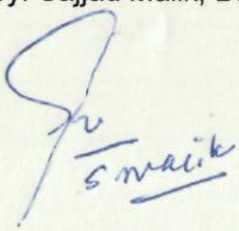
UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

UNHCR/AI/2023/03

Administrative Instruction on Public Health Programming

Approved by: Sajjad Malik, Director, Division of Resilience and Solutions

Signature: 

Approval date: 25/04/2023

Contact: Chief of Public Health Section, Division of Resilience and Solutions

Date of entry into force: 26 April 2023

Review date: by 31 December 2028

This and other official UNHCR Guidance is available on the Policy and other Guidance Page of the UNHCR-net

CONTENTS

1. PURPOSE

1.1. This Administrative Instruction (AI) provides overall guidance on public health programming in UNHCR including the approaches to be followed towards achieving universal health coverage, working with and full access to national health systems, the monitoring of public health programmes, medicines and medical supply management and the management of medical referral care. It also clarifies the roles of public health personnel in relation to staff health and wellbeing.

1.2. This AI is complemented by the Global Public Health Strategy (2021-2025).

2. SCOPE

2.1. This AI applies to all UNHCR operations planning or implementing public health programmes. It is specifically directed to UNHCR personnel engaged in:

- Strategic, programmatic, and operational planning and/or monitoring of public health programmes in operations
- Coordinating refugee public health responses, including in emergencies
- Public health-related procurement
- Human resource and administration staff with respect to responsibilities regarding staff health and wellbeing.

It also applies to UNHCR personnel at headquarters and regional bureaux providing strategic, programmatic, and operational support to operations on public health programming.

2.2. In all situations, UNHCR is accountable for promoting the equitable access to essential health care services for refugees and asylum seekers and for monitoring this access. The decision on when and how to engage in public health programming at country level rests with the country operation in consultation with the relevant regional bureau. Factors to be considered include, inter alia, the host country policies and laws on access to health services, the capacity of the national health system to effectively provide services to refugees including the geographic coverage of services. As such, these instructions do not prescribe a uniform course of action in responding to health needs.

2.3. Overall compliance with this AI is mandatory for operations undertaking public health related programming[1]. Given the nature of programming, there are several actions covered by the AI which while not mandatory are recommended. Throughout the document, an action which **must** be done is to be considered mandatory and when an action **should** be done it is to be considered recommended.

3. RATIONALE

3.1. UNHCR supports governments, and particularly ministries of health, to ensure that refugees receive the health services they need at sufficient quality to be effective without suffering financial hardship.

3.2. Public health programming is life saving and life sustaining. It consists of a wide range of measures and services from preventive, promotive and curative primary health care; sexual and reproductive health, HIV; nutrition; mental health and psychosocial support (MHPSS); rehabilitative services; palliative care; referral care to secondary and tertiary level; community health; surveillance and monitoring of health information; and behaviour change communication[2].

3.3. It is essential that health services supported by UNHCR meet minimum quality standards, on par with national health services, and are based on the most up-to-date evidence in public health programming. Some activities carried out under public health programmes involve risks that the organization must take steps to manage. Medicine procurement must follow stringent quality standards due to risk of counterfeit or substandard products. Medicines are high value items that can be easily diverted from their intended use without robust management and monitoring. Medical referrals to a higher level of care are highly sought after in many settings but stringent criteria must be applied. In addition to the potential harm to refugees and other people we serve, failure to mitigate these risks can undermine community, partner, and donor confidence in UNHCR.

3.4. For many years UNHCR has been working with refugee-hosting governments and their national health services. Many of these are in low and low-middle income

[1] Public health programming in the context of this AI encompasses operations contributing to COMPASS Outcome Area 10 as well as operations with public health programming contributing to other Outcome Areas
[2] UNHCR - UNHCR Global Public Health Strategy 2021-2025

countries with fragile health systems. Working with national systems is of increased strategic importance in line with the Global Compact on Refugees (GCR) and the Sustainable Development Goals (SDGs) and requires a phased and medium to long-term approach. Failure to adequately support national health systems or catalyse others to do so can undermine host government confidence in UNHCR, erode the protection and asylum space, threaten peaceful coexistence and result in poorer health outcomes for host communities and refugees alike.

4. OVERALL INSTRUCTION

Country operations that engage in public health programming must apply UNHCR's public health approach and global standards, as described in the sections that follow.

