should use a 'Mental Health and Psychological supports approach.[47] This may require advocacy from MHPSS professionals to ensure that these services and assistance are inclusive for people with specific vulnerabilities including people with mental disorders, survivors of sexual and gender based violence, but avoid exclusively targeting a single group as this can lead to discrimination, stigma, and potential further distress.

STRENGTHEN COMMUNITY AND FAMILY SUPPORTS

Refugees as anyone else, maintain their mental health and psychosocial wellbeing through using key community and family support. In many refugee settings there are significant disruptions of family and community networks and it is therefore important to enable refugee communities to establish these support systems. Emergencies often damage the social structures among refugees and may negatively affect the ability of people to support each other effectively. Activities to foster social cohesion amongst refugee populations are therefore very important. Within UNHCR coordinated operations activities related to this layer are usually implemented through Community-based Protection and their partner organizations and may include activities such as

[47]Bloland and P.B.William. Malaria Control during Mass Populations Movements andNatural Disasters. National Research Council and Program on Forced Migration and Health, *The Joseph L Mailman School of Public Health of Columbia University,* National Academies Press, Washington (2003).

supporting the reestablishment and/or development of refugee community based structures which are representative of the population from an age, gender and diversity perspective and supporting community opportunities to improve the wellbeing of persons of Concern.[48]

This UNHCR Strategic Plan for Malaria Control documents the vision, strategic objectives, and main strategies of UNHCR to fully integrate effective malaria control into UNHCR's overall mandate of protection of refugees and other PoCs. It also provides core indicators by which progress against these strategic objectives will be measured to ensure that UNHCR meets internal standards and complies with international standards.

[48]UNHCR, Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations 2013<http://www.unhcr.org/525f94479.pdf>*accessed on* 23rd may 2014.

## CHAPTER- V

## REFUGEES' HEALTH IN EMERGENCY SITUATION

Populations affected by armed conflict, internal dispute have experienced severe public health consequences mediated by population displacement, food scarcity, and the collapse of basic health services, giving rise to the term complex humanitarian emergencies. These public health effects have been most severe in underdeveloped countries in Africa, Asia, and Latin America. Refugees and internally displaced persons have experienced high mortality rates during the period immediately following their migration. The most common causes of death have been diarrheal diseases, measles, acute respiratory infections, and malaria. High occurrence of acute malnutrition have contributed to high case fatality rates. War-related injuries have been the most common cause of death among civilian populations; however, increased incidence of communicable diseases, neonatal health problems, and nutritional deficiencies especially among the elderly have been documented. The most effective measures to prevent mortality and morbidity in complex emergencies include protection from violence; the provision of adequate food rations, clean water and sanitation; diarrheal disease control; measles immunization; maternal and child health care, including the case management of common endemic communicable diseases; and selective feeding programs, when indicated.

The economic, social and ecological costs of a massive influx of refugees create an enormous burden for the host countries. As a consequence, effective aid to refugee and displaced populations in those countries is almost always dependent on a rapid response by the international community1. Population movements into areas with poor resources have usually led to high mortality rates. Relief programmes must therefore be initiated promptly if excessive mortality rates are to be rapidly reduced, and

priority must be given to measures likely to have a swift impact on mortality figures. Experience shows that mortality is reduced when assistance becomes well organized and coordinated.

Two phases may therefore be distinguished in refugee situations i.e., emergency phase and post emergency phase. The emergency phase following the arrival of refugees; this is the period during which mortality rates are higher than those experienced prior to displacement. The post-emergency phase, or consolidation phase, starting when mortality returns to the level of the surrounding population.

Information gathered has made it possible to analyze the health problems of refugee and displaced populations. As a result, the most effective strategies for controlling the mortality rate have now been properly defined, and procedures standardized.

Ideally, these interventions should be carried out simultaneously, which becomes feasible when different teams of relief workers are involved3. When several operational partners are present in the field, it is essential to rapidly assign responsibility for different programmes, as good coordination among partners is essential for their speedy implementation. It is also essential that each sector of activity is monitored, as every operating health agency needs to have a clear picture of the work being carried out in each of the different sectors.

### 5.1 PRIORITIES IN EMERGENCY PHASE

The emphasis is classically put on the quantity and availability of services, sufficient attention must be given to their quality as well. It is the responsibility of agencies to monitor not only the number of services available or the population that they cover, but also how these services are delivered.

