



UNHCR
The UN Refugee Agency

ANNEX B: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT



UNHCR GLOBAL STRATEGY FOR PUBLIC HEALTH

2021-2025

FRONT COVER PHOTO:

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Cameroon. Nigerian mothers hope for the best for their refugee babies.

BACK COVER PHOTO:

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Jordan. Syrian refugees return to Azraq camp after living in urban areas of Jordan.

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ACRONYMS

AAP	Accountability to Affected People
AGD	Age, Gender and Diversity
AIDS	Acquired immunodeficiency syndrome
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal care
CHW	Community health worker
CMAM	Community Management of Acute Malnutrition
DHIS	District Health Information Software
DHS	Demographic and health surveys
EPI	Expanded Programme of Immunization
GBV	Gender-based violence
GCR	Global Compact on Refugees
HAUS	Health Access and Utilisation Survey
HIS	Health Information System
HIV	Human immunodeficiency virus
ILO	International Labour Organization
iRHIS	Integrated Refugee Health Information System
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, and queer and other diverse identities
LLINs	Long lasting long lasting insecticidal nets
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MICS	Multi-indicator cluster surveys
MISP	Minimum initial services package
MUAC	Mid-upper arm circumference
NCDs	Non-communicable diseases
NGOs	Non-governmental organization
PHC	Primary health care
PLW	Pregnant and lactating women
SDG	Sustainable Development Goals
SMS	Short Message Service
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
SOPs	Standard Operating Procedures
SRH	Sexual and reproductive health
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization

UNHCR Public Health Strategy 2021-2025

VISION	UNHCR envisions a world where refugees and other persons of concern at all ages have healthy lives and in which their well-being is promoted (SDG3).				
GOAL	Refugees and other persons of concern to UNHCR access the preventive, promotive, curative, palliative and rehabilitative health services they need, at an affordable cost and of sufficient quality to be effective, in order to lead healthy and productive lives.				
APPROACHES	Integration and inclusion into national systems				
	Working in partnership				
	Capacity strengthening of UNHCR, partners, refugees and other persons of concern				
	Strategic health information				
	Multisectoral approaches to health				
OBJECTIVES	Support, monitor and advocate for access of refugees and other persons of concern to essential health services of sufficient quality to be effective, throughout the displacement cycle	Support national health systems to meet the health needs of refugees, asylum-seekers and host communities	Promote and support equitable provision of health care services	Strengthen cross-sectoral collaboration within UNHCR and with partners to create synergies and maximize positive impact on health status, welfare and dignity of refugees and other persons of concern	Actively engage communities in activities to promote and sustain their health
	<ul style="list-style-type: none"> Adequate emergency health and nutrition response realized in refugee emergencies including in disease outbreaks Access to essential primary health care safeguarded Access to comprehensive health services supported through a functional referral mechanism Health risks mitigated throughout voluntary repatriation and support to health services during reintegration 	<ul style="list-style-type: none"> National health policies, plans and systems meet the health needs of refugees Financing for refugee inclusion and integration into national health systems is established Inclusion of refugees in national health policies, plans and services is monitored 	<ul style="list-style-type: none"> Disaggregated data allows identification and analysis of disparities in access, utilization and outcomes Gender responsive policies are promoted Barriers to accessing health services identified and addressed Health services are accessible and responsive to the needs of specific population groups Targeted health and related services are provided for groups whose needs may not be adequately met by mainstream services 	<ul style="list-style-type: none"> Promote inclusion of health within overall assessment, planning and policy making Ensure effective intersectoral collaboration to strengthen collective outcomes including reducing health vulnerability and promoting mitigation and adaptation to climate change 	<ul style="list-style-type: none"> Strengthened participation, consultation and empowerment of refugees and other persons of concern Refugee communities are engaged in and benefit from a strong community health approach adapted to the context Refugees and other population of concern settings have functional systems for communication of health-related risks and promoting health and behavior change Monitoring of community health programmes including community-based data collection systems strengthened
RESULTS					

UNHCR Results-Based Management Outcome Area: Healthy Lives

INTRODUCTION

Changes in the global development and humanitarian landscape provide increased opportunities and momentum to promote and advance refugee and other UNHCR populations of concern's health and well-being. The Global Compact on Refugees (GCR) outlines a multi-stakeholder approach to better respond to refugee situations to achieve protection and solutions whilst easing the burden on host communities and promoting self-reliance. This has garnered the support of major development actors, including the World Bank through its Window for Host Communities and Refugees, creating development opportunities for eligible countries in recognition of the challenges they face in pursuing development goals when hosting significant populations of refugees.