4.1. Public health approach

4.1.1. UNHCR's public health programmes are based on the **primary health care approach**[3] and must be developed in line with the universal health coverage (UHC) and other targets of Sustainable Development Goal 3.

4.1.2. Access to comprehensive primary health care is a key pillar of universal health coverage and is a core component of UNHCR's public health programming.

4.1.3. UNHCR supports refugees and asylum seekers to access the preventive, promotive, curative, rehabilitative and palliative services they need at sufficient quality to be effective and at a price they can afford. Access to comprehensive primary health care is a key pillar of **universal health coverage** and is a core component of UNHCR's public health programming. Operations supporting access to health services must give priority to an essential package of primary health care as outlined in Objective 1 of the Global Public Health Strategy.

4.1.4. In line with the objective of the Global Compact on Refugees to ease pressure on host communities, country operations must catalyse **support for national health systems**. Depending on both the context and where refugees are located, enabling access to health services may require multiple modalities of financing, advocacy, and service delivery support by UNHCR and other stakeholders.

4.1.5. UNHCR's engagement in support to public health activities in situations of **statelessness, internal displacement and reintegration** is limited and context specific:

- In general, UNHCR is not involved in the direct provision of health services to internally displaced persons (IDPs). UNHCR may engage in mixed situations, involving both refugees and IDPs, where support may be extended to both these populations and their host communities. Through UNHCR's engagement with the protection, shelter and camp coordination/camp management clusters, UNHCR may also contribute to health-related advocacy and monitoring of access, including for MHPSS and HIV related services[4].
- UNHCR advocates for the universal access to health care for stateless and returnee populations.

[3] A primary health care approach includes three components: meeting people's health needs throughout their lives; addressing the broader determinants of health through multisectoral policy and action; and empowering individuals, families and communities to take charge of their own health. See https://www.who.int/health-topics/primary-health-care#tab=tab_1

[4] UNHCR | UNAIDS

4.1.6. Public health programmes in UNHCR must take into account **age, gender and diversity** dimensions and Accountability to Affected People (AAP) and contribute towards the fulfilment of rights of people who UNHCR works with and for, including through meaningful dialogue, to ensure that programme interventions and advocacy are informed by community perceptions and priorities.[5] Country operations must consider the specific needs of children, women, men, older people, people with disabilities, and gender diverse populations as well as vulnerable groups in the design and delivery of services to address protection risks effectively, including through the use and strengthening of existing capacities.

4.1.7. Country operations that pursue public health programmes must integrate appropriate results within their multiyear strategies. In some operations, there may be a need for more detailed **response plans** to guide interagency public health responses in emergency or post-emergency contexts and/or medium to long-term inclusion and integration plans with governments and other stakeholders. See Global Public Health Strategy (2021-2025) Annex 1.

4.2. Working with national health systems

4.2.1. The potential for refugees to benefit from national systems depends on the existing mechanisms for financing health and social services and the degree to which they aim to provide universal health coverage and social protection for nationals, as well as the legal or policy environment and political willingness to include refugees.

4.2.2. Wherever conditions allow, UNHCR must collaborate with the government, UN partners[6], other multilateral donors/technical actors[7] and civil society, to facilitate the inclusion and integration of refugees into national health systems and services.

4.2.3. The vast majority of refugee hosting countries already have policies which allow access to primary health care facilities under the same conditions as nationals as seen in the Public Health Inclusion Survey. In many situations national health systems may need to be strengthened to ensure the health systems are able to meet the needs of refugees as well as host communities.

Establishing supplementary services

4.2.4. Country operations may establish supplementary health services (e.g. primary health care services delivered through an NGO partner) as a component of an emergency response or in countries where national systems are fragile or poorly functioning in order to minimize avoidable morbidity and mortality. To the extent possible, country operations must foster an emergency health response that is supportive to the national health system, such as working towards accreditation of health facilities, secondment of staff from the national system, supervision by the ministry of health, and harmonization of standards and treatment protocols.

Social health insurance

4.2.5. Social health insurance is one mechanism of financing access to an essential package of health care services. If this option is available in a country (paid for by mandatory or voluntary contributions from refugees), the inclusion of refugees

[5] Policy on Age, Gender, and Diversity
[6] This includes WHO, UNICEF, UNFPA, ILO and UNAIDS
[7] This includes the Global Fund for HIV, TB and Malaria, Gavi, the Global Vaccine Alliance, and the World Bank

in the scheme may improve access for refugees, reduce costs and avoid duplication of services.

