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Programme questions: evaluation

## Evaluation of the Office of the United Nations High Commissioner for Refugees

### Report of the Office of Internal Oversight Services

#### *Summary*

The Office of the United Nations High Commissioner for Refugees (UNHCR) implements public health programmes with a vision of ensuring that all refugees are able to fulfil their rights to have access to the following subsectors of public health: (a) primary and secondary health care; (b) HIV prevention, protection, care and treatment and reproductive health services; (c) food security and nutrition; and (d) water, sanitation and hygiene services. It works with partners, including host Governments, to ensure direct service provision and access to national health systems.

The global strategy for public health for the period 2014–2018 provided a good overarching framework for relevant operation programming, but gaps remained in relation to the integration of refugees into national health systems. The health needs of refugees were well understood, but funding gaps have compelled operations to adopt their own criteria for prioritizing or targeting their public health interventions, and planning beyond emergency phases was generally insufficient.

Most stakeholders rated UNHCR public health interventions as effective, although actual outcomes indicated a more mixed performance, with more successes in primary care. Most refugees were able to gain access to national health systems but faced critical barriers, in particular costs.

The coordination of service delivery and implementing partner management was mostly effective, but there were challenges relating to delays in the signing of agreements, the varied capacity of partners and coordination with United Nations

\* The dates for the substantive session are tentative.

\*\* E/AC.51/2019/1.



agencies. The inclusion<sup>1</sup> approach has necessitated increased partnerships with Governments and development actors to strengthen health systems.

Insufficient integration across public health subsectors and between public health and the protection, education and shelter sectors and inadequate global monitoring of health outcomes presented challenges for the effective and efficient delivery of public health programmes. Public health staff felt that health was not seen as part of the core protection mandate of UNHCR within the agency.

The Office of Internal Oversight Services makes five important recommendations to UNHCR:

- (a) Include stronger emphasis on shifting towards more sustainable, inclusion-based support for health systems in the next public health strategy;
- (b) Plan in a forward-looking and strategic manner at the operation level, with public health mainstreamed into operation-wide planning;
- (c) Improve monitoring of out-of-camp health outcomes, including by using data for strategic decisions;
- (d) Enhance partner-specific, concrete follow-up mechanisms to address potential overlaps and/or gaps with United Nations and other operational partners and implement the lessons learned from the multi-year, multi-partner pilot;
- (e) Enhance multisectoral links by emphasizing them in the next public health strategy and by demonstrating and documenting successful models of integrated programming.

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<sup>1</sup> In the present report, “inclusion” and “integration” are used interchangeably to describe access to national health systems.

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## I. Introduction and objective

1. The Inspection and Evaluation Division of the Office of Internal Oversight Services (OIOS) identified the Office of the United Nations High Commissioner for Refugees (UNHCR) for evaluation on the basis of a risk assessment designed to identify Secretariat programme evaluation priorities. The Committee for Programme and Coordination selected the evaluation of UNHCR for consideration at its fifty-ninth session, to be held in June 2019 (A/72/16, para. 95). The General Assembly endorsed the selection in its resolution 72/9.

2. The general frame of reference for OIOS is set out in General Assembly resolutions 48/218 B, 54/244 and 59/272, as well as the Secretary-General's bulletin on the establishment of OIOS (ST/SGB/273). Evaluation by OIOS is stipulated in the Regulations and Rules Governing Programme Planning, the Programme Aspects of the Budget, the Monitoring of Implementation and the Methods of Evaluation (ST/SGB/2018/3, regulation 7.1).

3. The overall objective of the evaluation was to determine, as systematically and objectively as possible, the relevance, effectiveness and efficiency of UNHCR public health interventions for refugees and asylum seekers in the period from 2014 to 2018. The evaluation topic emerged from a programme-level risk assessment described in the evaluation inception paper (IED-18-009 of 24 July 2018). The evaluation was conducted in conformity with the norms and standards for evaluation in the United Nations system, as issued by the United Nations Evaluation Group.

4. The comments of UNHCR management were sought on the draft report and taken into account in the final report. The formal UNHCR response is included in the annex to the present report.

## II. Background

### Mandate

5. The primary objective of UNHCR is to ensure international protection to refugees and others of concern and to seek permanent solutions to their problems in cooperation with States and other organizations, including through the provision of humanitarian assistance. The primary instruments governing the rights of refugees and the legal framework underpinning the work of UNHCR are the statute of the Office of the High Commissioner, the Convention relating to the Status of Refugees of 1951 and the 1967 Protocol thereto, with 146 and 147 State parties, respectively, and, where relevant, regional instruments.

6. By mid-2018, the number of refugees under the mandate of UNHCR was 20.2 million.<sup>2</sup> Approximately 69 per cent of refugees live outside camp settings.<sup>3</sup>

### Resources

7. The comprehensive budget (operations plan) of UNHCR represents the amount of funding required to fully implement programmes according to the needs of its populations of concern, as identified through an annual global needs assessment. The comprehensive budget for 2018 was \$8.3 billion as at 30 June 2018 (see A/AC.96/1180). In 2018, regular budget contributions accounted for 0.5 per cent

<sup>2</sup> Office of the United Nations High Commissioner for Refugees (UNHCR), "Mid-year trends 2018", 21 February 2019.

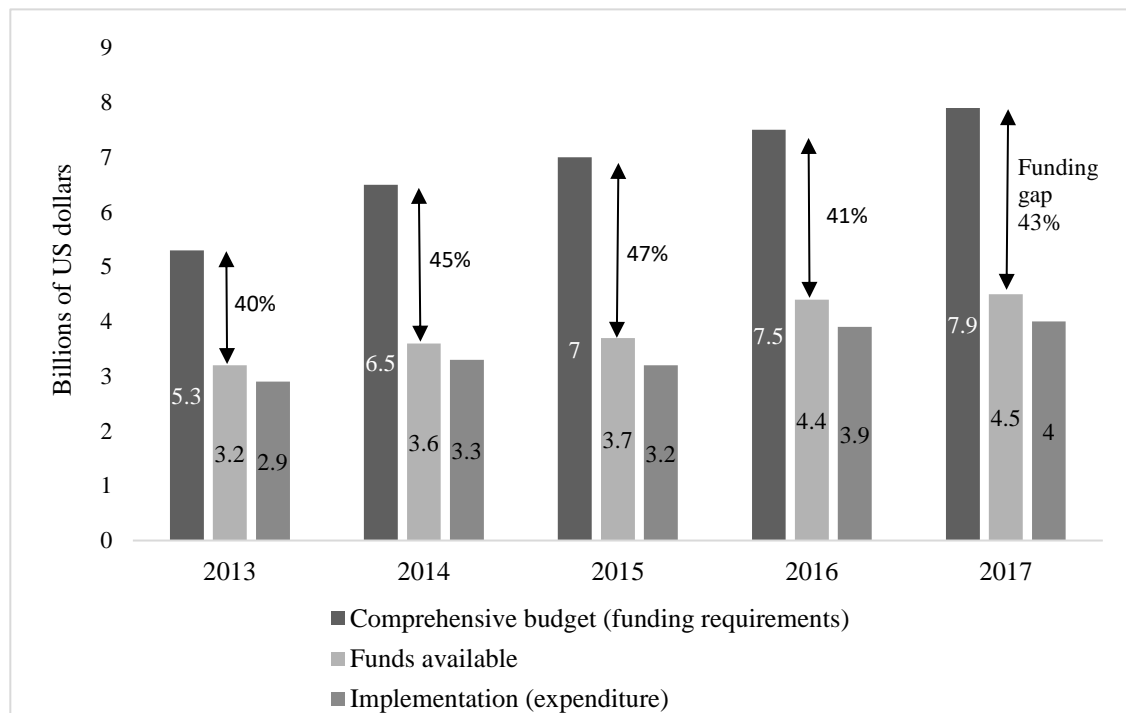
<sup>3</sup> UNHCR, "UNHCR diagnostic tool for alternatives to camps: 2017 global results".

of the total UNHCR funding requirements, with the remainder funded by voluntary contributions.

8. The funding requirements (operations plan) have routinely been only partially funded. The gap between the operations plan and funds available was 43 per cent in 2017. Implementation against funds available remained at about 90 per cent from 2013 to 2017 (see figure I).

Figure I  
**Comprehensive budget, funds available and expenditure, 2013–2017**

(Billions of United States dollars)



Source: [A/AC.96/1180](#).

### Leadership

9. UNHCR is headed by the High Commissioner, who is supported by a Deputy High Commissioner and two Assistant High Commissioners, and is governed by the General Assembly and the Economic and Social Council. The Executive Committee, comprising 101 States, meets annually and approves UNHCR programmes and budgets.

10. The headquarters of UNHCR are located in Geneva. The Executive Office and eight divisions constitute the main office and divisions of UNHCR. The five regional bureaux serve as a bridge between field offices and headquarters. UNHCR is present in 478 locations in 130 countries.<sup>4</sup>

### Public health programmes of the Office

11. In 2014, UNHCR launched the global strategy for public health for the period 2014–2018. Its vision is to ensure that all refugees are able to fulfil their rights to have access to four broad subsectors of public health: (a) primary and secondary

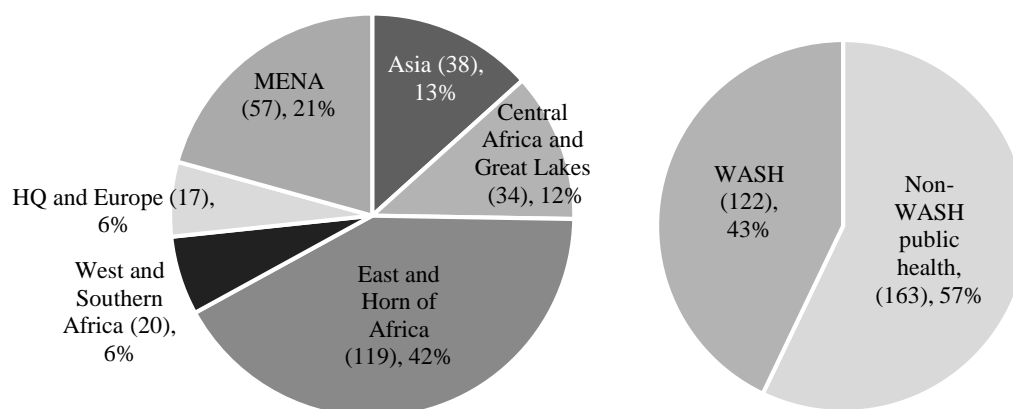
<sup>4</sup> UNHCR, *Global Report 2017* (Geneva, 2017).

health care;<sup>5</sup> (b) HIV prevention, protection, care and treatment and reproductive health services; (c) food security and nutrition; and (d) water, sanitation and hygiene services.<sup>6</sup>

12. The global strategy for public health is implemented by the regional bureaux and field operations, with ongoing support from the Public Health Section, headed by a Chief and located in the Division of Programme Support and Management. Public health programmes were supported by a total of 285 staff globally in 2018, comprising 2.5 per cent of all UNHCR staff, including 10 staff in the Public Health Section based at headquarters, 9 in regional bureaux and offices and the remaining 266 in 36 country operations (see figure II).