The Sustainable Development Goals and the 2030 Agenda with their emphasis on leaving no one behind provide further incentive for inclusive and comprehensive approaches to public health and nutrition at global and country level.

The signing of a new memorandum of understanding between UNHCR and WHO supported by the World Health Assembly-approved Global Framework on Promoting the Health of Refugees and Migrants¹ and the subsequent global action plan², provide tools to advance more collaborative and predictable responses at country level.

However, the COVID pandemic has highlighted the capacity gaps in national health systems and the critical role health plays in realizing rights, well-being and development. The ramifications of COVID-19 extend far beyond health with major impacts on food security, socio-economic status, psychosocial well-being, living conditions, educational attainment and diversion from other health priorities.

UNHCR's Public Health Strategy 2021-2025 is based on the lessons learnt, and builds on the achievements, of the Global Strategy for Public Health 2014-2018. Progress was made on policies favouring inclusion and integration into national systems³ with 92% of 48 operations surveyed reporting refugees having access to national primary health care facilities under the same conditions as nationals and 96% reporting refugees having access to all relevant vaccines under the same conditions as nationals. While many refugee hosting countries have policies that allow refugees

to access national health services, many face partial access, prohibitive out-of-pocket expenditures and other barriers including distance to facilities, language and provider acceptance. Furthermore, more work is needed on strengthening these systems to be able to meet the needs of both host communities and refugees.

Inclusion approaches in countries with weak health systems require the mobilization of significant additional support and a medium to long-term time frame. Refugees continue to face barriers of discrimination, long distances to health facilities and inability to pay, particularly when they are denied the right to work. Lessons learnt from assessments of the feasibility of including refugees in national or community health insurance schemes have demonstrated that refugees are still required to pay in most cases, demonstrating the importance of pursuing self-reliance strategies and the strategic use of cash assistance alongside inclusive approaches.

The Public Health Strategy 2021-2025 reaffirms the importance of public health in preparation for, and in response to, refugee emergencies addressing the main causes of morbidity and mortality.

VISION

UNHCR envisions a world where refugees, and other persons of concern⁴ at all ages have healthy lives in which their well-being is promoted (Sustainable Development Goal 3).

GOAL

Refugees, and other persons of concern to UNHCR access the preventive, promotive, curative, palliative, and rehabilitative health services they need, at an affordable cost and of sufficient quality to be effective, in order to lead healthy and productive lives.

¹ https://www.un.org/en/development/desa/population/migration/generalassembly/docs/globalcompact/WHA_RES_70.15.pdf

² <https://www.who.int/publications/i/item/promoting-the-health-of-refugees-and-migrants-draft-global-action-plan-2019-2023>

³ [Public Health Inclusion Dashboard](#)

⁴ Persons of concern to UNHCR is a term used to describe a person whose protection and assistance needs are of interest to UNHCR, including refugees, asylum-seekers, stateless people, internally displaced people and refugee or internally displaced returnees. <https://reporting.unhcr.org/glossary>

GUIDING PRINCIPLES

UNHCR's *Global Strategy for Public Health 2021-2025* is guided by the right of all persons to "the highest attainable standard of physical and mental health"⁵ as well as by other international rights doctrines.⁶ Ensuring refugees, and other persons of concern to UNHCR, achieve the 2030 Sustainable Development Goals for health requires attention to both health service provision and the social determinants of health, including access to sufficient food and nutrition, adequate and safe housing, clean cooking⁷, safe water and sanitation, dignified and safe livelihoods or other means to access cash assistance, and a healthy and violence-free environment. To achieve this, the Strategy promotes a multisectoral approach, working in partnership with communities and key stakeholders both within, and external to, UNHCR. The right to health also requires that health services are equitable so that they are available, accessible and adapted to meet the needs of all persons, with particular attention to at-risk groups, in accordance with UNHCR's [Age, Gender and Diversity \(AGD\) policy](#). Further supporting the principle of equity and in line with the ambitions of Universal Health Coverage (UHC), the inclusion and integration of refugees into national health systems will be promoted, in line with UNHCR's strategic directions, as well as the principles of the GCR.

THE ROLE OF UNHCR IN SUPPORTING ACCESS TO PUBLIC HEALTH SERVICES

One of the objectives of the Global Compact on Refugees is to ease pressure on host countries. This can be achieved through comprehensive responses which entail rapid and well-supported reception and admissions, support for immediate and ongoing needs including health, assistance for local and national institutions and communities receiving refugees, as well as expanded opportunities for solutions.