4.2.6. Country operations that are considering social health insurance schemes must carefully assess health financing options. Assessments must consider whether the use of an existing social health insurance is feasible, will provide sufficient coverage and will result in acceptable health access for refugees.[8] A detailed assessment must be conducted before engaging in social health insurance schemes. The decision to engage in a social health insurance scheme must be taken in consultation with the respective regional bureau and Public Health Section at headquarters.

4.3. Working with partners

4.3.1. UNHCR does not directly implement health service provision. When public health services and facilities are not available, or the national health care system lacks capacity to extend services to refugees, country operations must partner with appropriate health NGOs, Red Cross/Red Crescent societies and/or civil society partners.

4.3.2. Country operations implementing public health programmes must assure that funded partners have the necessary capacity to deliver the specific services required and be selected in line with UNHCR partnership agreement guidance and procedures[9]. Funded partners must be equipped to prevent, mitigate the risk of and respond to allegations of sexual exploitation and abuse[10].

4.3.3. As much as possible, country operations should use one partner to provide a comprehensive package of primary health care, referral care, sexual and reproductive health including HIV, community health, MHPSS and nutritional services. The use of multiple partners for different elements of public health programming may result in fragmented programmes, at higher cost.

4.3.4. In urban situations, depending on the context and the national health system capacity to include refugees, UNHCR should support the increased efficiency of health services by identifying and supporting a select number of quality service providers/facilities for primary and essential referral care[11]. Preference should be given to supporting national services wherever possible.

4.3.5. Country operations must make every effort to integrate health services provided by partners with those of the ministry of health, particularly funded partners, and where feasible, seek their accreditation by relevant authorities. The structures, equipment, and design of health facilities must be in line with the national or subnational standards for the level of health care provided, or WHO standards where national standards are not available.

Specialized partners

4.3.6. In rare situations, **specialized health partners** may be required. Examples may include contexts with a high acute malnutrition prevalence and where complex mental health needs can not to be met through the national system. The

[8] Different mechanisms exist to cover health care costs and improve effective access to affordable health care services. They are not all equivalent in terms of effectiveness of the coverage they provide or their equitability.
[9] UNHCR/AI/2021/11 Administrative Instruction on the Selection and Retention of Partners for Partnership Agreements
[10] UNHCR/AI/2021-06 Administrative Instruction on Implementing Partner PSEA Capacity Assessment
[11] UNHCR - Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas

above includes urban situations where access to these services through the national system is limited or compromised.

4.4. Essential Medicines and Medical Supplies including medical equipment

4.4.1. Universal health coverage can only be achieved when there is affordable access to safe, effective, and quality medicines and medical supplies. Country operations may face a wide range of obstacles to achieving this, including the growing problem of substandard and counterfeit medical products entering the global supply chain.

Procurement

4.4.2. Procurement of medicines and medical supplies by UNHCR country operations is normally done through direct implementation, and through international suppliers. UNHCR purchases medicines using UNHCR Global Frame Agreements with international suppliers that have been established for this purpose. In addition, UNHCR may use existing Frame Agreements of other UN agencies for procurement.

4.4.3. Even though some partners have a prequalification status[12] from UNHCR for procurement, the procurement of medicines and medical supplies must be based on approval from Public Health Section upon review of the partner's quality assurance policies and procedures.

4.4.4. The procurement request of medicines and medical supplies, whether by UNHCR or partners, must be based on the most recent UNHCR Essential Medicines and Medical Supplies List, (EML) using the standard template. It must also be based on the size of the population, consumption and morbidity data or on morbidity-based calculations for new onset emergencies. More information is available in the UNHCR Essential Medicine and Medical Supply Guidance[13].

4.4.5. Due to the complexity, verification requirements and high risk associated with medicine and medical supplies procurement, the following review and clearance process must be followed:

- All medicine and medical supply orders must be technically cleared by the regional bureau, who will provide recommendations. In the absence of Regional Public Health staff, the Public Health Section will take this role. The country office will finalize the order based on the feedback received.
- In the rare event that items are required that are not included in the UNHCR EML, the country operation should provide a strong justification and approval by the Public Health Section at headquarters is needed. These exceptional requests should focus on primary and secondary health care level.