Figure II

**Public health staff of the Office, by region and subsector (285 staff)**



Source: UNHCR staff list received in October 2018.

Abbreviations: HQ, headquarters; MENA, Middle East and North Africa; WASH, water, sanitation and hygiene.

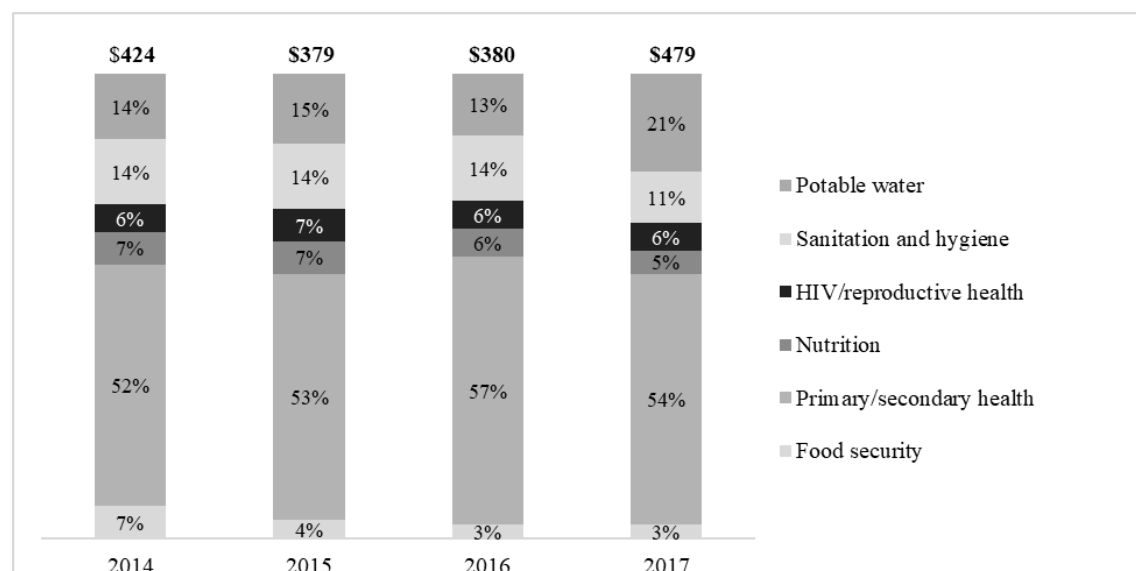
13. The total funding requirements (operations plan) for public health were \$898 million in 2017. Public health programmes accounted for 21 per cent of total UNHCR annual expenditure in 2014, 19 per cent in 2015, 17 per cent in 2016 and 20 per cent in 2017. A total of 62 country operations had a public health budget in 2017. Figure III shows the expenditure by subsector.

<sup>5</sup> Referred to in the global strategy for public health as “life-saving and essential health care”. The present report uses “primary and secondary health” instead of “public health” as a subsector, reserving the term “public health” to encompass all subsectors.

<sup>6</sup> UNHCR, *Global Strategy for Public Health: Public Health – HIV and Reproductive Health – Food Security and Nutrition – Water, Sanitation and Hygiene (WASH): a UNHCR Strategy 2014–2018* (Geneva, 2014).

Figure III  
**Public health expenditure for refugees and asylum seekers, by subsector, 2014–2017**

(Millions of United States dollars)



Source: UNHCR Global Focus Insight/Managing Systems, Resources and People.

Note: Figures do not reflect the full budget for food security with operational partners. Some costs for nutrition programming fall under primary and secondary health.

14. As shown in table 1, primary and secondary health activities were implemented by the most country operations, followed by water, sanitation and hygiene and HIV and reproductive health activities.

Table 1  
**Subsector coverage in country operations in 2017**

	Subsector					
	Primary/ secondary health	Water	Sanitation and hygiene	HIV/ reproductive health	Nutrition	Food security
Number of country operations with a subsector budget	62	35	34	31	27	26
Percentage of all country operations with a public health budget	100	57	56	51	44	43

Source: UNHCR Global Focus Insight, 2017 operating-level budget for refugee programming.

Note: Country operations include the regional office in Pretoria, which reported country activities in South Africa in 2017.

### III. Methodology

15. The evaluation used a mixed-method approach featuring the following data sources:

(a) Interviews: 87 semi-structured interviews with 108 UNHCR staff and partners in field locations and at headquarters;

(b) Focus group discussions: 14 discussions with 142 refugee community members (69 women and 73 men) in four operations;

(c) Surveys: a web-based survey of all UNHCR public health staff and a sample of non-public health staff (51 per cent response rate, 192 respondents)<sup>7</sup> and a web-based survey of implementing and operating partners (26 per cent response rate, 187 respondents);

(d) Case studies: four in-depth country case studies entailing on-site data collection (Cameroon, Jordan, Malaysia and Uganda) and two light-touch cases studies consisting primarily of desk reviews and limited interviews (Chad and Pakistan). All six country operations implemented primary and secondary health-care services and HIV and reproductive health activities, while water, sanitation and hygiene and nutrition were covered by four country operations and food security by two;

(e) Direct observations of camps, settlements, 11 health facilities, 5 water, sanitation and hygiene facilities, a staff training workshop and coordination meetings;

(f) Document reviews: country and regional strategies, global policies, public health annual reports, narrative reports from the Global Focus Insight system and audits;

(g) Secondary analysis of UNHCR monitoring data: the Health Information System, health access and utilization surveys, the Global Focus Insight system and the Managing Systems, Resources and People system.

16. The evaluation faced the following limitations:

(a) The lack of a globally comparable data set on public health outcomes, in particular the lack of data on health outcomes for out-of-camp refugees;

(b) A small sample size and low survey response rate for non-public health staff; consequently, only responses from public health staff were used in the evaluation results;

(c) Limited on-site data collection, which hindered the ability to draw generalized conclusions, in particular given the wide range of operational contexts and related public health interventions globally.

The OIOS Inspection and Evaluation Division mitigated these limitations by using a combination of global-level evidence from document reviews, available data sets and surveys, with case studies as illustrative examples.

17. The OIOS Inspection and Evaluation Division wishes to thank UNHCR, and in particular its focal points in the Public Health Section, for its cooperation throughout the evaluation.

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<sup>7</sup> Response rates were 62 per cent for public health staff and 12 per cent for non-public health staff.



## IV. Evaluation results

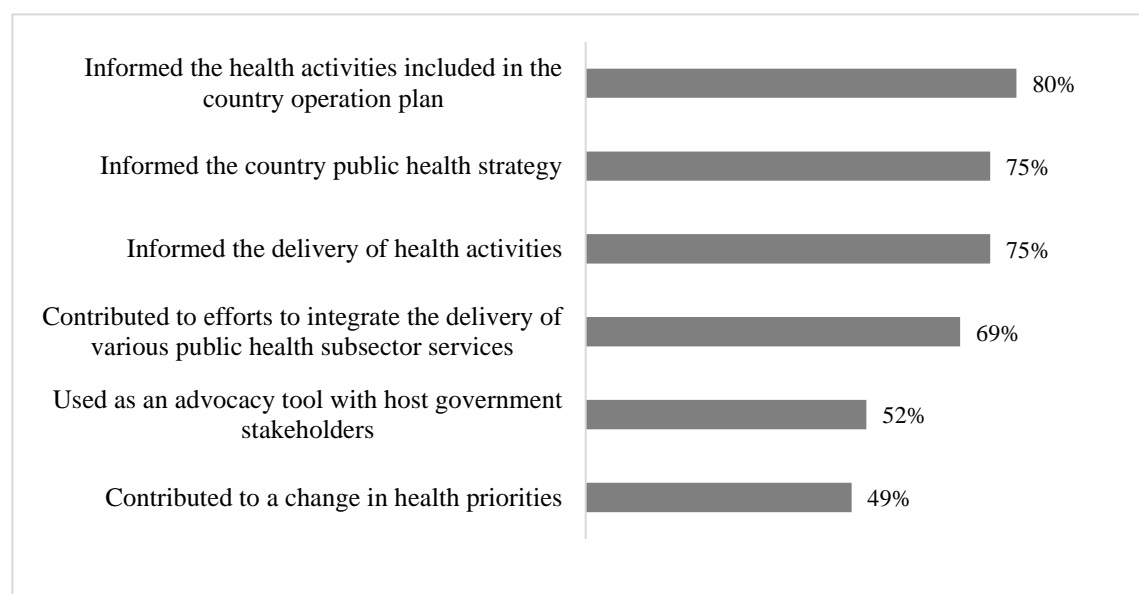
### A. The global strategy for public health for the period 2014–2018 provided a good overarching framework for relevant operation programming, but important gaps remained in relation to inclusion and longer-term planning

**Public health staff considered the strategy to be a useful guide with sufficient flexibility to allow adaptation to operational contexts, but the strategy contained some gaps and was less relevant to programming for integration into national health systems**

18. Nearly all public health staff surveyed (97 per cent) thought, strongly or somewhat strongly, that the global strategy for public health reflected an accurate understanding of the public health needs of refugees globally. A large majority (82 per cent) also reported that their offices had used the strategy to guide or inform health programming. Among them, most noted that the strategy had informed the health activities included in the country operation plans, the country public health strategies and the delivery of health activities. About half reported that the strategy had been used as an advocacy tool with host government stakeholders or that the strategy had contributed to a change in health priorities (see figure IV).

Figure IV

**Contributions of the global strategy for public health for the period 2014–2018 to public health programming at the national and subnational levels (115 staff)**



Source: OIOS survey of UNHCR public health staff.

19. Public health staff interviewed in case study countries thought that the strategy provided country operations with a good framework and the flexibility to allow necessary local adaptation. Public health programming in these operations was guided broadly by the strategic objectives of the strategy, while also reflecting the specific needs and contexts of refugees, and was aligned with the strategic direction of the broader country strategy, where available.

20. However, the global strategy for public health contained significant gaps in terms of guiding health programming on the integration of refugees into national

systems. While integration an objective of the strategy, many of the other objectives and indicators were of little relevance to settings in which refugees have access to local health services owing to the limited ability to monitor them. In many operations, including all case study countries, no disaggregated health data for refugees were available from national health institutions. Furthermore, the strategy did not clarify the role of UNHCR public health programmes in relation to other actors, including the World Health Organization and development agencies, in supporting the host Government with integration programming. The delivery of essential refugee services through national systems, supported by international assistance to strengthen them for both host communities and refugees, has been increasingly recognized as a core element of refugee response, accelerated by the adoption of the comprehensive refugee response framework as part of the New York Declaration for Refugees and Migrants of 2016. To date, the framework has been rolled out in 15 countries, including Uganda, where staff noted that it had served as a primary instrument to guide health programming. Other operations, such as Cameroon and Jordan, have also supported the strengthening of national health systems as part of their health programming without a formal framework or global strategy. In addition, staff interviewed noted that mental health and cash-based interventions beyond food security should be accorded greater prominence in the strategy.