Within the context of the GCR, UNHCR's support to Public Health services will differ according to the context and phase of displacement namely emergency, post-emergency and protracted situations.

In many situations, refugees will access existing ministry of health services which may be provided free of charge or subsidised, especially in the early phase of an emergency. If refugees cannot access ministry of health services of sufficient quality to

be effective due to barriers such as geographical inaccessibility; restrictive national policies; prohibitive user-fees or insufficient service capacity, then supplementary services may be supported by implementing or operational partners to meet immediate and ongoing needs while medium-term solutions are being sought. UNHCR will also catalyse the engagement of other partners to jointly support national health care services in areas hosting refugees. In this situation, UNHCR will move more towards supporting national services especially as the situation stabilises.

In most situations, these above approaches are complementary where refugees may have access to some services through the national system such as primary health care, Expanded Programme of Immunization (EPI), tuberculosis (TB) and HIV treatment, while UNHCR and other partners may support other services such as those for secondary referral care, mental health and psychosocial support (MHPSS), and gender-based violence (GBV).

UNHCR's engagement in support to public health activities in situations of internal displacement is limited and context-specific. In general, UNHCR is not involved in the direct provision of health services to internally displaced persons (IDPs) except 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 at country level and in line with the centrality of protection, UNHCR may contribute to health-related advocacy and monitoring of access to health and nutrition services especially for people with increased protection risks including GBV survivors, persons with disabilities, persons with severe mental health conditions, persons living with HIV and LGBTIQ+ persons. At global level, UNHCR may contribute to the development of interagency technical guidance for populations in humanitarian contexts. Different activities under the specific objectives should be read in line with the above.

UNHCR advocates for the universal access to health care for stateless and returnee populations. In some contexts, UNHCR may extend the provision of health services to these populations as well.

Access to health services is essential but, by itself, insufficient to reach good health and well-being. It is equally important to take preventative measures and to address the social – including gender – determinants of health, as well as the impacts of climate change on health.

⁵ CESCR General Comment No. 14: [The Right to the Highest Attainable Standard of Health \(Art. 12\)](#) CESCR (Committee on Economic, Social, and Cultural Rights). 2000.). 11 August. Doc. E/C.12/2000/4

⁶ Including international refugee law; international humanitarian law; human rights law

⁷ <https://www.who.int/news-room/fact-sheets/detail/household-air-pollution-and-health>

The pathways by which social determinants impact mental and physical health are complex and vary between populations. Collaboration between sectors is of vital importance to reduce health inequities and promote good health. Therefore, food security, access to safe water and sanitation, adequate housing and settlement infrastructure, clean cooking, developing economic security, mitigating the impact of climate change and access to education all contribute to the best socioeconomic, cultural and environmental conditions to promote health, avoid the emergence of diseases and the overload of health services.

STRATEGIC APPROACHES

To realise the objectives of this strategy and in alignment with the Global Action Plan on Promoting the Health of Refugees and Migrants, the following cross cutting strategic approaches will be applied:

- 1) Integration and inclusion into national systems
- 2) Working in partnership
- 3) Capacity strengthening and support
- 4) Strategic health information and
- 5) Multisectoral approaches to health.

1) Integration and inclusion into national systems

- Integration refers to access to national health systems and services for refugees and/or other populations of concern under the same conditions as nationals.
- Inclusion refers to including refugees and/or other populations of concern in all their diversity and in a non-discriminatory way into national health policies, strategies and plans with specific reference to populations of concern as relevant.

Even if refugees are fully or partially included in national health policies, strategies and systems, they may still face financial, administrative, geographic, language, gender and social barriers to access services. Furthermore, national services may lack the capacity and be under-resourced and unable to meet the needs of the host population (even before the additional requirements of refugees).

The GCR supports inclusion of refugees into national policies, strategies and plans and integration into national systems while emphasising the importance of support to those systems. In this global public health strategy, UNHCR outlines how to work with and through national services to foster inclusion

and integration of refugees whilst ensuring that immediate and ongoing needs are met. Working with national health systems, including with partners such as WHO, to meet the needs of both refugees and affected host communities has always been part of UNHCR's approach to health, but with more and more refugees living outside of camp settings, particularly in middle income countries, the necessity to strive for integration and inclusion has become increasingly relevant.