Local Procurement

4.4.6. Local procurement by country operations may only be considered in three cases:

1. where there are insurmountable import restrictions; or
2. in a situation of unplanned emergency needs; or

[12] UNHCR/AI/2018/1 Administrative Instruction on Procurement by Partners under Partnership Agreements (with Implementing Partnership Management Guidance Note No. 4, Rev. 1)
[13] UNHCR Medicines and Medical Supplies Guidance 2023

3. the Government mandates procurement through nominated suppliers; and,

In all cases, a local market assessment (LMA) for quality assurance must be performed.

4.4.7. Local procurement must comply with the UNHCR quality assurance international standards irrespective of the maturity level of the National Regulatory Authority (NRA). All local procurement requests must be reviewed by the regional bureau and justified by the country operation in a memorandum to the Public Health Section who will provide recommendations.

4.4.8. In cases where the establishment of local Frame Agreement for procurement is justified, an LMA is mandatory as well as an assessment of the sources of individual products. The details of the UNHCR country level quality assurance should be assessed by the Public Health Section. Details of the UNHCR quality assurance requirements for the procurement of essential medicines and other health products are available in the UNHCR Essential Medicines and Medical Supplies Guidance[14].

4.4.9. All local procurement must follow the UNHCR Policy on Procurement and the UNHCR Administrative Instruction on Procurement following standard procedures on tendering and evaluation of offers from approved suppliers. UNHCR will purchase medicines using best value for money criteria of quality assured medicines.

4.4.10. In case of UNHCR procurement through the national system via the supplier(s) mandated to supply ministry of health / government facilities, UNHCR continues to have a responsibility for the quality of medicines. Country operations should request the national supplier to undergo an assessment by an independent quality assurance entity to determine the quality of the supplier (and by extension quality of medicines and supplies) if this has not already been done. The Public Health Section should be consulted. The assessment can also be used to support the national system to identify areas that could be strengthened. If the supplier does not meet acceptable quality standards, then country operations should use international procurement channels and/or local FAs where applicable while, and until, the recommended improvements are put in place.

Quality Assurance

4.4.11. All internationally and nationally procured medicines and medical supplies, including those procured by partners or through the ministry of health supply chain, must comply with the UNHCR quality assurance requirements[15] available in the UNHCR Essential Medicine and Medical Supply Guidance.

4.4.12. A global frame agreement to conduct local market assessments has been established[16] to support operations to comply with the quality assurance requirements. Note that an LMA can assess suppliers (Good Distribution Practice) but does not assess the quality of products themselves. The Good Manufacturing Practice still needs to be assessed by UNHCR before

[14] Same as above.
[15] Based on WHO Quality Assurance Policy for the Procurement of Essential Medicines and Other Health Products
[16] For more information on the global frame agreement, refer to Public Health Section, Division of Resilience and Solutions

procurement as detailed in the UNHCR Medicines and Medical Supplies Guidance.

In-kind contributions

4.4.13. UNHCR does not accept in-kind donations of medicines and medical supplies from commercial entities, including not-for-profit entities associated with a commercial entity. However, under exceptional circumstances UNHCR may consider accepting medicines, vaccines, and medical supplies on a case-by-case basis as approved by the Public Health Section in DRS. Any approval of donations is made in strict adherence to the World Health Organization (WHO) Guidelines on Medicine Donations (2010) and the Administrative Instruction on the acceptance and formalization of donor contributions (cash or in-kind donations) [17] - in particular Annex 6**.**

4.4.14. UNHCR does not proactively seek and accept donations of nutritional products and food items. UNHCR does not call for, support, accept or distribute commercial products targeted to infants or young children, including Breast Milk Substitutes (BMS) (infant formula, other milk products, commercial complementary foods) and feeding equipment (such as bottles, teats, and breast pumps). Required BMS supplies should be purchased by UNHCR or a designated partner and provided as part of a sustained package of coordinated care based on assessed needs. This should be compliant with International Code of Marketing of Breast-Milk Substitutes as reflected in the Infant and Young child feeding in emergencies operational guidance

4.4.15. Under exceptional circumstances, however, UNHCR may consider accepting nutritional products on a case-by-case basis as approved by the Public Health Section in DRS. Any approval of donations is made in strict adherence to the Administrative instruction on the acceptance and formalization of donor contributions (cash or in-kind donations).Annex 6.