21. There was significant variation in the presence and comprehensiveness of formal public health strategies at the country and regional levels, indicating a lack of a systematic approach to strategic planning at the operation level. Of the 62 operations with public health activities, 10 had country-level strategies in place in 2017, while three regional strategies covered an additional 12 countries and Europe, covering 36 per cent of the total refugee population. The levels of guidance and subsector coverage in the strategies varied.

#### **Needs were well understood through multisectoral participatory assessments and other mechanisms and tools**

22. UNHCR country operations regularly conducted multisectoral participatory needs assessments. Of the public health staff surveyed, 93 per cent reported that their operations had undertaken needs assessments during the past two to three years and 88 per cent said that refugee populations had been consulted during the assessments. Staff and partners interviewed noted positively the utility of these assessments and the inclusion of relevant stakeholders. Reviews of assessment reports confirmed the use of the UNHCR age, gender and diversity framework. The coverage of the public health needs of out-of-camp refugees in the assessments, however, varied across country operations. Of the staff who reported that their operations had undertaken needs assessments, 56 per cent thought that the public health programming at their respective locations was based on the assessments to a great extent and 42 per cent to some extent.

23. The public health needs of refugees were monitored more routinely through partner reports and regular meetings with refugee representatives, partners and staff from other sectors both in and outside camps. Staff highlighted data from standardized expanded nutrition surveys and knowledge, attitudes and practices surveys on water, sanitation and hygiene, used in 26 and 12 country operations, respectively, as key sources of information on needs.

24. In addition, seven country operations conducted health access and utilization surveys to supplement information on out-of-camp refugees. In Jordan and Malaysia, the findings of such surveys informed public health programming. For example, in the health sector humanitarian response strategy of Jordan for 2017–2018, explicit references were made to the findings of the survey. Community outreach, led by the community-based protection unit, also supported the assessment of the needs of out-

of-camp refugees in case study countries. Staff interviewed considered regular interaction with refugee community leaders to be particularly critical to receiving feedback and to reaching out to those in non-camp settings. However, this approach depended largely on the existence of refugee community structures. For example, in Malaysia, where there were few such structures, the operation struggled to engage Rohingya refugees. Partners and staff interviewed in Cameroon also highlighted challenges in identifying the needs of populations spread across vast rural areas.

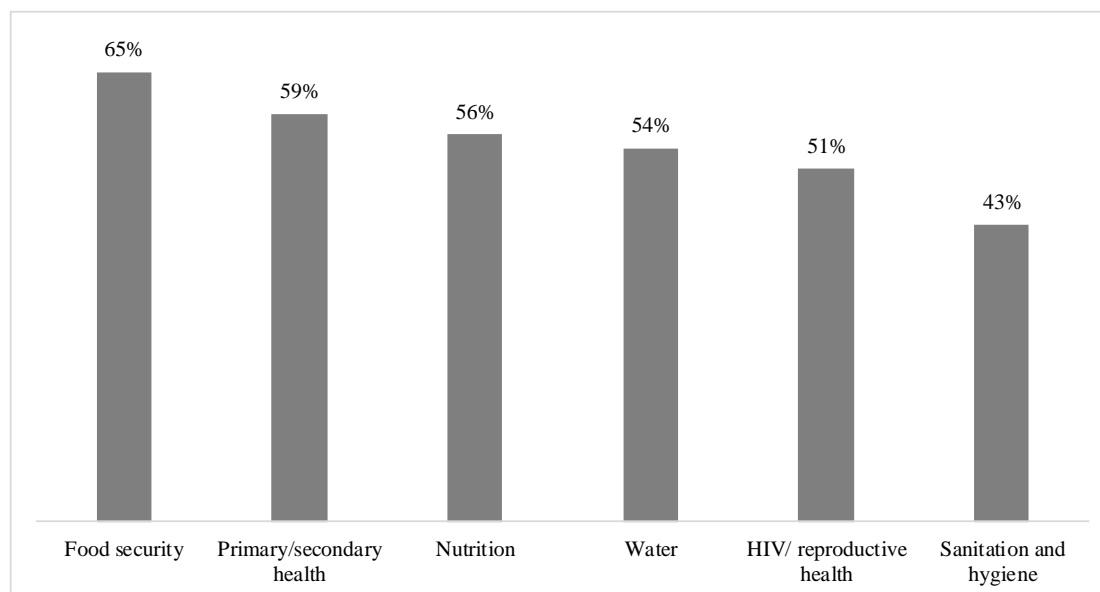
**The Office developed funding requirements on a needs basis, but the gap between requirements and funds available compelled country operations to adopt their own criteria for prioritizing or targeting their public health interventions**

25. As noted in section II, UNHCR develops annual comprehensive funding requirements (operations plan) on the basis of identified needs. A prioritized budget (operating level) is subsequently formulated on the basis of actual fund availability (see [A/AC.96/1180](#)).

26. For public health programming for refugees in 2017, the operating-level budget represented only 55 per cent of the funding requirements globally. By subsector, food security had the highest percentage of its funding requirements met at the beginning of the year (65 per cent), followed by primary and secondary health (59 per cent) (see figure V). Sanitation and hygiene had the lowest (43 per cent). However, since food security represented only 2.4 per cent of the overall operations plan budget (see figure VI), the prioritized budget for food security was small compared with other subsectors.

Figure V

**Percentage share of the prioritized budget (operating level) in comprehensive funding requirements (operations plan) for public health programming for refugees, by subsector, in 2017**

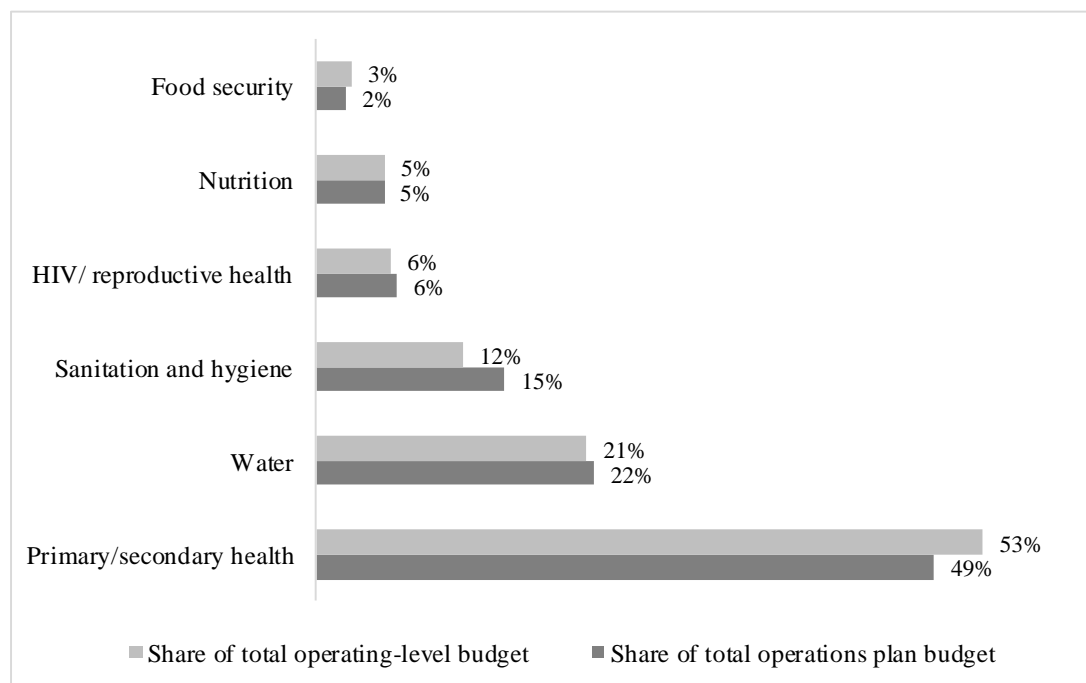


Source: UNHCR Global Focus Insight, 2017 operating-level budget and operations plan budget.

27. As shown in figure VI below, the share of primary and secondary health, making up 49 per cent of the overall operations plan budget, rose the most in the operating-level budget, to 53 per cent. The share of sanitation and hygiene decreased the most, from 15 per cent of the overall operations plan budget to only 12 per cent

in the operating-level budget. When allocating available funds, UNHCR may therefore have prioritized primary and secondary health over other subsectors, notably sanitation and hygiene, relative to the identified needs. Staff interviewed also noted that, at the operation level, management priorities often influenced the degree of engagement in each subsector.

Figure VI  
**Comprehensive funding requirements (operations plan) and prioritized budget (operating level) breakdowns, by subsector, in 2017**



Source: UNHCR Global Focus Insight, 2017 operating-level budget and operations plan budget.

28. The large funding gaps and funding earmarked by donors compelled country operations to target subpopulations or to prioritize interventions on the basis of their own criteria. For example, in Cameroon, where the percentage of funded needs decreased sharply, from 72 per cent in 2014 to 53 per cent 2017, the operation moved to a targeted approach by limiting its public health interventions to five categories: children under the age of 5, pregnant women, emergencies, chronic illnesses and the elderly. In focus group discussions, refugees expressed widespread dissatisfaction with the approach, and some staff and partners noted that socioeconomic factors were not taken into account in the targeting. In Jordan, the prioritized budget covered 79 per cent of the comprehensive funding requirements, but the gap represented close to \$7.4 million; interventions for urban Syrian refugees were prioritized on the basis of refugee vulnerabilities, which were assessed through the operation's existing multisectoral vulnerability assessment framework, and the criticality of intervention.

#### **Planning beyond emergency phases was generally insufficient**

29. Case studies indicated insufficient early planning for transitions beyond emergency phases, including the eventual handover of primary responsibilities for the delivery of public health services for refugees and support for national health systems. Transition planning often began only after an operation experienced funding cuts. The strategy of UNHCR in Pakistan of slowly disengaging from the delivery of health services and focusing on integration into the national system was prompted largely

by donor cutbacks and driven by the refugee-affected and hosting areas programme, initiated in 2009 by the Government of Pakistan, following more than 30 years of maintaining a parallel health system for refugee villages.<sup>8</sup> A shift away from direct delivery in Malaysia was also driven by funding reductions. The Internal Audit Division, in an audit conducted in 2016, found that only 2 out of 12 operations had calculated the cost of water, sanitation and hygiene activities for planning.<sup>9</sup> In Uganda, some stakeholders indicated that the transition from resource-intensive water trucking to a piped system had been delayed. The annual funding cycle was noted as a constraint on longer-term planning, but this was mitigated to some extent by longer-term approaches, such as the comprehensive refugee response framework. Cameroon began a multi-year, multi-partner strategy in 2018, although its focus on health was limited.