Supervision of staff plays a key role in this regard. These priorities are discussed below,

### 5.1.1 INITIAL ASSESSMENT

Health priorities are identified on the basis of a rapid collection and analysis of data, which should lead to a prompt assessment within the first few days.[49] Information is required on the background to the displacement, the population itself the risk factors related to the main diseases, and the requirements in terms of human and material resources. This involves quantitative as well as qualitative information. Data may be gathered by sample surveys, mapping, interviews and observation. Methods will often be approximate and results may need to be corroborated later with other studies.[50]

The main objectives of the initial assessment are:

- To decide whether or not to intervene: whether an intervention is required and is feasible in view of the context.
- To define the priorities of intervention although these priorities are mostly standardized, it is frequently necessary to adapt them to the particular situation.
- To plan the implementation of these priorities: deciding strategies, determining the resources needed and working out the time frame.
- To pass on information, as well as observations of refugee living conditions and the human rights situation to the international community and donors.

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[49]Moren, A. Rapid Assessment Of The State Of Displaced Populations or Refugees. *Medical News*, 1992, 1(5): p.5-10.
[50]*Ibid.*

The initial assessment may be undertaken in two steps.[51] This first phase should result in a rapid decision on whether or not to intervene and the type and size of intervention. It will also lead to a decision as to whether or not a second assessment phase is required and when it should take place. The second phase will be delayed or left out altogether when intervention is extremely urgent, the needs are obvious and/or resources are limited; for instance, when a major outbreak of disease is affecting the population, action will be taken immediately.

The second phase should allow for proper programme planning and for disseminating information to the international community. It should be carried out simultaneously with the implementation of relief actions; essential interventions should not wait for the completion of the assessment. The timing would therefore normally be one to three weeks after the arrival of relief agencies, i.e. as soon as the appropriate resources and expertise are available and time allows.[52] The time needed to complete both phases of the initial assessment will depend on the remoteness of the location, its accessibility, the security conditions, the degree to which local authorities cooperate, the resources available. In most situations, valuable and complete information may be gathered during a period of 7 to 10 days.[53]

A description of the situation in the country of origin, the causes of the displacement and the circumstances will allow a better understanding and interpretation of the data collected during the initial assessment. It may also help to predict the outcome of the refugee problem and the number of newcomers to expect. A description of the situation in the host country security, acceptability of international organizations, etc. is also essential for assessing the feasibility of interventions, and whether refugees will have

[51]Toole, M.J. The Rapid Assessment of Health Problems in Refugee and Displaced Populations. *Medicine and Global Survival*, 1994, 1(4): pp200-207.
[52]*Ibid.*
[53]*Ibid.*

access to the local infrastructure etc. Security conditions must be clearly described since they can have a limiting effect on the presence of intervention teams, and affect the implementation of programmes.

The crude mortality rate is the best indicator for assessing the severity of the situation and must be estimated in order to establish a baseline for evaluating the ongoing effectiveness of assistance programmes.[54] Data concerning the causes of death make it possible to identify the most common killer diseases. Disease patterns, and particularly the occurrence of diseases with epidemic potential, should be assessed; the information should cover diseases which may occur in the area of origin, the host area, and those currently present in the population. Early information on which diseases are present, or potentially present, makes it possible to undertake appropriate curative and preventive measures urgently. Vaccine coverage can be measured for measles vaccine, but it is rarely necessary to do this at the beginning of a programme, since mass measles immunization of children remains a priority even in a population known to have had a previous high coverage. In some cases, it may be useful to know the meningitis vaccine coverage.

The initial assessment is aimed at allowing decision-makers to decide whether or not to intervene, to identify intervention priorities,[55] to plan the implementation of these priorities and to pass on information to the international community and donors. The initial assessment should be undertaken by an independent and experienced team.[56] The first rapid assessment, which must be completed within three days, should use fast, simple straightforward methods to obtain information and result in a quick decision on whether to intervene or not, and the type and size of intervention.

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[54] *Ibid.*

[55] Mears C. and Chowdhury S. *Health Care for Refugees and Displaced People.* Oxford: OxfamPractical Health Guide No. 9, 1994. P. 63.