4.5. Management and monitoring of medical referrals

4.5.1. Medical referrals to secondary or tertiary level facilities may be supported by UNHCR if other options are not available and accessible. The management of access to secondary and tertiary health care depends on the context, costs, and budgets available. Medical referral care should be in line with the *Guidelines for Referral Health Care in UNHCR Country Operations*[18] whether the referral is through partners; through the provision of cash assistance; or payment of facilities directly (or through a third-party administrator).

4.5.2. Medical referral must always be based on a decision by a medical professional by the health service provider.

4.5.3. Operations with an annual expenditure on medical referral care above USD 250,000 must establish an SOP using the guidance available in the Guidelines for Referral Health Care in UNHCR Country Operations[19] and use the UNHCR Medical Referral Database (MRD)[20] (or equivalent) to monitor referrals.

4.5.4. The SOP must at a minimum cover the following:

[17] UNHCR/AI/2021/03 Administrative instruction on the acceptance and formalization of donor contributions (cash or in-kind donations)
[18] Guidelines for Referral health Care in UNHCR Country Operations
[19] Same as above
[20] The Medical Referral Database is a tool that supports the monitoring of the referral care programmes by partners. The system captures the reason for referral, the treatment provided, the outcome and costs

i. Hospitals selected for referral care
ii. Types of referral care covered
iii. Non-referrable medical conditions
iv. Decision-making processes for referral care
v. Mechanisms for engaging other actors in referral care
vi. Cost settlement
vii. Monitoring

For simple referral care procedures and annual expenditure of below USD 250,000, an SOP is still recommended and the MRD may be used. All referral care decisions in these operations should be documented adequately.

4.5.5. Operations with medical referral SOPs must review them every two years. In emergencies or similar situations when adjustments are required in the SOP, operations can record the changes in a signed annex to the SOP. The SOP for referral care should be signed by senior management in the operation and be shared with the regional bureau.

4.5.6. Operations with an annual expenditure above USD 500,000 must establish a Medical Referral Committee / Exceptional Care Committee using the guidance available in the Guidelines for Referral Health Care in UNHCR Country Operations. Operations with an expenditure below USD 500,000 may establish a committee according to context and direction from the regional bureau. This is to ensure fair, equitable and cost-effective management of persons requiring referral care for complex and costly conditions. The committee must consist of medical doctors, some of whom should ideally be external to UNHCR and partners, and must be guided by the procedures as stipulated in the country referral SOP and the committee's terms of reference. Their role in decision-making must be included in the SOP.

4.5.7. Financial reporting for cash assistance for referrals will be in line with the Administrative Instruction on the Financial Procedures for Cash-Based Interventions[21].

4.6. Monitoring of public health programmes

4.6.1. An effective health information system is crucial to detect emerging health problems including outbreaks; monitor access and quality of health services; and health outcomes, all which support evidence-based decision-making. Public health monitoring feeds into the operation's results framework, as well as global core indicators. It enables the regular monitoring of the health partner performance.

4.6.2. For the most part, national health information systems are not interoperable with UNHCR's system and disaggregated data on refugees is often not obtainable. While UNHCR's Results Monitoring Surveys and the Flagship Surveys are designed to meet corporate monitoring and reporting requirements, they are insufficient to monitor health programmes. UNHCR has developed a set of health information tools to use in different contexts as described in the following paragraphs.

4.6.3. The integrated Refugee Health Information System (iRHIS)**,** must be used in all refugee camps and settlements, for the systematic, harmonized, and

[21] https://intranet.unhcr.org/en/policy-guidance/administrative-instructions/unhcr-ai-2023-01.html

structured collection of key health data from primary health care facilities supported by UNHCR as well as by operational partners. It allows monitoring of the health status of populations, disease trends, early detection, and monitoring of outbreaks[22]. Any exceptions to the above must be justified to the regional bureau. This may be the case in contexts where use of iRHIS is not feasible or required as a functioning alternative is in place, e.g. District Health Information System (DHIS2) where the relevant data is shared with UNHCR.