INCLUSION AND INTEGRATION

Inclusion and integration are not binary concepts and range from:

- No inclusion and/or integration at all (no specific reference to refugees in relevant policy documents or these documents are explicit on excluding refugees and therefore, requiring separate health facilities and no commodities provided including for TB, HIV and contraceptive supplies and vaccines supported by the national system); or refugees are charged the same rates as foreign nationals (usually unaffordable) to access services or access to emergency services only.
- Partial inclusion (inclusion in some national policies, strategies and services such as TB, HIV, malaria, EPI, and some access to national services such as children under five and/or pregnant women.
- Full inclusion with explicit mention of refugees in national policies and full access to national services provided through the ministry of health, including primary, secondary and tertiary care and all associated costs, on par with host nationals AND these services are able to meet the needs of both refugees and host communities with or without additional support

2) Working in partnership

UNHCR will continue to identify, develop and nurture key strategic partnerships to ensure coordinated capacity for emergency response and sustained engagement of relevant actors for the realization of the objectives of the GCR. UNHCR will play a convening and catalytic role based on identification of needs, leveraging partners with a comparative advantage to jointly develop approaches to meet refugee health and nutrition needs.

In pursuit of this, UNHCR works in partnership with ministries of health and will galvanise engagement from United Nations partner agencies particularly WHO, but also UNICEF, WFP, UNFPA, ILO, UNDP, IOM and UNAIDS. UNHCR is a cosponsor

of UNAIDS and will continue to engage in the promotion and implementation of the new *Global AIDS Strategy 2021-2026: End Inequalities, End AIDS*⁸ to ensure refugees and other populations of concern are not left behind in the advances towards ending AIDS as a public health threat by 2030.

Fundamental to UNHCR's work in public health are partnerships with national and international civil society organisations to support service delivery and jointly develop strategies and approaches. Considering UNHCR's Grand Bargain commitments, UNHCR will endeavour to expand partnerships with national civil society organisations, currently already constituting 63 % of its partners in health and nutrition, as well as national institutions such as academic institutions, civil society and private sector actors.

It is also essential to deepen existing partnerships and establish new partnerships with development banks and financing institutions, private foundations and bilateral donors. UNHCR will continue to strengthen and expand its partnerships with major health development actors including the Global Fund for AIDS, Tuberculosis and Malaria and Gavi, the Vaccine Alliance and will continue to engage in the Global Action Plan on Child Wasting, a framework for action to accelerate progress in preventing and managing child wasting and the achievement of the Sustainable Development Goals.

Strengthened partnerships with academia are important to further develop the evidence base on inclusion and integration of refugees, and where relevant other populations of concern, into national health systems and help identify and adapt innovative, cost-effective, contextually appropriate approaches to improve health and nutrition outcomes. Partnerships will be particularly sought with national academic institutions to foster national capacity building, promote credibility and political will.

Lastly, but most importantly, UNHCR recognises that refugees and other persons of concern themselves are key partners in responses and will strengthen engagement with communities to ensure responses are meaningful, appropriate and inclusive.

3) Capacity strengthening of UNHCR, partners, refugees and other persons of concern

UNHCR will endeavour to provide and promote opportunities to public health and nutrition personnel, ministry of health staff, partner staff, refugees and, where relevant, other persons of concern to build their capacities in health and nutrition programming. Knowledge exchange will be strengthened for personnel at country, regional and global level through a well-functioning community of practice and expanded internal and external opportunities for trainings using different formats. In line with the localisation agenda, particular focus will be given to strengthening capacity of national partners in jointly agreed priority areas. Strengthened approaches will be based on feedback from capacity strengthening needs assessments, field experiences with various capacity building approaches as well as findings from evaluations. Effectiveness of different approaches will be monitored. Knowledge management will be strengthened to better document, discuss and disseminate field experience, good practices, challenges and learnings to ensure both individual and organisational learning and their application.

4) Strategic health information

The availability of reliable data on health and nutrition access, utilisation, coverage and quality of services as well as health and nutrition status is fundamental to monitoring programme quality and effectiveness and strengthening accountability in line with UNHCR's Results based Management (RBM) System. UNHCR's public health and nutrition programmes will be supported by the strategic collection, analysis and use of data to both monitor health and nutrition outcomes and the operationalisation of the GCR.

UNHCR will strengthen health and nutrition programme responses, accountability and learning by improving the availability, quality and utilization of data on non-camp refugees including through the integration into national data collection systems and expanded use of the health access and utilisation surveys (HAUS) as well as inclusion of key health indicators into multisectoral surveys in support of core indicator monitoring of RBM. In line with the GCR, UNHCR will also promote the inclusion of refugees in relevant national health and nutrition surveys including disaggregation of results by refugee or nationality status, vital registration systems and national health information systems, such as District Health Information Software (DHIS) 2, as well as promoting interoperability between the UNHCR HIS and DHIS 2 where possible.