[56] Scrimshaw, S. and Hurtado, E. *Rapid Assessment Procedures for Nutrition and Primary Health Care.* Tokyo: United Nations University, UNICEF, UCLA Latin America Centre, 1987.

Measles remains a major cause of childhood mortality throughout the world, especially in developing countries. However, the disease can be prevented by the administration of measles vaccine, which is one of the most cost-effective public health tools.[57] Measles immunization has been included in the Expanded Programme on Immunization and has significantly contributed to reducing both measles morbidity and mortality in most countries.[58]

The major objective of mass measles immunization is to prevent measles outbreaks. If a measles outbreak occurs before mass immunization has taken place, the objectives are to reduce the number of cases and help prevent measles deaths; it should be remembered that, even among already exposed individuals, measles vaccine may reduce the severity of the disease if administered within 3 days of exposure.[59]

### 5.1.2PREVENTIVE MEDICINE

Measles is one of the most serious health problems met in refugee situations and has been reported as the leading cause of death in children in several refugee emergencies. Outbreaks of measles are frequent, especially in camp settings. An important risk factor for measles transmission is overcrowding.[60]WHO has included refugee children among the groups at high risk from measles.[61] The major objective of mass measles immunization is to prevent measles outbreaks. To achieve this, it is necessary to aim for a vaccination coverage level close to 90-100% in the age group from 6 months to 12 or15 years. If a measles outbreak occurs before mass immunization

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[57]WHO. *Measles control in the 1990s: revised plan of action for global measles control.* Geneva: WHO, 1994. WHO/EPI/GEN/94.2.

[58] Expanded programme on immunization: accelerated measles strategies. Wkly Epidemiol Rec, 1994, 69(31): p229-34.

[59] WHO. *Efficacy of Measles Immunization Shortly After Exposure in Preventing Disease Transmission.* Geneva: WHO, 1989. EPI/RD/PROTOCOL/89.1.

[60]Steketee, R W. and Waldman, R J. Measles prevention and control in emergency settings. *Bull WHO*, 1989, 67(4): 381

[61]Strassbourg, M. and Torel, C. The Epidemiology of Measles.*World Health Stat Q*, 1992, 45(2-3): pp285-91.

has taken place, the objectives are to reduce the number of cases and help prevent measles deaths; it should be remembered that, even among already exposed individuals, measles vaccine may reduce the severity of the disease if administered within 3 days of exposure.[62]

VACCINE USEFULNESS

A study of vaccine efficiency should be undertaken if vaccine failures are suspected for instance, if a measles outbreak should occur or continue, despite a high level of vaccination coverage, and in the absence of any significant population movement. The study should assess the field vaccine efficacy, i.e. the vaccine efficacy under field conditions, and compare it to the theoretical vaccine efficacy of 85% when administered at 9 months of age. If the field vaccine efficacy is well below the theoretical one, possible causes should be investigated inadequate cold chain, poorly respected vaccine schedule etc.

Mass immunization against measles is always one of the top priorities in the initial phase of a refugee influx, even if no cases are reported or refugees are coming from areas with a high level of vaccination coverage. An evaluation of the vaccination programme, based on routinely collected data, should be carried out. A vaccination coverage survey does not have to be undertaken systematically after each campaign this is only necessary when the accuracy of the results is questionable.

### 5.1.3WATER AND SANITATION

Water and the environment play an essential role in the spread of many communicable diseases and epidemics. Diarrhoeal diseases, mostly caused

[62] WHO. *Efficacy of measles immunization shortly after exposure in preventing diseasetransmission.* Geneva: WHO, 1989. EPI/RD/PROTOCOL/89.1.

by poor hygiene and a lack of safe water, are a major cause of morbidity and mortality among refugee and displaced populations. Large-scale and severe outbreaks have occurred frequently, particularly in the initial phase of a refugee crisis situation.

The goal of a water, hygiene and sanitation programme is therefore to plan for and maintain a minimum risk threshold in regard to water and environment related morbidity and mortality. Such a programme must be considered as an integral part of preventive health activities in the same way as measles immunization.