4.6.4. The Health Access and Utilization Survey Plus (HAUS Plus) is a cost-effective survey tool that is particularly recommended in non-camp situations to monitor knowledge, access and utilization of health programmes and the impact of policy changes. Where relevant, the HAUS is recommended to be carried out by the operation on a yearly basis. It can also be used in camp settings.

4.6.5. The Balanced Score card (BSC) is an important tool for systematic monitoring of UNHCR-funded partner health facilities and the quality of services provided. It allows identification of areas in need of improvement. The BSC must be conducted in all health facilities managed by UNHCR-funded partners at least yearly irrespective of whether these are provided in camp or urban settings. Depending on the scores the BSC may need to be repeated within 3 or 6 months.

4.6.6. When refugees are not included in national nutrition surveys, operations should use the standardized expanded nutrition survey (SENS) to measure the nutritional status of the refugee population. Depending on the nutritional outcomes and operational responses, the survey should be conducted as per below indicated frequencies:

(i) every two years in refugee operations with Global Acute Malnutrition (GAM) prevalence from >=5 to <10%
(ii) yearly in operations with GAM prevalence >=10%.

4.6.7. In stable operations with GAM prevalence <5%, a survey is to be considered if the situation changes e.g., when there is a large influx, when food assistance is inadequate or reduced for long periods or when there is an outbreak of disease likely to affect the nutritional situation negatively[23].

5. DIVISION OF ROLES BETWEEN PUBLIC HEALTH OFFICERS AND STAFF HEALTH AND WELLBEING SERVICE

5.1. UNHCR Public Health personnel are accountable for managing UNHCR's public health programmes in line with their terms of reference. Public Health Officers are not accountable for the health of the UNHCR workforce. Similarly, personnel working in mental health and psychosocial support (MHPSS) for displaced and stateless communities are not accountable for the mental health and psychosocial wellbeing of personnel.

5.2. As Public Health Officers often have a clinical background, other UNHCR personnel may be inclined to consult them for medical advice or recommendations on staff health or occupational health issues. Similarly, personnel working in mental health and psychosocial support (MHPSS) for refugees and other people we serve, may be approached by other personnel to provide psychiatric support or psychological counselling or advice to UNHCR staff or personnel. Senior management, administration and human resource staff need to actively prevent such practices

[22] iRHIS (unhcr.org)
[23] Standardized Expanded Nutrition Survey | UNHCR SENS v3

because Public Health personnel, including those working in MHPSS, are not legally protected or accountable to provide medical, psychosocial, or other occupational health advice regarding staff or personnel health and wellbeing including relating to medical insurance claims of staff. Moreover, normal working relationships between personnel working in the same office can be disturbed when they enter in a 'therapeutic relationship'.

5.3. Matters related to personnel health including occupational health and safety, as well as mental health and psychosocial support, must be referred to the Staff Health and Wellbeing Service under the Division of Human Resources[24]. The exception to this is for medical emergencies where qualified personnel have a duty to provide emergency care.

6. ROLES, AUTHORITIES AND ACCOUNTABILITIES

6.1 Public Health Section, Division of Resilience and Solutions

The Chief of the Public Health Section in DRS, supported by their team, has the authority to:

- Technically review and provide recommendations orders of medicine, medical supplies, and equipment and provide recommendations to country operations in regions without regional public health personnel.
- Technically review and provide recommendations for requests of local procurement of medicines by country operations.
- Maintain frame agreements with suppliers for the provision of medicines and supplies and entities able to conduct local market assessments of medical suppliers.

They are accountable for:

i. Overall technical oversight, support, and monitoring of the application of this Administrative Instruction.
ii. Providing leadership on public health programming in UNHCR including technical guidance, capacity building and knowledge management, promoting inclusion in national health systems and services and global level interagency coordination and partnerships.
iii. Medicines and medical supplies:
    - Provision of technical guidance on medicine, medical supplies, and equipment orders in regions without regional public health personnel.
    - Provision of guidance for local procurement of medicines and medical supplies.
    - Provision of support to conduct local pharmaceutical market assessments at the request of country operations.
    - Maintenance of frame agreements with global suppliers for the provision of medicines and supplies and with entities able to conduct local market assessments (together with SMS/PS).
iv. Management of global systems for health information including iRHIS, medical referral database, public health inclusion and nutrition surveys.
v. Analysis of global health information and reporting.