30. In case studies, the preparedness for often-inevitable funding decreases and partner departures as operations moved beyond emergency phases was found to be insufficient. In Jordan, the operation did not have a contingency plan for the looming departure of the operating partner leading water, sanitation and hygiene programmes in camps. In Uganda, water, sanitation and hygiene programmes were also hampered by a series of partner departures as funding began to decline, at times without proper handover of responsibilities, as confirmed during an observation of a camp-level coordination meeting. Furthermore, while the World Bank had been engaged in strengthening the public health systems in Cameroon, Jordan and Uganda, with UNHCR health programming shifting towards supporting integration in the latter two countries, there was little evidence of comprehensive planning for engaging development partners in a phased transition process globally.

## **B. While most stakeholders rated public health interventions of the Office as effective, actual public health outcomes indicated a more mixed performance, and refugees faced critical barriers to gaining access to national health systems**

### **Public health performance outcomes varied greatly by operation, subsector and population group, with more successes in primary care**

31. UNHCR public health performance was assessed positively for the most part by stakeholders, with 92 per cent of partners and 90 per cent of staff surveyed stating that they believed that health outcomes for refugees had significantly or somewhat improved during the reporting period. In three case studies, staff and partners interviewed reported that refugees in non-urban settings received better health care than host nationals, and government representatives in Cameroon and Uganda praised the emergency health response of UNHCR. However, most refugee participants in focus group discussions in the four country case studies expressed discontent about the quality and availability of the health care received in both urban and camps settings, citing reduced care owing to declining resources, a lack of speciality services, a shortage of drugs and food and stigmatization by some personnel.

32. Results were strongest in primary health care, which represented the largest proportion of UNHCR public health expenses (see table 2). Primary health care was rated good or excellent by 88 per cent of staff (see figure VII), and staff and partners believed it to be the subsector that is most aligned with the needs of refugees (see figure VIII). Several successes in primary health-care services over the period were

<sup>8</sup> UNHCR, "Refugee health strategy 2014–2018: Pakistan".

<sup>9</sup> Office of Internal Oversight Services (OIOS), Internal Audit Division, "Report 2016/027: audit of the arrangements for water, sanitation and hygiene programmes in the Office of the United Nations High Commissioner for Refugees", 28 March 2016.

illustrated in case studies. In Cameroon, the health facility utilization rate increased from 0.34 in 2013 to 1.04 in 2015, according to Health Information System data, together with an increase in the construction and rehabilitation of several health facilities. In Uganda, the mortality rate was reduced, and staff and partners interviewed rated outcomes positively. An analysis of camp-based Health Information System data from 18 operations showed that the average crude mortality rate of 0.25 in 2017 was significantly lower than the rate of 8.2 for host country nationals in the same sample.<sup>10</sup> In 2017, UNHCR and its partners successfully contributed to the management of multiple outbreaks, including outbreaks of cholera, malaria, measles and typhoid among refugees in several African countries and Bangladesh.<sup>11</sup>

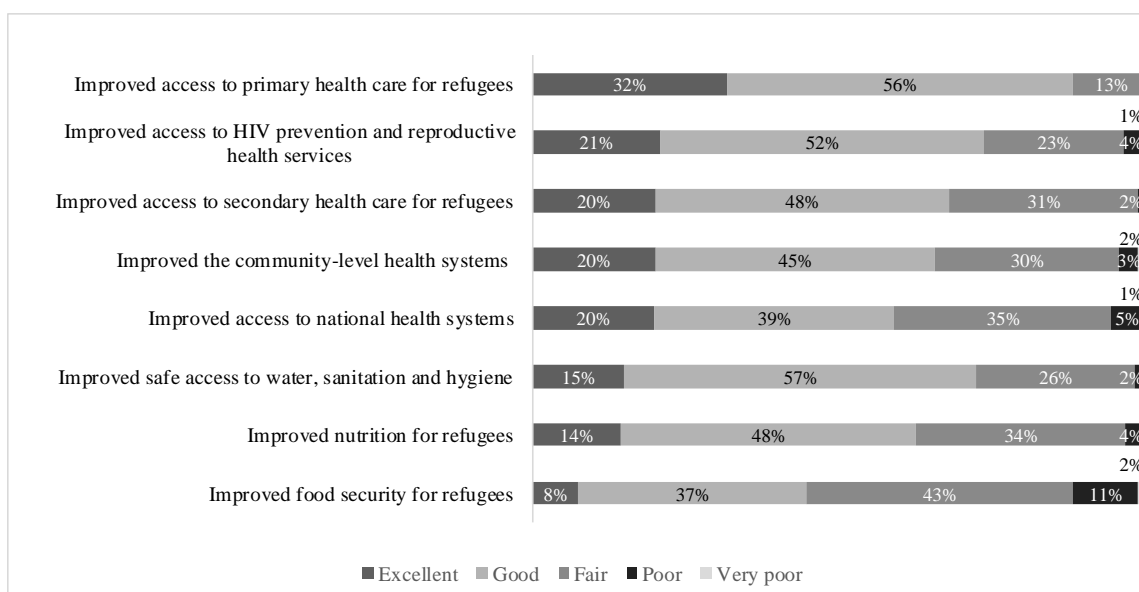
Table 2  
**Composition of public health expenses for refugees and asylum seekers**

(Percentage)

Subsector	2014	2015	2016	2017
Primary/secondary health care	52	53	57	54
Supply of water	14	15	13	21
Sanitation and hygiene	14	14	14	11
Nutrition	7	7	6	5
HIV/reproductive health	6	7	6	6
Food security	7	4	3	3

Source: UNHCR Global Focus Insight/Managing Systems, Resources and People.

Figure VII  
**Staff perceptions of the performance of the Office in public health outcomes, 2014–2018 (157 staff)**

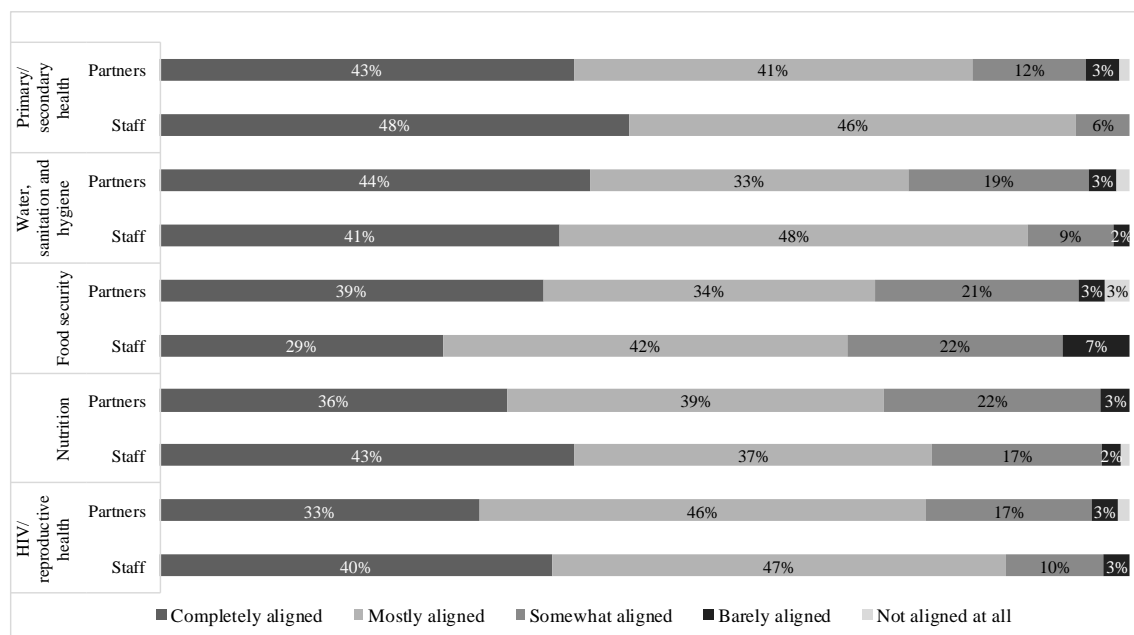


Source: OIOS survey of UNHCR public health staff.

<sup>10</sup> World Bank, “Death rate, crude (per 1,000 people)”, World Bank Open Data, data for 2016.

<sup>11</sup> UNHCR, “UNHCR public health: 2017 annual global overview”, 2018.

Figure VIII  
**Partner and staff perspectives on the alignment of public health activities with the needs of refugees (126 staff, 102 partners)**



Source: OIOS surveys of UNHCR public health staff and partners.

33. An analysis of health indicators for the 18 countries reporting to the Health Information System painted a more mixed picture of primary health outcomes. The under-5 mortality rate improved in 11 countries and worsened in 7, but the overall sample average deteriorated from 0.48 to 0.58 between 2014 and 2018.<sup>12</sup> In reproductive health, 14 of the 18 countries saw improvements in the proportion of births attended by skilled health workers. With regard to under-5 morbidity, UNHCR was able to manage several peaks over the period, such as with the outbreaks of malaria in Ethiopia in 2016 and watery diarrhoea in Cameroon in 2015, but was less effective in halting the continuous increase of under-5 morbidity since 2016, as a result, for example, of lower respiratory tract infections in Bangladesh or malaria in the Republic of Congo. Data on health outcomes for out-of-camp contexts were not available.

34. Secondary health care, often provided by national facilities, and referrals were found to be problematic in several country operations by numerous stakeholders interviewed. The cost of referrals, the distances and transport to referral hospitals and the gap between resources and needs were the most challenging factors, although the referral systems of 86 per cent of the countries covered by the Health Information System were governed by standard operating procedures in 2017.<sup>13</sup> Secondary health care was also the lowest rated area by staff survey respondents, with 44 per cent rating performance as good or excellent.

35. Refugee food security is supported through a joint approach with the World Food Programme (WFP) in accordance with a global memorandum of understanding of 2011, by which WFP is responsible for the provision of food assistance while both agencies conduct joint assessments, monitoring and analysis. Food security was deemed to be the subsector that is least aligned with the needs of refugees by both

<sup>12</sup> Comparisons may be affected by changes in contexts and improved mortality reporting.

<sup>13</sup> UNHCR public health annual reports.

partners and staff, which is reflective of the reduced funding and the concentration of funding on a limited number of operations. The resulting gaps were also reflected in the high number of complaints by refugees during focus group discussions.