⁸ <https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>

UNHCR will also systematically monitor the extent of inclusion of refugees into national health systems through standardised tools. Country operation situational analysis and yearly implementation plan reviews envisaged in the new RBM will contribute to the assessment and monitoring of effective access to health services.

Increasing attention will be paid to linking health programme data to costs and expanding the evidence base for cost effectiveness and value-for-money in refugee settings. When setting indicators and targets, UNHCR will increasingly harmonize these in non-emergency operations around SDG Goals towards 2030 targets in line with the RBM, combined with measuring indicators for UHC 2030, a principle of Agenda 2030.

5) Multisectoral approaches to health

Good health and well-being cannot be achieved through interventions in the health sector alone. A significant part of the burden of disease is related to social determinants of health: the conditions in which people are born, grow, work, play, live, age, and die. Modifying social, environmental and economic determinants of health requires multisectoral approaches, anchored in a human rights perspective. Therefore, multisectoral action is central to the SDG agenda, recognizing that people's health is influenced by income level, housing, living conditions, gender differences, educational status and other social determinants.⁹ Most of the SDGs contribute in one way or another to health and well-being. For UNHCR's populations of concern many of these social determinants of health are particularly salient, for example, education opportunities – particularly of women and girls-, gender equality, poverty and financial risk protection, safety and security, nutrition and food security throughout the life cycle, water, sanitation and energy access, and housing and settlement conditions.

Multisectoral action is therefore essential to achieve the objectives in this strategy. UNHCR staff and partners will continue to work closely together in a multisectoral way at global, regional and country level to strengthen collaborative actions with areas of work that have clear links with health and/or nutrition outcomes.

STRATEGIC OBJECTIVE 1

Support, monitor and advocate for access of refugees and other populations of concern to essential health and nutrition services of sufficient quality to be effective, throughout the displacement cycle

Throughout all phases of displacement, UNHCR aims to ensure equitable access to quality, essential packages of health care including preventive, promotive, curative, rehabilitative and palliative care. This includes maintaining and strengthening operational capacity of health service provision through national health systems where possible, including at sub-national level and in collaboration with national and international organizations, including WHO.

Result 1: Adequate emergency health and nutrition response realized in refugee emergencies, including in disease outbreaks

Health and nutrition interventions in refugee-related emergencies, including disease outbreaks, target the prevention of excess morbidity, mortality, suffering and impairments resulting directly from the emergency as well as from absent or deficient essential health care services. While host countries hold the primary responsibility to provide health and nutrition services for refugees and other persons of concern, in many situations they will require the support of UNHCR, WHO and other actors. The scope of the response will depend on several factors: the type and phase of the crisis; the number of people affected; pre-existing levels and patterns of morbidity, mortality, nutrition status and vulnerability; and the capacity of the national services to meet the needs of the affected population without detriment to the host community.

Implementation of relevant public health measures in preparation for, and in response to, refugee emergencies is paramount. Refugee emergencies highlight the importance of an adequate level of preparedness and response capacity, including through efficient and sustained coordination with national authorities and partners, adequate training of health care workers, effective surveillance, mechanisms to rapidly access medicines and medical supplies and the crucial role of refugees, other populations of concern and the surrounding host communities in the response as well as ensuring their inclusion in national plans.

⁹ The Declaration of Alma-Ata on Primary Health Care, (1978), the Ottawa Charter for Health Promotion (1986), the Rio Political Declaration on the Social Determinants of Health (2011), the Helsinki Statement on Health in All Policies (2013), and the Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (2016) all provide useful guidance on an integrated response.



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Rwanda. First group of evacuees from Libya arrive in Gashora

During emergency situations, Sphere standards and generally accepted emergency mortality and nutrition thresholds are key in monitoring the response. Once the situation stabilizes health programming targets will be guided by national standards, while increasingly harmonizing these around SDG Goals and Agenda 2030 targets, combined with measuring indicators for UHC 2030. It is important that every public health response consists of a timely set of actions, decisions, and interventions so that the relevant actions are undertaken in the different phases of a refugee emergency. The UNHCR Public Health in Emergencies Toolkit¹⁰ provides guidance and tools that can be adapted to different contexts.