In the emergency phase

The water supply to the population, focusing on providing sufficient quantities of water; the quality should be improved as quickly as possible, but improvements must not affect the quantity actually distributed, Increasing public awareness of the basic rules of hygiene.[63]

Like any other population, refugees require immediate access to an adequate water supply in order to maintain life and health and this becomes even more vital in refugee camps where overcrowding increases the risks of pollution and epidemics of water-borne diseases. Attention must therefore be paid to water provision from the outset of any attempt to deal with a refugee emergency.[64] It is essential that water is supplied in sufficient quantities. Extreme water shortages can lead to dehydration and death.[65]

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[63]Moren, A. and Stefanaggi, S. Practical field epidemiology to investigate a cholera outbreakin a Mozambican refugee camp in Malawi, 1988. *J Trop Med Hyg*, 1991, 94: 1-7.
[64] UNHCR. *Water manual for refugee situations.* Geneva: UNHCR, 1992.
[65] Cairncross, S, and Feachem, R. G. *Environmental health engineering in the tropics: Anintroductory text.* John Wiley, 1993.

### 5.1.4 CHILD HEALTH CARE

The normal conditions of a refugee camp mean that children in the under-five age group are more at risk of developing health problems, and therefore under five mortality rates may be very high. Services targeted at children should aim at preventing illness and nutritional deficiencies, and ensuring early diagnosis and adequate treatment for health and nutritional problems. The under-fives should be targeted for most preventive activities[66] and children up to 15 for curative activities. Every possible means should be employed to ensure that these target groups are reached.

It is essential to detect children with nutritional problems early on as malnutrition is a major cause of mortality among children. For screening purposes, it is recommended to use the mid-upper arm circumference measure, which is a quick way of identifying children at risk. Referral to feeding programmes must be organized in line with Mid-Upper Arm Circumferences cut-off points and the criteria selected.[67] The time and resources devoted to malnutrition screening will depend on the degree to which malnutrition is a cause of mortality.

### 5.1.5 HIV and AIDS

It is important to recognize that from an epidemiological point of view, no study has indicated that refugee have a higher risk of contracting AIDS, and no specific measure, discriminatory or otherwise is justified in relation to them1. On another side, there is obviously no evidence that refugees are at a lower risk than others of AIDS and all efforts should be undertaken to decrease the risk of HIV transmission.

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[66] Simmonds, S. and Vaughan, P. *Refugee community health care.* Oxford: Oxford University Press, 1983.

[67] Médecins sans Frontières. *Nutrition Guidelines.* Paris: Médecins sans Frontières,1995.

It is essential that the strategies of HIV prevention are adapted to the particular[68] situation. one agency decided to make condoms more available and accessible to the refugees by distributing them through 'non-traditional' outlets such as shops, boutiques, and social events this strategy was selected because AIDS awareness among the population was already very high, and there was already a demand for condoms.[69] A large part of the morbidity and mortality linked with AIDS is due to infections for which specific, and effective treatment is possible, even when only limited means are available. Appropriate treatment of the most common infectious complications results in a significant reduction in the suffering of these patients and may lengthen their lives. Such treatment should be provided as soon as health services are in place, as part of normal curative care.

The aim of emergency response is to provide protection and ensure that the necessary assistance reaches people in time. The country of asylum is responsible for the safety of, assistance to, and law and order among refugees on its territory. Governments often rely on the international community to help share the financial burden, UNHCR provides assistance to refugees at the request of governments.

[68]WHO. *Guidelines for the nursing management of people infected with human immunodeficiency virus (HIV)*. Geneva: WHO, 1988. WHO AIDS Series, 3.
[69] A first AIDS work with refugees. *AIDS Analysis Africa*, 1995, 5(1): p10-11.

## CHPTER-VI

## REFUGEE IN INDIA

India is neither party to the 1951 Convention on Refugees nor the 1967 Protocol. The lack of specific refugee legislation in India has led the government to adopt an ad hoc approach to different refugee influxes. The status of refugees in India is governed mainly by political and administrative decisions rather than any codified model of conduct. The ad hoc nature of the Government's approach has led to varying treatment of different refugee groups. Some groups are granted a full range of benefits including legal residence and the ability to be legally employed, whilst others are criminalized and denied access to basic social resources.