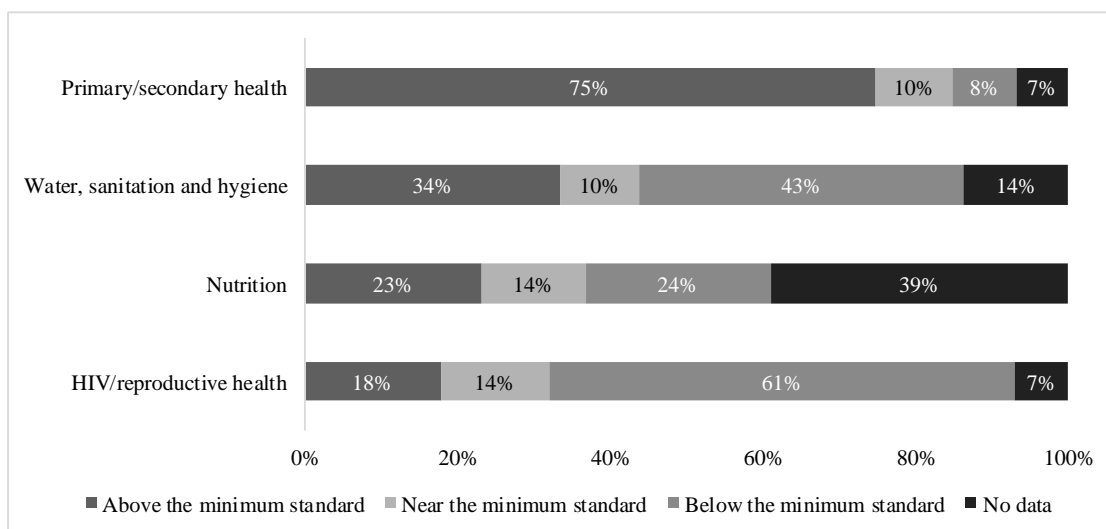
36. In 2017, the prevalence of global acute malnutrition improved at 8 out of 36 sites<sup>14</sup> in Djibouti, Ethiopia, Mauritania and South Sudan that had a high prevalence of malnutrition before 2017. The prevalence of stunting also improved in 14 per cent of the 36 sites. A secondary analysis of UNHCR data showed that 37 per cent of nutrition indicators for 22 countries between 2014 and 2017 were above or near the minimum standard (see figure IX).

37. The outcomes of the implementation of water, sanitation and hygiene activities were uneven. In 2017, while 100 per cent of sites in the Middle East and North Africa and Asia met the standards for litres per person per day, only 58 per cent of sites in Africa did so. For latrine construction, 100 per cent of sites in the Middle East and North Africa met the standards in 2017, compared with 92 per cent in Asia and 78 per cent in Africa.<sup>15</sup> Field visits highlighted unintended consequences of the planning and implementation of water, sanitation and hygiene services, such as communal latrines being vandalized in Jordan and a lack of space and the filling of waste pits in Cameroon.

38. Analysis of 13 indicators<sup>16</sup> in UNHCR public health annual reports<sup>17</sup> showed that primary health care was the most successful subsector in terms of meeting minimum standards and reproductive health the least successful (see figure IX), while there was a significant lack of data for nutrition. The percentages of indicators both meeting and below the minimum standards declined from 2014 to 2017, as shown in figure X.

Figure IX

**Percentage of public health minimum standards achieved, by subsector, 2014–2017, 22 countries**



Source: UNHCR public health annual reports, sample of 13 indicators.

<sup>14</sup> UNHCR, standardized expanded nutrition survey database, 2015–2017.

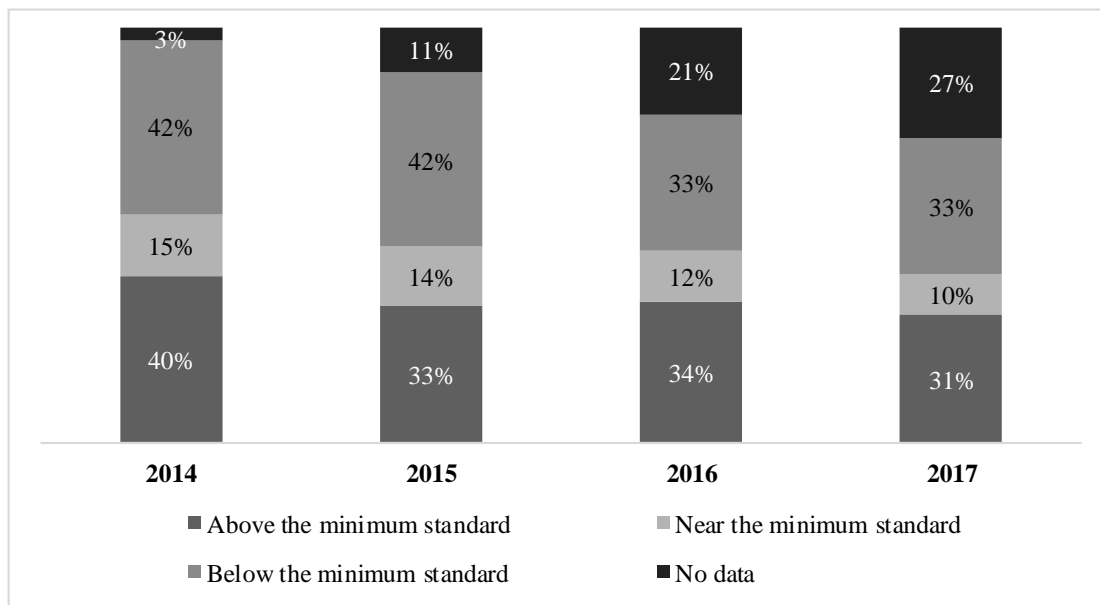
<sup>15</sup> UNHCR public health annual reports.

<sup>16</sup> Crude mortality rate; under-5 mortality rate; health utilization rate; antenatal care coverage; skilled birth attendance; postnatal care coverage; contraceptive prevalence rate; prevention of mother-to-child transmission; global acute malnutrition; severe acute malnutrition; stunting; average number of litres of water per person per day; and average number of persons per communal latrine.

<sup>17</sup> For the 22 countries for which there were data.



Figure X  
**Comparison of public health indicators against minimum standards per year, 2014–2017, 22 countries**



Source: UNHCR public health annual reports, sample of 13 indicators.

39. UNHCR performance also varied among different refugee population groups. While 73 per cent of staff believed that the needs of children were mostly or fully met, only 33 per cent said the same for persons with disabilities or lesbian, gay, bisexual, transgender and queer refugees. Interviewees and participants in focus group discussions also noted gaps in the identification of the needs of and programming for persons with disabilities. In case studies, disparities were also found in health-care coverage for Syrian and non-Syrian refugees in Jordan owing to government policies and earmarking by donors and among Central African refugees in Cameroon owing to the targeting of vulnerable groups.

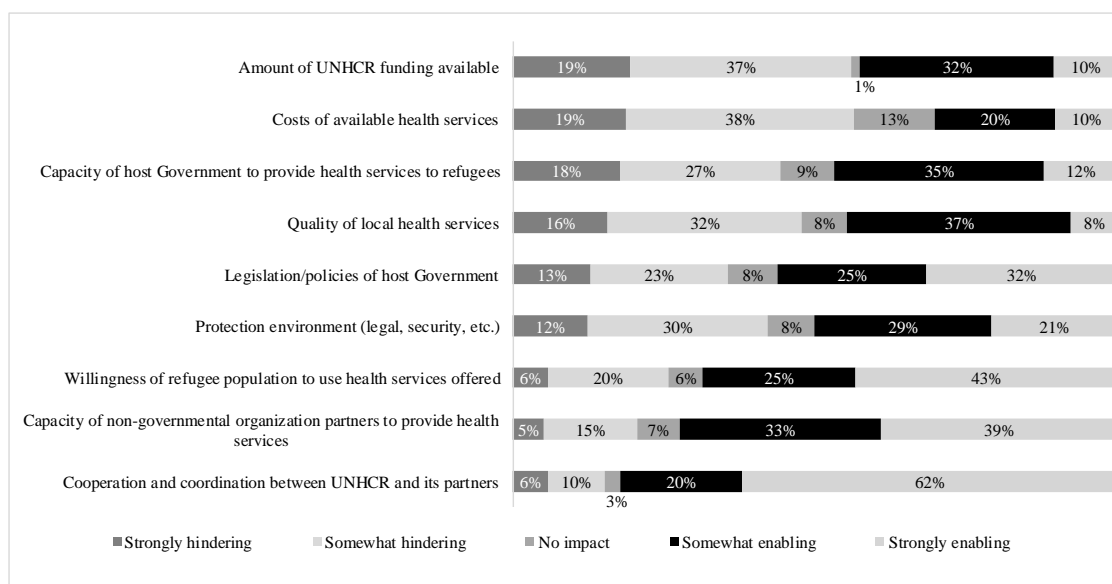
40. Various sources highlighted disparities between out-of-camp and in-camp settings. While 79 per cent of staff surveyed believed that the needs of in-camp settings were fully or mostly met, only 33 per cent expressed the same view for non-camp settings. The health access and utilization survey found that out-of-camp refugees faced challenges in gaining access to health services. In Iraq and Egypt, 50 and 42 per cent of refugees, respectively, knew that they had the right of access to free or subsidized health care. In Malaysia, 39 per cent of women had difficulty gaining access to antenatal care services, although 100 per cent had at least one antenatal visit in 2016. In Cameroon, nutrition for urban malnourished children screened through community activities was not covered by UNHCR services. In Chad, out-of-camp refugees used State facilities with inadequate personnel and equipment.

#### **Several internal and external factors contributed to the mixed performance of the Office in public health interventions**

41. Partners and staff rated cooperation and coordination between UNHCR and its partners and the capacity of partners to provide health services as the top two enabling factors (see figure XI). The support of senior management for programming and advocacy was a noted success factor in two operations visited. Stakeholders interviewed and staff survey respondents cited insufficient resources as the biggest

challenge. Resource constraints had an impact on service delivery in all case study countries, affecting equipment, supplies, staffing levels and staff living conditions, as corroborated by observations in Cameroon, Uganda and the United Republic of Tanzania,<sup>18</sup> leading to high workloads and turnover of partner staff. Stakeholders in two countries and partner survey respondents expressed serious concerns related to drug shortages and delays in international procurement.