Enabling actions

- Strengthen the health and nutrition components of multisectoral contingency planning and emergency preparedness at global, regional and country levels.
- Conduct a joint public health and nutrition needs assessment at the onset of an emergency to guide key and timely actions by relevant stakeholders.
- Ensure coordination and partnership with governments, international and national organizations, civil society and faith-based organizations and other sector coordination mechanisms throughout the response.
- At the onset of an emergency focus on the delivery of an initial set of essential health and nutrition services and progressively broaden the scope.
- Consider the socio-economic situation, the housing/ living conditions, the ability to meet basic needs and expenditure patterns. Refer to existing vulnerability and cash feasibility assessments in the operation.
- Implement and promote effective coordination around the Minimum Initial Services Package (MISP) for sexual and reproductive health and expand to comprehensive services as soon as possible.
- Achieve maximum impact across the population by using known evidence-based health and nutrition interventions based on epidemiological profile, disease risks and vulnerabilities.
- Access to health care should be free of charge in an emergency. If national policies require user fees, advocate that they should be affordable and on par with nationals, consider the need for cash assistance to facilitate access in line with [guidance on use of cash to support health service access](#)
- As part of emergency preparedness, facilitate policies that support the rapid entry of emergency medications, medical supplies and medical equipment into the country.
- Support the transition from prioritised emergency response actions to comprehensive health care services.
- Monitor the effectiveness and appropriateness of emergency response activities based on UNHCR's Public Health Emergency Toolkit.

¹⁰ <https://emergency.unhcr.org/entry/526020/sectoral-coordination-toolkit-public-health-in-emergencies-toolkit#2,1620658380362>

ESSENTIAL PRIMARY HEALTH CARE SERVICES

- Management of acute conditions and communicable diseases
- Integrated Management of Childhood Illnesses (IMCI) including malaria, pneumonia, diarrhoea; micronutrient deficiencies including vitamin A and Zinc
- Integrated management of the most common non-communicable diseases (NCDs)
- Essential mental health and psychosocial support (MHPSS) services as in mhGAP
- Preventive and promotive services such as immunization, micronutrient supplementation, vector control measures, including long lasting insecticidal nets (LLINs) when required for malaria and other vector-borne disease prevention
- Sexual and reproductive health services such as antenatal and postnatal care, contraceptive services, skilled birth attendants providing essential maternal and newborn care; timely access to basic and comprehensive Emergency Obstetric and Neonatal Care (BEmONC) and (CEmONC) and care for sick and small newborns
- Rehabilitation services including access to assistive devices
- HIV and TB prevention, counselling, testing, treatment and care and viral hepatitis services including inclusion in national viral hepatitis vaccination and treatment programmes
- Clinical management and mental health and psychosocial support to survivors of gender-based violence including intimate partner violence
- Prevention of all forms of malnutrition using Infant and Young Child Feeding (IYCF) activities from conception to 2 years of age, such as counselling and promotion of recommended breastfeeding and complementary feeding practices, mothers' and fathers' support groups, and cooking demonstrations
- Identification and treatment of acute malnutrition integrating the Community Management of Acute Malnutrition (CMAM) approach through the PHC platform for children under 5 years of age, the Family MUAC approach for case identification, and the provision of supplementary food for malnourished PLW and people living with HIV and TB, and of micronutrient deficiencies such as anaemia, scurvy, beriberi or pellagra

Result 2: Access to essential primary health care safeguarded

Meaningful access to promotive, preventive, curative, rehabilitative and palliative care within a primary health care approach for women, girls, men and boys, should be needs-based and tailored as necessary to the specific needs of people of all age groups, including those with disabilities, adolescents, LGBTIQ+ people, people who sell or exchange sex, and regardless of ethnicity, religion, linguistic or political affiliation.

Enabling actions

All UNHCR supported public health programmes for refugees and other persons of concern are based on principles of primary health care (PHC); people centred rather than disease centred, a whole-of-society approach, providing care in the community as well as care through the community, addressing individual, family and community health needs, and the health of the population through public health approaches.¹¹

- Where refugees and other persons of concern are accessing national services, advocate that they have access to services and clearly defined packages of essential primary health and nutrition services at a similar level to those of host communities.
- Wherever available and accessible, prioritize access to national health service delivery and support in preference to setting-up supplementary services.
- UNHCR will carefully assess the potential role of cash assistance as one of the available interventions to address health and nutrition needs in line with [The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and for other People of Concern to UNHCR](#) and UNHCR's policy on cash-based interventions 2021-2026. In doing so UNHCR should prioritize assistance to those most in need based on country-specific vulnerability criteria and ensure monitoring.
- National health services in refugee hosting areas need to be adequately supported including with equipment, medicines and medical supplies, human resources, rehabilitation, construction or extension and adequate water supply, sanitation and energy sources.
- Facilitate recruitment and use of qualified refugees in health service delivery in line with national standards.