The legal status of refugees in India is governed mainly by the Foreigners Act 1946 and the Citizenship Act 1955. These Acts do not distinguish refugees fleeing persecution from other foreigners; they apply to all non-citizens equally[70]. Under the Acts it is a criminal offence to be without valid travel or residence documents. These provisions render refugees liable to deportation and detention. The United Nations High Commissioner for Refugees (UNHCR) is based in New Delhi. Once recognized, Afghan, Burmese, Palestinian and Somali refugees receive protection from the UNHCR.

### 6.1TIBETAN REFUGEES IN INDIA

China continued to commit human rights violations in Tibet despite pleas from the Dalai Lama and his government. The efforts of the Dalai Lama to

[70] Human Rights Law Network, *Report of Refugee Populations in India* (2007) <www.hrln.org/admin/issue/subpdf/Refugee_populations_in_India.pdf> accessed on 22nd may 2014.

find a peaceful solution to the ongoing violence proved futile and his personal security was threatened. Calls for help to the international community went unheeded and the Dalai Lama was forced to flee. His flight was followed by an exodus of Tibetan people unable to live under Chinese oppression.

## 6.2STATUS OF TIBETAN REFUGEE IN INDIA

India is not a signatory to the 1951 UN Refugee Convention and does not have national legislation regarding refugees. Although UNHCR is present in India, the government only permits access to refugees living in urban centres and does not formally recognize UNHCR's grants of refugee status. India, however, is a member of the UNHCR Executive Committee and responds to refugee groups through administrative decrees on a case-by-case basis, primarily depending upon their nationality.[71]

The Indian government has yet, tried to make up for the country's non-signatory status regarding the UN Refugee Convention by taking certain political decisions. As early as 1953 the Prime Minister, Jawaharlal Nehru, informed Parliament that India would abide by international standards governing asylum for refugees by adopting similar, non-binding domestic policies. Since then, the Indian government has consistently affirmed the right of the state to grant asylum on humanitarian grounds. Based on this policy, India has granted asylum and refugee status to Tibetans.[72]

A number of Indian court rulings have advanced the protection of refugees whom the government had considered to be economic migrants.[73] In 1996 the Supreme Court of India declared that the Indian Constitution's

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[71] See Bhairav Acharya, *TheLaw, Policy and Practice of Refugee Protection in India*, <http://www.indlaw.com/publicdata/articles/pilsarc04.pdf.> accessed on 22nd may 2014

[72] South Asia Human Rights Documentation Centre, *Refugee Protection in India* (October 1997), http://www. hrdc.net/sahrdc/resources/refugee_protection.htm. accessed on 22nd may 2014.

[73]Maitra, R. 'Nepal Bows to China's Demands', *Asia Times* Hong Kong, 2003, http://www.atimes.com/atimes/South_Asia/EF17Df04.html. (accessed on 23rd may 2014).

guarantees of life and personal liberty protected refugees from refoulement. Delivering its judgment in the case of the National Human Rights Commission versus the State of Arunachal Pradesh, which resulted from the agitation of the All Arunachal Pradesh Students' Union against the settlement of Chakma refugees, the court provided a liberal interpretation of the law to suggest that refugees are a class apart from foreigners deserving of the protection of Article 21 of the Constitution.[74]

The court ruled that "We are a country governed by the Rule of Law. Our Constitution confers certain rights on every human being and certain other rights on citizens. Every person is entitled to equality before the law and equal protection of the laws. So also, no person can be deprived of his life or personal liberty except according to procedure established by law. Thus the State is bound to protect the life and liberty of every human being, be he a citizen or otherwise, and it cannot permit anybody or group of persons. Tibetans do not enjoy the same rights as Indian citizens, such as formal participation in Indian politics or the ability to carry a legal Indian passport, but they are free to work and own property in India.

### 6.3HEALTH SERVICES

The Department of Health was created in 1981 by the Central Tibetan Administration, with the mandate to improve the health of Tibetan refugees through the establishment of medical centres that provide both treatment and preventative services and through the development of "a comprehensive health care system" serving Tibetan exiles in Nepal and Bhutan, as well as India.[75] The Health Department based in Dharamsala is registered under the

[74]Article 21 of the Indian Constitution guarantees protection of life and personal liberty. The article reads:"No person shall be deprived of his life or personal liberty except according to procedure established by law."
[75] Central Tibetan Administration, <http://www.tibet.net> accessed on 23rd may 2014.