Figure XI  
Perspectives of staff of the Office on hindering and enabling factors (159 staff)



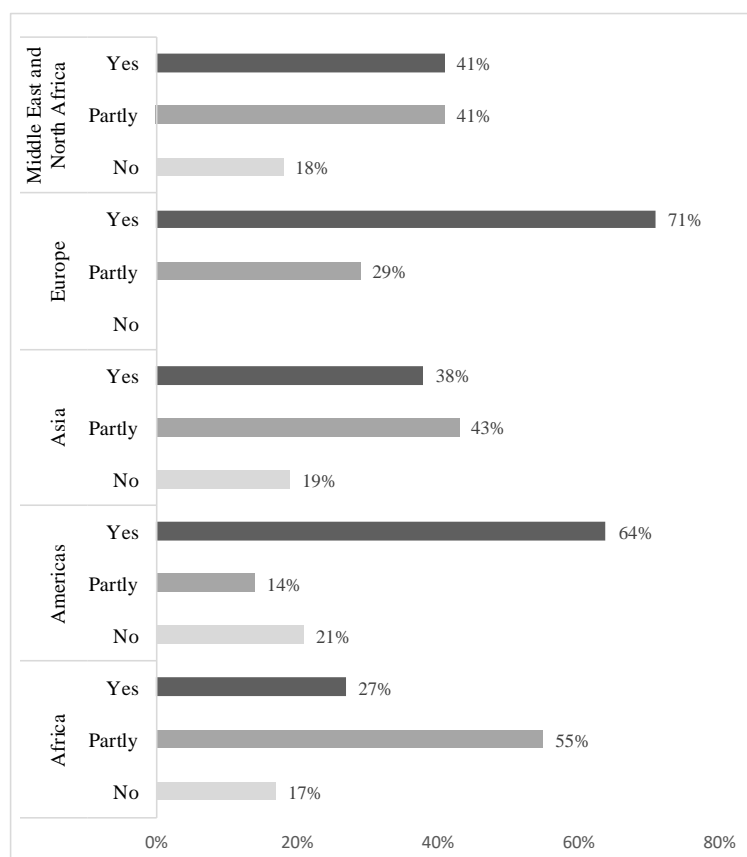
Source: OIOS survey of UNHCR public health staff.

### Overall, refugees had access to national health systems but still faced critical barriers

42. According to an inclusion assessment tool of UNHCR, refugees had the right of access to national health systems in 94 per cent of assessed countries, but barriers to access remained. An internal exercise conducted in 2017 covering 79 countries showed varying levels of integration by region (see figure XII). UNHCR employed different approaches to reduce the barriers. In Cameroon, UNHCR signed an agreement with the Ministry of Health in which the responsibility of the Government to allow access to national facilities was formally recognized and a 30 per cent discount on fees for refugees was provided. In 2018, UNHCR successfully negotiated with the Ministry of Health of Malaysia to extend the 50 per cent discount on the foreigner rate at public facilities to asylum seekers. In Uganda, strong collaboration with national and district authorities and the comprehensive refugee response framework ensured equal access for refugees to the national system and the inclusion of host communities in facilities in refugee settlements. In Jordan, a cost-effective programme to provide cash assistance for essential health services was created in response to the change in the government policy on coverage in 2015. In Pakistan, refugees had equal access to national health systems and UNHCR implemented a transition strategy to improve sustainability, with a focus on maternal and child health. Globally, 59 per cent of UNHCR public health staff rated the improvement of access to national health systems positively (see figure XIII).

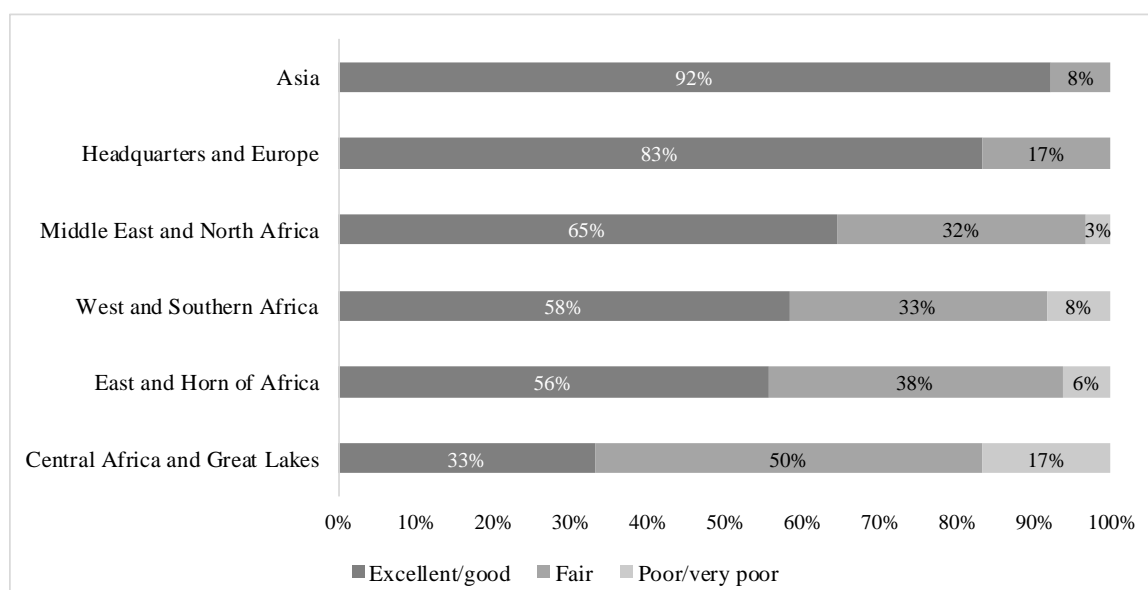
<sup>18</sup> The United Republic of Tanzania was observed by the OIOS-Internal Audit Division.

Figure XII  
Operations in which refugees are integrated into national health-care systems



Source: UNHCR, “UNHCR diagnostic tool for alternatives to camps: 2017 global results”.

Figure XIII  
Perspectives of staff of the Office on the improvement of access to national health systems, 2014–2018 (152 staff)

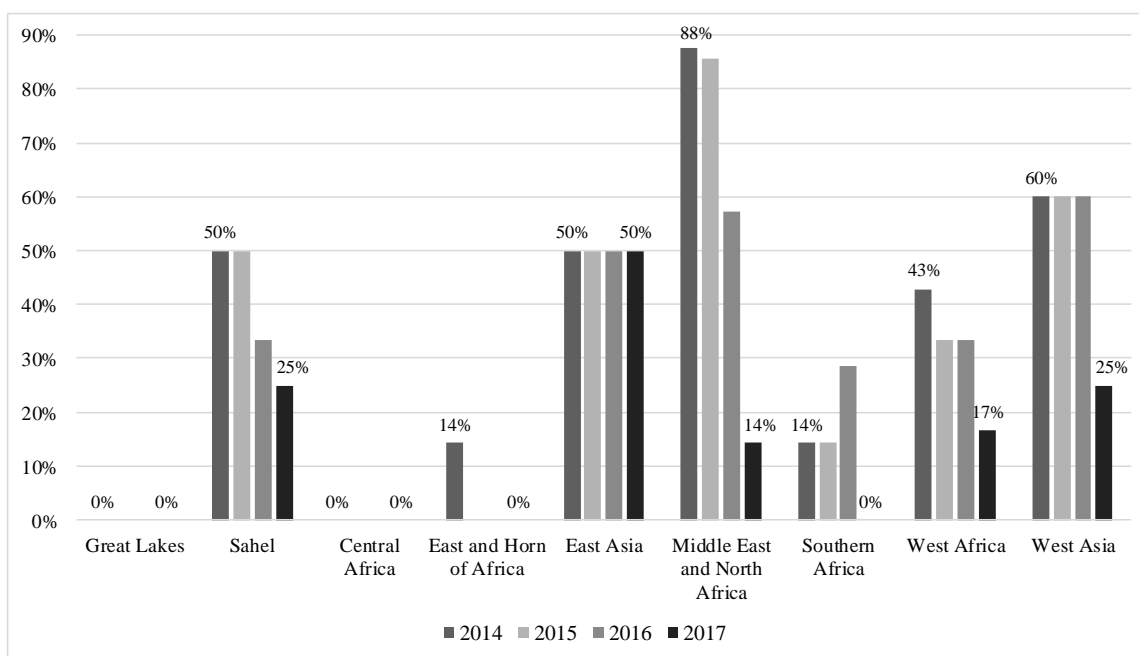


Source: OIOS survey of UNHCR public health staff.

43. UNHCR continued to face external limitations on inclusion, related primarily to the policies of host Governments, the state of national health systems and the cost of national health-care services available in country operations. In the staff survey, the legislation and policies of host Governments were deemed a hindering factor by 61 per cent of public health staff in the Middle East and North Africa but an enabling factor by 83 per cent of staff in West Africa. In Malaysia, stakeholders cited the challenging protection environment and the lack of legal documentation as key hindrances to access.<sup>19</sup> In Jordan, interviewees noted that, as a result of the ending by the Government of its subsidies for the health-care coverage of refugees in 2018, UNHCR had been required to adapt its eligibility criteria. Integration into weak national systems, such as in Chad,<sup>20</sup> presented an additional dilemma, as compromises had to be made on the quality of services as a result of inclusion policies, unless significant support was provided to the national system in refugee-hosting areas. Refugees themselves reported the same barriers across different countries, namely, the inability to pay for health care because of having no right to work, long distances to reach health facilities and cultural stigmatization. Figure XIV shows the impact of some of those barriers on access to reproductive health care.

Figure XIV

**Proportion of countries, per region, reporting that the access of refugees to maternal and newborn services is ensured on an equal basis to host nationals, 2014–2017**



Source: UNHCR public health annual reports.

44. To address cost barriers, UNHCR introduced health insurance schemes for refugees in 14 countries, 10 of which had multi-year plans. While several studies on community-based health insurance in low-income countries showed that health insurance coverage had a positive impact,<sup>21</sup> stakeholders in case study countries

<sup>19</sup> For more, see Fiona Leh Hoon Chuah and others, “The health needs and access barriers among refugees and asylum-seekers in Malaysia: a qualitative study”, *International Journal for Equity in Health*, vol. 17, No. 120 (2018).

<sup>20</sup> United Nations Office for the Coordination of Humanitarian Affairs, “Chad: humanitarian situation overview (August 2018)”, 9 August 2018.

<sup>21</sup> Paul Spiegel, Rebecca Chanis and Antonio Trujillo, “Innovative health financing for refugees”, *BMC Medicine*, vol. 16, No. 90 (2018).

mentioned challenges for refugees in transitioning from a free access model to paying premiums. In Malaysia, an insurance scheme became financially unsustainable owing to insufficient promotion and the lack of an enrolment grace period, as refugees enrolled just before bills were expected.<sup>22</sup> In December 2018, UNHCR and the International Labour Organization jointly reviewed the guidance note on health insurance schemes for refugees and other persons of concern to UNHCR, drawing from lessons learned over the past 10 years.

### **C. Partnerships and coordination have been critical to effective and efficient implementation and have been leveraged in some cases to address gaps and constraints**

#### **The management and monitoring of implementing partners were mostly positive, but there were challenges relating to delays in the signing of agreements and the varied capacity of partners**

45. UNHCR delivered public health services through implementing partners receiving funding from the Office. The engagement of implementing partners was governed by the Enhanced Framework for Implementing with Partners, detailed in which are the selection process, the signing of annual project partnership agreements and the monitoring of implementation. Stakeholders rated the management and monitoring by UNHCR of health implementing partners positively overall. Of the implementing partners surveyed, 77 per cent rated their partnership with UNHCR as good or excellent, and partners interviewed in operations, such as Cameroon and Uganda, rated their collaboration with UNHCR very positively. Partners and staff agreed that the reporting processes provided UNHCR with high-quality data on the operations of implementing partners (84 and 90 per cent, respectively).