¹¹ <https://www.who.int/news-room/fact-sheets/detail/primary-health-care>

- Adequate pharmacy management through staff with appropriate training and qualifications; stock management tools; periodically complete inventories, consumption and distribution monitoring reports; sufficient storage arrangements; rational drug use and timely procurement.
- Quality of health service provision must be promoted through regular monitoring of health service utilization and outcome indicators using a health information system (iRHIS or national system).
- Improve water, sanitation and hygiene (WASH) services, access to electricity and infection prevention and control at health facilities as a core component of quality service provision.
- Where UNHCR is supporting direct service provision, the Balanced Score Card can be used in conjunction with partners to monitor minimum staffing levels; staff training and skills; availability of essential medicines and equipment; basic infrastructure such as water, electricity, sanitation, hazardous solid waste management and hygiene; and use of clinical guidelines and protocols in line with national or international best practice standards.

Result 3: Access to comprehensive health services supported through a functional referral mechanism

Functional and timely referral care is essential to ensuring access to relevant medical and surgical care beyond primary health care. While the primary health care approach is the core of all interventions, access to secondary and tertiary health care is also important. Cost, availability and quality of services, as well as timely access to treatment, are key factors to consider in making referral decisions. Referral committees are recommended to facilitate objective decision-making.

Monitoring of referral care, including the costs, is critical to strengthen analysis of the main conditions referred and to undertake relevant comparisons between referring entities. Tools to facilitate implementation and monitoring of medical referrals are key to efficient referral programming. Proper and consistent use of the UNHCR medical referral care database, or its equivalent, remains crucial to monitor the reasons for referrals, outcomes and related costs. This should be supported by regular reviews (at least annually).

Enabling actions

Referral criteria are guided by country level Standard Operating Procedures (SOPs) with clear decision-making criteria.

- Though the focus will continue to be on emergency life-saving referral care, many elective procedures are cost-effective. UNHCR will move beyond emergency referral care, and facilitate and promote access to essential elective surgical services based on the 44 essential surgical procedures¹², such as cataract surgery (a major cause of preventable blindness), orthopaedic corrective surgeries (to prevent mobility-related impairment and disability), and other procedures to reduce the likelihood of complications requiring emergency interventions. Though referral budgets are becoming increasingly restricted, UNHCR will make efforts to explore other options to provide this care, including through mobilizing other partners, facilitating visiting surgical teams for the benefit of refugees and hosts, maintaining lists of persons in need of such services and endeavour to make provisions within the referral budget for elective procedures to help alleviate waiting times.
- Disability-related services such as provision of assistive devices, physiotherapy and occupational therapy should be reflected in the referral protocols with clear decision-making criteria.
- Tools to facilitate implementation and monitoring of medical referrals should be made available and implemented, including use of the online medical referral database to track referrals, their appropriateness and costs.



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Uganda. Lynda is a Lab Technologist and the Infection Prevention and Control focal person working in Kyaka II refugee settlement

¹² [https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(15\)60160-X.pdf](https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(15)60160-X.pdf)



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Sudan. Ethiopians flee to Sudan to take Shelter.

Result 4: Health risks mitigated throughout voluntary repatriation and through support to health services in reintegration

In line with the GCR objective to support conditions in countries of origin for return in safety and dignity, access and continuity of essential health care will be included as one of the key components of the repatriation process to ensure that the health and nutrition status of returnees is not undermined in the process of repatriation.¹³

Enabling actions

- Seek to address basic health and nutrition needs of the returnees in conjunction with partners during the three phases of the repatriation operation: pre-repatriation, movement, and re-integration.
- Plan for returnee movements and anticipate disruptions in health service provision; develop SOPs with national authorities and partners to ensure continuity of services and to minimise risks on return; this will include immunization for children and women of reproductive age, continuity of medication for those with chronic diseases including HIV, continuity of contraceptive supplies and guidance on management of pregnant and early post-partum women and their neonates, tuberculosis and households with hospitalised members.
- Seek support of WHO for risk assessment of disease outbreaks and other public health risks in advance of large returnee movements in line with the memorandum of understanding.
- Advocate for access to public health and nutrition services in the areas of return, acknowledging that the quality of services in the areas of return may be lower.