Indian Society Registration Act[76] as a charitable organisation and is known as the Tibetan Voluntary Health Association. The department does not have a fixed budget but depends on fundraising. Donors include such institutions as the American Himalayan Foundation[77] and the Tibet Relief Fund.

The Department of Health also manages programmes such as the Mother and Child Health Program,[78]the Disease Control Program and the "Tibetan Torture Survivors Program".

## 6.4TIBETAN MEDICARE SYSTEM

Now in the settlements, clinics and hospitals admit Tibetans living in India whether they have a Green Book or not as well as Indian citizens. Services at these clinics and hospitals are not generally free. However, they are cheaper than services offered by Indian hospitals, and the poorest people do not have to pay.

The Central Tibetan Administration Health Department launched a new programme known as the "Tibetan Medicare System on April 2012,[79] offering secondary and tertiary health-care coverage aimed at providing "financial assistance to poor Tibetan families as well as to provide proper medical care to those in need of urgent medical attention.[80] The system, based on a

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[76] The Societies Registration Act (Act XXI of 1860), 21 May 1860, An Act for the Registration of Literary, Scientific and Charitable Societies,<http://www.usig.org/countryinfo/laws/India/India%20Societies%20Registration%20Act.pdf > accessed on 23rd may 2014.

[77] *see* http://www.himalayan-foundation.org

[78] Goldstein, M.C., Jiao, B., Beall, C.M. Tibetan Fertility Transitions in China and South Asia. *Population and Development Review,* 31:2(2005), 337–348. CTA Department of Health. *Mother and Child Health program,*<http://tibet.net/health/programs/mother-and-child-heatlh-progrm> accessed on 23rd may 2014.

[79] Micro Insurance Academy. *Project Title: Setting up a holistic Tibetan Medicare System for the Tibetan population in India,* <http://www.microinsuranceacademy.org/content/setting-holistic-tibetan-medicare-system-tms-tibetan-population-india> accessed on 23 rd may 2014.

[80] *Department of Health Launches Tibetan Medicare System*, 2 April 2012, <http://tibet.net/2012/04/02/department-of-health-launches-tibetan-medicare-system>accessed on 25th may 2014

public-private partnership, aims to provide equitable and comprehensive coverage on a yearly basis to serve the health-care needs of the entire Tibetan exile community. All Tibetans living in India are entitled to enroll.

## 6.5GENERAL MEDICAL INFRASTRUCTURE

Now the Central Tibetan Administration Department of Health manages 7 hospitals, 4 primary health centres and 31 clinics in refugee settlements across India. The number of health-care resources varies by settlement. For instance, at the Majnu ka Tilla settlement in New Delhi, there is a clinic with two full-time Tibetan nurses and a dental clinic, an Indian doctor visits two days a week.[81]

Tibetans can also be trained as Tibetan doctors in India. There is a medical school in Dharamsala, the *Tibetan Medical and Astrological Institute*, which has 15 branch offices in India.[82]To become a Tibetan doctor, one needs to follow a five-year course of study and then perform a one-year internship. Once the six-year programme is complete, the student is a qualified Tibetan doctor.[83]All Tibetan refugees in India own a medical booklet in which their medical history is recorded. Tibetans born in India receive their booklet at birth, and all vaccinations since birth are recorded in it. For Tibetans born in Tibet, the medical booklet is issued at the Reception Centre in Kathmandu.

The rights and services afforded to Tibetans arriving after the 1970s are scarce and indicative of a changing Indian policy arguably in an effort to preserve Sino-Indian relations. In 1963, the Indian government ceased to legally recognize arriving Tibetans as refugees. Tibetans are given more

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[81]http://tibet.net/health/programs/tibetan-medicare-system-tms.(Accessed on 25th may 2014).

[82]Tibetan Medicine and Astrological Institute. *Medicine Courses*,<http://www.men-tsee-khang.org/college/course/med-course/medcollege.htm#6> accessed on 25th may 2014

[83]Pietkiewicz, I. *Culture, religion, and ethnomedicine: The Tibetan diaspora in India.* Lanham, Md.: University Press of America, 2008. Probst, A. and*Precious Pills: Medicine and social change amongst Tibetan refugees in India.* New York: Berghahn Books, 2008. P-86.

rights than most other refugee groups in India. They are provided with residence permits, which enable them to seek formal employment. They are the only refugee group to receive travel permits from the Indian government.