[24] Medical Section (unhcr.org)

6.2 Supply Management Services/ Procurement Services, Division Emergency Support and Supply:

Supply Management Services (SMS) in DESS is accountable for:

i. Administration of frame agreements for the provision of medicines and supplies and entities able to conduct local market assessments (together with PHS).
ii. Procurement of medicines and medical supplies for countries where procurement has not been delegated to country level.

6.3 Regional bureaux:

Regional bureaux (Regional Senior Public Health Officer or designated focal person) have the authority to:

i. Provide oversight, technical support and monitoring of the application and adherence to this Administrative Instruction in each operation in their region.
ii. Provide oversight of the application of the Guidance on Medicines and Medical Supplies[25] at country level including:
    - Monitor the application of the UNHCR quality assurance requirements.
    - Monitor results of pharmacy and medicines management monitoring e.g., regular inventories, balanced scorecard findings and warehouse checklists
    - Review orders of medicine, medical supplies, and equipment and provide recommendations to country operations.
    - Review requests of local procurement of medicines by country operations before review by Public Health Section.

iii. Provide oversight of the medical referrals management including:
    - Monitor compliance that eligible countries have referral SOPs in place, and that they are updated periodically and in line with global guidance[26].
    - Ensure that a referral database is in place to monitor referrals when indicated.

Regional bureaux are accountable to:

iv. Monitor and provide support to country operations in the development of public health response plans aimed at supporting inclusion and integration of displaced and stateless people into national systems and services including:
    - Supporting operations to keep country public health strategies/plans up to date and in line with global guidance and country context.
    - Monitor and provide support to country operations in planning, assessment, implementation, and monitoring of health service provision through national systems including development of multiyear, multi-stakeholder integration and inclusion plans where appropriate.
    - Support to assessments of national social health protection schemes including social health insurance along with relevant partners when indicated.
v. Support and monitor the use of health information system tools at country level including the Balanced Scorecard[27] (at a minimum, on yearly basis), and health information system in camps and settlements.
vi. Support linkages to national systems and the health access and utilisation survey.
vii. Provide oversight and support to any other public health related programming at the country level.

[25] UNHCR Medicines and Medical Supplies Guidance 2023
[26] Guidelines for Referral health Care in UNHCR Country Operations
[27] Balanced Scorecard is a tool to assess the quality of care provided in a primary health facility

6.4 Country operations:

Country operations have the authority to:

i. Put in place the measures outlined in this Administrative Instruction, including the decision to initiate or phase out of UNHCR public health programming.
ii. Lead the coordination of country level partners including in emergencies to optimize refugee health responses and promote inclusion and access to national health services in support of the ministries of health.
iii. Work towards inclusion of displaced and stateless communities into national health programmes

Country operations have the accountability to:

iv. Conduct assessment, planning, implementation, monitoring and evaluation of UNHCR public health and nutrition programmes.
v. Ensure partners are aware of the requirements relating to Balanced Scorecard, health information system, and medical referral database under the Appendix on "Specialized project activities" of the Partnership Agreement, namely under "Public health and/or nutrition".[28]
    - Monitor and provide support to partners to implement these tools and take action on information generated.
    - Support the rational use of medicines for public health programmes through the promotion of rational prescribing, dispensing and consumption of pharmaceuticals at all levels. To this effect, formulate the necessary guidelines and organize training activities for both health workers and consumers from the community.
    - Provide local capacity-building and staff development training in managing medicines and rational medicine use for UNHCR staff and health partners through monitoring, field visits and training courses.
    - Seek technical advice and support relating to social health insurance and its application at country level where relevant.

7. REFERENCES

UNHCR Global Public Health Strategy 2021-2025

UNHCR Medicines and Medical Supplies Guidance 2023

Guidelines for Referral health Care in UNHCR Country Operations

UNHCR-ILO Handbook on social health protection for refugees: Approaches, lessons learned and practical tools to assess coverage options

8. MONITORING AND COMPLIANCE

Compliance with this Administrative Instruction is overseen by the regional bureaux and the Public Health Section in the Division of Resilience and Solutions.

9. DATES

This Administrative Instruction is effective upon release and will be reviewed by 31 December 2028.

[28] For up to date templates and conditions of contract see Partnership Agreements (unhcr.org)

10. CONTACT

The contact for this AI is the Chief of the Public Health Section, Division of Resilience and Solutions.

11. HISTORY

This is the first issuance of this instruction