46. However, a review of 24 audit reports from 2017 and 2018 on overall partner management showed that 67 per cent of operations had deficiencies in performance monitoring. A number of partners interviewed expressed frustration at the fact that delays in the signing of project partnership agreements affected implementation. Of the operations audited in 2017 and 2018, 42 per cent had delays in the signing of agreements, and 27 per cent of partners surveyed noted that the duration of the partner selection and onboarding process adversely affected the delivery of services. In Uganda, the involvement of the Government in the selection of implementing partners compromised the process, although steps were later taken to rectify this.<sup>23</sup>

47. Partner and staff interviews and field visits highlighted significant variation in the capacity and availability of partners. In addition to the staffing and equipment constraints noted in result B, shortcomings in organizational capacity were noted in Jordan and Malaysia, despite training provided by UNHCR. Of the implementing partners surveyed, 35 per cent were barely or not satisfied with the training opportunities provided by UNHCR, and the high staff turnover and the declining number of available organizations after emergency phases contributed to capacity challenges. The availability of international non-governmental organizations was in some cases affected by the laws of host Governments.

48. Case studies highlighted trade-offs between partner consolidation and diversification. In three operations, consolidation had reduced the management burden and allowed for greater responsibility of implementing partners for service delivery, consistent with the guidance in the global strategy for public health, whereas

<sup>22</sup> In 2017 and 2018, claim payments exceeded the premiums collected.

<sup>23</sup> OIOS, Internal Audit Division, "Report 2018/097: audit of the operations in Uganda for the Office of the United Nations High Commissioner for Refugees", 17 October 2018.

in another, diversification had mitigated the risk of having one partner and allowed for implementing partners with more specialized capacities. In all case studies, efforts had been made to engage local and national partners to improve sustainability, in line with the Grand Bargain of 2016.

#### **Case studies showed some weaknesses in coordination with United Nations agencies**

49. Challenges were displayed in UNHCR operational partnerships, in particular with United Nations agencies, owing in part to differences in mandate and approach. While most staff and partners (91 per cent and 83 per cent, respectively) felt that the distribution of roles and responsibilities between UNHCR and non-United Nations partners were clear and well defined, slightly fewer (86 per cent of staff and 80 per cent of partners) thought that the same was true for United Nations partners. UNHCR has a global memorandum of understanding with the World Health Organization, which has a more normative role and is the primary counterpart for the Ministry of Health at the country level, but few examples of joint advocacy or clear responsibilities for the strengthening of health systems were identified in case studies. Interviewees in field locations noted challenges with WFP, with whom UNHCR also has a global memorandum of understanding and conducts joint assessment missions, monitoring and planning. The relationship varied at the country level and was very poor in one case study, affecting the delivery of food assistance at an appropriate level to meet needs.

50. The United Nations Children's Fund (UNICEF) plays a role globally in under-5 nutrition, school health and water, sanitation and hygiene, but its engagement varied significantly by operation, preventing systematic approaches and engagement. In Jordan, UNICEF implemented a water, sanitation and hygiene programme, with UNHCR in a monitoring role. While operating partnerships provided additional capacity and resources, different approaches, governing structures and donor relationships also presented challenges to UNHCR, given its role as "provider of last resort". Partners and staff interviewed mentioned competition for funding as a challenge to the relationships.

#### **The inclusion approach has necessitated increased partnerships with Governments and development actors**

51. Government partnerships at the national and local levels facilitated access to varying levels in all case studies, as noted in result B, and addressed, to varying extents, the strain placed on host services during large influxes of refugees. The comprehensive refugee response framework as implemented in Uganda offered a strong inclusion framework. In Cameroon, the approach of upgrading national facilities and allowing the access of host communities helped to improve health services for host and refugee populations in previously underserved areas.

52. To promote integration and the strengthening of health systems and to address resource constraints, some operations forged links with development actors, such as the World Bank. Uganda received \$50 million in financing from the World Bank through the Refugee and Host Population Empowerment initiative to improve services and bridge the gap to development. In Cameroon and Chad, World Bank funding packages were approved in 2018 to improve services for refugees, including health, for \$274 million and \$60 million, respectively. Cameroon also implemented the multi-year, multi-partner strategy, and Pakistan took a development-oriented approach to transitioning refugee health responsibilities to the host Government. In

2017, the pool of development financing was about nine times larger than humanitarian financing, representing an opportunity to mitigate declining funds.<sup>24</sup>

**The Office used its convening power to provide coordinated service delivery in public health**

53. UNHCR facilitated working-level coordination to avoid duplication in service delivery. Of those surveyed, 89 per cent of partners and 96 per cent of staff agreed that coordination ensured that services were complementary and not duplicative, and 95 per cent of staff reported that coordination ensured that gaps and needs were covered. Supporting examples were provided in case studies and partner interviews. In Uganda, UNHCR jointly led the coordination of more than 30 water, sanitation and hygiene partners with the district government, which was reported by stakeholders to have worked very successfully. In Malaysia, the health working group brought implementing and government partners together to address common problems.

54. Partnerships with refugee communities provided opportunities for community participation, more effective dissemination of messages and greater sustainability. Partnership engagement worked particularly well in the Middle East and North Africa, where 80 per cent of staff rated such engagement as good or excellent, compared with between 62 and 68 per cent of staff for other regions. In Cameroon and Uganda, community members were responsible for the maintenance of water, sanitation and hygiene sites, including boreholes. In Pakistan, refugee committees maintained community funds and provided oversight of health facilities. However, in focus group discussions, refugees complained of insufficient communication with UNHCR.

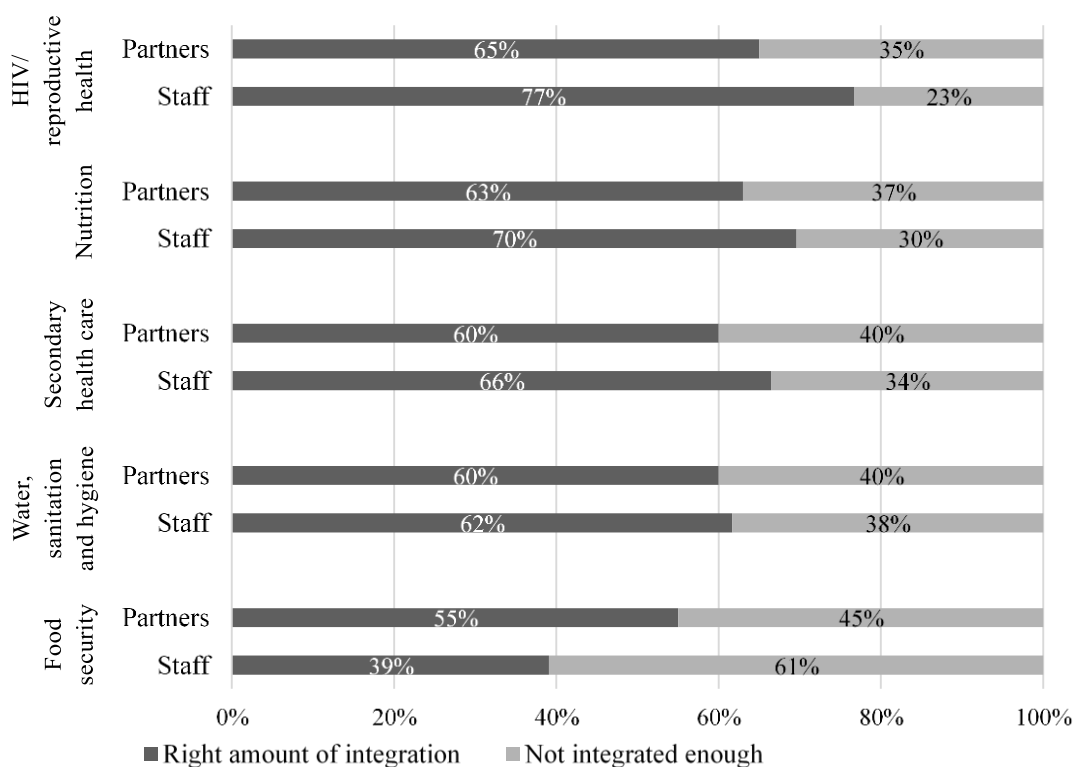
**D. Insufficient integration across public health subsectors and between public health and the protection, education and shelter sectors and inadequate global monitoring of health outcomes presented challenges for the effective and efficient delivery of public health programmes**

**The level of integration between primary health care and other subsectors varied across countries, but was generally limited for food security**

55. Globally, public health partners and staff surveyed felt that HIV and reproductive health was the subsector that was most integrated with primary health care, followed by nutrition, secondary health care and water, sanitation and hygiene (see figure XV). Food security was considered the least integrated.

<sup>24</sup> \$147 billion compared with \$16.5 billion (Organization for Economic Cooperation and Development).

Figure XV  
**Partner and staff perceptions of the integration between primary health care and other subsectors (113 partners, 152 staff)**



Source: OIOS survey of UNHCR public health staff and partners.

56. There was broad consensus among staff that it was appropriate to place water, sanitation and hygiene within the public health programme. However, staff in three of the four case study countries with water, sanitation and hygiene activities stated that the integration of water, sanitation and hygiene into the overall public health programme was insufficient. One such country was Uganda, where, although the country public health strategy included water, sanitation and hygiene, partners and staff pointed to a lack of harmonization between the outreach programmes on hygiene promotion run by public health and water, sanitation and hygiene partners. The Internal Audit Division, in an audit of water, sanitation and hygiene programmes globally in 2016, also recommended that the Division of Programme Support and Management ensure better collaboration between the two subsectors in hygiene awareness.

57. A number of staff at headquarters and in country operations felt that separate budgets for subsectors hindered integrated delivery. Some mentioned that earmarked funding contributed to a fragmented approach to certain specialized areas of health, which affected integrated planning and implementation.