# CHAPTER-VII

# BARRIERS & CONCLUSION

## 7.1 BARRIERS IN REFUGEES HEALTH POLICY

The international human rights system largely has been constructed on the basis of concepts of state responsibility. Existing international mechanisms hold *States* accountable when they violate international norms. In the refugee context, however, this paradigm is of limited value, especially in terms of ensuring refugee women nondiscriminatory access to health care and other vital social services. The Guidelines on Sexual Violence are an important development in that they invoke local and international enforcement mechanisms for protecting refugee women against sexual violence, prosecuting the perpetrators, and, where necessary, holding States accountable. For too long, refugee women have been marginalized from these processes. The Guidelines on Sexual Violence also call upon UNHCR field staff to take measures to ensure their implementation. The model of enforcement is of limited value in ensuring the economic and social rights of refugee women.

UNHCR has made progress in creating policies, guidelines and other tools to protect refugee but has had difficulty translating these into practical measures in the field. While some senior managers are dedicated to the principles of the Guidelines and strive to implement them, the organization has yet to work them into standard operating procedures. The lack of female staff has been cited as a major barrier to the protection of refugee women and girls, yet the problem continues. The relative absence of female staff is a serious obstacle both to obtaining information from refugee women and girls and to addressing the protection issues they face.

Insufficient participation of refugee in decision-making is also a barrier to the full implementation of the Guidelines.

Lack of resources is another serious barrier to implementation of the Guidelines.HIV/AIDS is a challenge for UNHCR programs, health budgets is less for this purpose. Meanwhile, refugee women and girls are at risk of infection due to their limited power which makes them vulnerable to sexual violence and exploitation.HIV transmission from men to women is more likely; approximately 12 to 13 women become newly infected with HIV for every 10 men.[84]

## 7.2 CONCLUSION

The term refugee have wide consequences for the people concerned, specially regarding their rights to protection and assistance which are embedded in international law and under universal declaration of human rights and every states have the responsibility to protect their citizens, but some people believe that the international law of human rights is not really law at all but simply a set of noble aspirations describing an ideal world which has little relation to reality. Those who work with refugees may be particularly tempted to hold such a view, since the growing number of refugees in the world is apparent proof of the failure of the system of international human rights protection. If the governments of their country is no longer to protect the basic rights of the refugee, then the international community take steps in to ensure that those basic rights are respected. After the world war IInd , the United Nations general Assembly established the office of the united nations high commissioner for refugee. The high commissioner in the performance of

[84] UNHCR Policy on Refugee Women and Guidelines on Their Protection: An Assessment of Ten Years of Implementation, *An independent assessment by the Women's Commission for Refugee Women and Children*, 2002

his or her duty concerning refugee falling under the competence of the office. The work of the high commissioner is humanitarian, social and non-political character. The activities of the UNHCR are based upon a framework of International law and standards that includes the 1948 Universal declaration of human rights and the four Geneva conventions on international humanitarian law as well as a collection of international and regional treaties and declaration both binding and no-binding specially address the needs of refugees.

The convention relating to the status of refugees of 1951 sets out the principles upon which the regime of international protection for refugee is built. The convention is both a status and rights based instrument. Under the refugee convention, UNHCR is compelled to protect the any person who is owing the to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion. UNHCR seeks to ensure that those who qualify for refugee status are granted asylum and legal status.

The difficulties of enforcing international human rights law are similar to the difficulties of enforcing most branches of international law. Like many human rights treaties, the1951 Convention is not always honored by states parties but it continues to be of real help to countless numbers of individuals who rely on its provisions and UNHCR continues to maintain on respect for the principles it establishes.

Human rights standards can provide one framework to guide intergovernmental agencies and member states in the design and implementation of policies for promoting the health of refugee. While the Guidelines on the Protection of Refugee are impressive on paper, they have not been implemented effectively by field staff or by implementing partners. Some form of enforcement or monitoring mechanism is needed to ensure

that UNHCR's field staff and its implementing partners comply with UNHCR policies and operating procedures. But the country like India, it is not the state party to the 1951 convention relating to the status of refugee even then providing the good health facilities to the refugee. It all depends upon the country how to manage and what should provide to the refugee.

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