**Public health staff felt that health was not seen as part of the core protection mandate of the Office within the agency, and integration with the education and shelter sectors was considered insufficient**

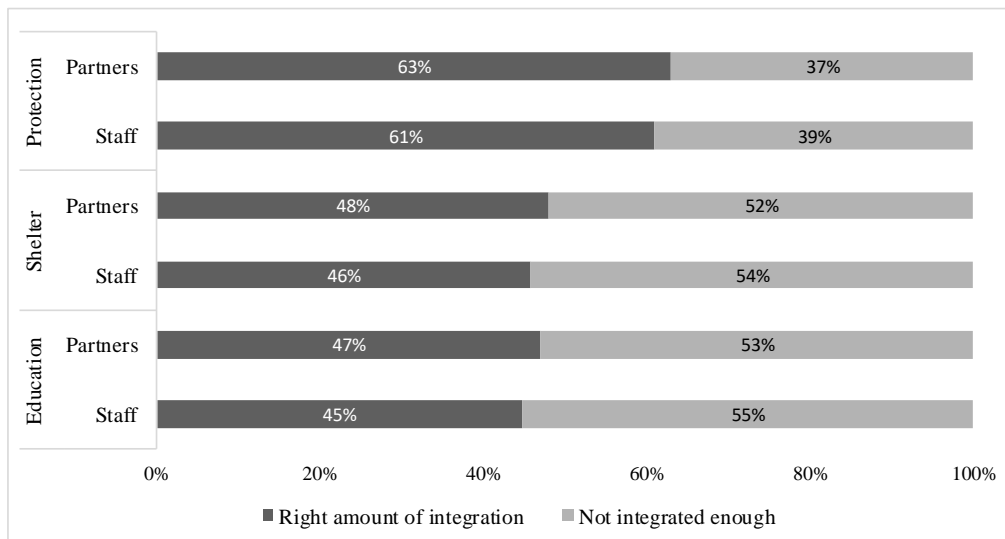
58. Despite the strong link between public health and protection highlighted in the global strategy for public health, public health staff interviewed felt that ensuring access to health care was not seen universally as a protection issue and as such was



not given adequate priority within UNHCR. Several staff from headquarters, both within and outside public health, further noted that there was a broader debate within the agency on whether the delivery of basic services, including health, was a component of its protection mandate. Globally, 63 per cent of partners and 61 per cent of staff thought that the level of integration between public health and protection was right (see figure XVI), and some examples of collaboration on responses to sexual and gender-based violence were shown in case studies.

Figure XVI

**Partner and staff perceptions of the integration between public health and other sectors (113 partners, 156 staff)**



Source: OIOS survey of UNHCR public health staff and partners.

59. Partners and staff interviewed in case study countries generally considered the coordination between public health and other sectors, including protection, to be effective at camps, where there was regular interaction between sectors and all sectors reported to the camp manager. At headquarters and country offices, however, staff noted that a multisectoral approach to programming, including structural links, was largely missing and that the involvement of protection staff in public health programmes was ad hoc and based largely on individual interests and relationships.

60. Less than half of the public health partners and staff surveyed believed that there was the right level of integration with the shelter or education sectors, as shown in figure XVI. Some noted that the role of UNICEF in leading education, including refugee school health programmes, in many countries might explain the disconnect with the education sector. Staff surveyed and interviewed mentioned other areas in which further cross-sectoral coordination would benefit health outcomes for refugees, such as mental health and psychosocial support (with protection) and community outreach and mobilization (with community-based protection). Staff and partners also highlighted the importance of cash-based assistance and increased integration of public health programming with livelihoods, both to ensure food security and to address cost barriers to health services.

**Health outcomes for refugees were monitored and used to inform programming in countries, but there were gaps in global monitoring**

61. The Health Information System is used by UNHCR to collect standardized clinical and epidemiological data on refugees, with 22 categories and 2,513

indicators. In 2017, the system was used at camps and sites in 18 countries.<sup>25</sup> Data on health outcomes for refugees were also collected through reporting from implementing partners and, in a limited number of countries, health access and utilization surveys, knowledge, attitudes and practices surveys and standardized expanded nutrition surveys, referred to in result A. A total of 80 health facilities in seven countries were assessed through balanced scorecard exercises. At the country and subcountry levels, most public health partners and staff surveyed thought that the data collection systems of UNHCR were adequate to monitor public health activities and outcomes (78 per cent of partners and 89 per cent of staff) and that UNHCR programme managers used available data to make decisions on public health programming (83 per cent of partners and 91 per cent of staff).

62. At the global level, the Public Health Section at headquarters collected data annually from country operations and prepared global and country-specific reports. The data included site- and country-level refugee health indicators collected through the Health Information System, a set of key public health indicators reported annually through the Twine platform by country operations with a public health budget of \$0.5 million or more and a questionnaire on the inclusion of refugees in national health systems, which was piloted in 2018. In late 2018, a new health information system was in development to replace Twine.

63. However, outcomes were not thoroughly monitored at the global level, in particular for out-of-camp refugees, for whom no data on health outcomes were available. Data from the Health Information System for the 18 country operations in 2017 covered 4.3 million camp or site-based refugees,<sup>26</sup> which represented only 58 per cent of the refugee population in those operations, and 27 per cent of the global refugee population. Data on public health indicators were available for only 40 of the 62 operations with a public health budget. The 21 operations for which annual data were not reported included 8 that had a public health budget larger than \$0.5 million that year. Furthermore, a full view of public health indicators was lacking even for those 40 country operations reporting annual data, since data were collected only for the subsectors covered by UNHCR in each country operation. The lack of comprehensive and comparable country data, as well as data on out-of-camp health outcomes, posed a challenge to the role of headquarters and regional offices in monitoring the standards set in the global strategy for public health and ensuring that they were met for all subsectors and in ensuring predictable decision-making to engage in various subsectors.

## V. Conclusion

64. To fulfil its mandate to enable refugees to realize their rights to health care, food security and water, sanitation and hygiene, UNHCR has implemented a broad and complex public health programme in the context of increased displacement, constrained resources and complicated protection environments. Meanwhile, the New York Declaration for Refugees and Migrants and the increased involvement of Governments and development actors have opened up opportunities to respond to these challenges. The primacy of public health objectives and outcomes for refugees requires that these interventions be fully integrated as protection concerns in planning and implementation at the global and country levels, which has not always been the case. In addition, it is critical to move towards longer-term strategic approaches to ensure the continuity of service provision once funding and partner engagement

<sup>25</sup> UNHCR, “UNHCR public health: 2017 annual global overview”.

<sup>26</sup> Iraq and Jordan also use the Health Information System, covering an additional 400,000 refugees, but they were not included in the data sets provided to OIOS.

decline. UNHCR and its dedicated, hard-working staff have done an admirable job of providing good-quality primary health care, in particular in camp settings, within significant constraints, and have worked to reduce barriers to access to national health systems. However, more work is needed to address out-of-camp realities, in particular in more protracted crises, and to ensure that United Nations partnerships are optimized. Recent developments and changes in thinking towards sustainable solutions, including multi-year, multi-partner funding and engagement with Governments and development partners, are a step in the right direction, but UNHCR management also needs to ensure that strategic planning is systematized and that health is fully integrated into internal processes, programming and decision-making.

## VI. Recommendations

65. The OIOS Inspection and Evaluation Division makes five important recommendations to UNHCR.

### **Recommendation 1: global strategy for public health (results A and B)**

66. In the next public health strategy, UNHCR should include stronger emphasis on shifting towards more sustainable, inclusion-based support for health systems, with guidance for country operations on actions and indicators to measure progress towards inclusion, and define and develop the Office's role in strengthening health systems and facilitating the engagement of other actors in addressing public health for refugees.

Indicators: post-2018 global strategy for public health incorporates the inclusion elements noted.

### **Recommendation 2: planning (result A)**

67. UNHCR should plan in a forward-looking and strategic manner at the operation level to ensure systematic engagement with regard to needs and develop early options to respond to post-emergency and transition scenarios, with public health mainstreamed into operation-wide planning.

Indicators: guidance for systematic and evidence-based decision-making on engagement in public health at the country level developed and tracked; lessons learned on transition planning shared across operations; and the new results framework as part of the results-based management renewal project incorporates parameters of operation-wide scenario planning.

### **Recommendation 3: data (results A, B and D)**

68. UNHCR should improve the monitoring of out-of-camp health outcomes, including by using data for strategic decisions.

Indicators: post-2018 public health strategy reflects different approaches to improve the monitoring of health in out-of-camp populations; continued advocacy with host Governments on the collection, disaggregation and reporting of key refugee data, including health data, where the protection environment allows; provision of guidance and training to strengthen the capacity of UNHCR staff and implementing partners in the collection, analysis and use of programme data; and expansion of the number and/or scope of health access and utilization surveys where feasible.

**Recommendation 4: partnerships (result C)**

69. To improve operational partnerships, UNHCR should enhance partner-specific, concrete follow-up mechanisms to address potential overlaps and/or gaps with United Nations and other operational partners and implement the lessons learned from the multi-year, multi-partner pilot.

Indicators: institutionalization of multi-year, multi-partner programming and take-up of multi-year, multi-partner lessons learned through the results-based management renewal project; inclusion of longer-term outcomes in the new results framework to permit multi-year planning and monitoring of outcomes to be more in line with potential planning processes of operational partners.

**Recommendation 5: integration (result D)**

70. UNHCR should enhance multisectoral links by emphasizing them in the next public health strategy to support internal learning and links and by demonstrating and documenting successful models of integrated programming to support advocacy internally and with donors on funding requirements.

Indicators: documentation and sharing of integration models internally and with donors; strengthened emphasis on cross-sector links in the post-2018 public health strategy, including how links can be optimized at the country level.

*(Signed)* Heidi **Mendoza**  
Under-Secretary-General for Internal Oversight Services  
March 2019

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## Annex

### **Formal comments provided by the Office of the United Nations High Commissioner for Refugees**

In the present annex, the Office of Internal Oversight Services (OIOS) provides the full text of comments received from the Office of the United Nations High Commissioner for Refugees (UNHCR) on its evaluation. This practice has been instituted in line with General Assembly resolution [64/263](#), following the recommendation of the Independent Audit Advisory Committee.

### **Response of the Office of the United Nations High Commissioner for Refugees to its evaluation by the Office of Internal Oversight Services**

1. UNHCR thanks the OIOS Inspection and Evaluation Division for the opportunity to provide a management response on the evaluation of the UNHCR public health programme and, in particular, the global public health strategy for the period 2014–2018. UNHCR has read the evaluation report with great interest and has taken note of its findings and accepted its recommendations.

2. Since the launch of the public health strategy for the period 2014–2018, there have been significant changes in both the internal and the external environments that have brought greater attention to the long-term nature of many refugee situations and the subsequent impact on often already underresourced host communities and national and local health systems. Consequently, there is a clear need for greater engagement of development actors, including in early refugee responses, and for more strategic support for national health systems. For the past 15 years, UNHCR has made steady progress in this area through its policy and practices to enhance the inclusion of refugees and other persons of concern in national health systems. Indeed, UNHCR was pleased to note that many of its achievements in this area had been noted in the evaluation report.

3. We are confident that this important evaluation and its recommendations will further inform our efforts to expand and strengthen the engagement of other actors in addressing the public health issues of refugees in emergency and post-emergency situations, as well as in both camp and out-of-camp situations. We have therefore provided the UNHCR action plan in a management response matrix outlining the strategy areas that we intend to focus on in the coming years in response to the recommendations.

4. In conclusion, we extend our appreciation to the OIOS Inspection and Evaluation Division for its evaluation of our public health efforts, in particular the teams that collaborated closely with us on this effort.

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