- Where possible, provide reintegration support to access health services where required; this could be temporary cash support.
- Seek to strengthen national services in areas of return in collaboration with partners, including WHO, to ensure the health system is able to manage the additional needs of returnees and mitigate the impact of returnees on the system.
- Mechanisms to share confidential medical information before, during and after repatriation should be established. Persons with health needs should receive follow-up to ensure their access to health services and care, including continuation of treatment.

IN LINE WITH THE GCR UNHCR RECOMMENDS:

- Including refugees in national health plans, policies and strategies
- If there is a need to establish supplementary services for refugees, do this in line with national systems such as through accreditation of health facilities, secondment of staff from the national system, supervision by the Ministry of Health, and harmonization of standards, treatment protocols etc.
- Leverage development donors early in a response such as the World Bank and regional intergovernmental banks.
- In line with i.e. the SDGs advocate and support host countries to collect and report data disaggregated by refugees and nationals for key indicators in the DHIS, vital registration systems, national surveys such as multi-indicator cluster surveys (MICS) and Demographic and Health Surveys (DHS).

¹³ <https://www.unhcr.org/4f7080349.pdf>

STRATEGIC OBJECTIVE 2

Support national health systems to meet the health needs of refugees, asylum-seekers and host communities.

In line with the GCR objective to *ease pressure on host communities*, UNHCR will catalyse support to national health systems.¹⁴ Wherever possible, refugees should be included and integrated into national health systems and services, recognising that such systems may need support to ensure their capacities are strengthened to meet the needs of refugees as well as host communities. Refugees often have different health care needs such as gender-based violence, MHPSS, and immunization access but the aim is to meet them through differentiated responses delivered within one system.

Working through and supporting national systems will:

- Be more sustainable and ultimately more cost-effective but it is not cost-free; most governments will need additional resources to support the additional demands placed on the national system.
- Promote national resilience through support to already existing structures and systems.
- Help to promote peaceful coexistence both at the national and local levels and generate protection dividends *if done well*.
- Governments will be supported to meet the needs of both their own population and those of refugees with less likelihood of resentment at perceived disparities in the level of service provision.
- Help to achieve universal health coverage (SDG 3) and end hunger (SDG 2) for both nationals and refugees.
- Bolster preventative health care as well as prevention and response to disease outbreaks, including COVID-19, because these are most effective when pursued through a single, unified system that is inclusive of all.

UNHCR will work closely with partners, such as WHO, towards the full access and inclusion of refugees into national health systems wherever feasible and strengthen partnerships with ministries of health. **Rapid and effective emergency responses**, including establishing supplementary facilities where needed, will continue to be essential to both ease the burden on host communities and save lives.

UNHCR will develop and leverage key strategic partnerships to ensure this support, including sufficient financing, is provided early in the response and is sustained over time. Many refugee hosting countries have health systems that need strengthening especially in remote areas where refugees are often hosted. They may already have health sector reform or development plans supported by external donors. These will be generally too slow to respond adequately to emergency health needs and additional support will be needed especially early in the response.



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Ecuador. Venezuelan refugee and migrant older people get the Covid-19 vaccine with UNHCR support

Result 1: National health policies, plans and systems meet the health needs of refugees

UNHCR will work through national systems and support strengthening of national health systems to meet the needs of refugees and host communities. Where capacity gaps exist in national systems UNHCR will seek to further engage other actors to support UNHCR to address those gaps. Key partners are national ministries of health, UN agencies, such as WHO, UNICEF, UNFPA, UNAIDS, major bilateral donors, Global Fund for HIV, TB and Malaria, Gavi, and other development actors such as the World Bank, the African Development Bank and the Bill and Melinda Gates Foundation.

UNHCR will seek inclusion of refugees within

¹⁴ <https://www.unhcr.org/publications/brochures/5fb3ad4d4/public-health-nutrition-operationalizing-global-compact-refugees-comprehensive.html>

national policies/laws, plans and integration in systems provided the systems and services are of sufficient quality to be effective. Full inclusion and integration in national systems is complex, multi-phased and requires political and donor commitment and support. Inclusion and integration will usually need to be done in a progressive manner, according to the context, and through a medium to long-term approach. Refugees are usually well included into vertical disease programmes such as national TB, HIV, malaria and immunization programmes, which are frequently supported by key donors including provisions for additional support to include refugees.

To advance inclusion and integration into national health systems, consideration should be given to UNHCR catalysing the development of medium to long-term, multi-year plans at country level in conjunction with the ministries of health, ministries of finance, WHO, ILO, UNICEF, IOM, humanitarian and development donors, including the World Bank (Annex 1). The aim should be to support greater inclusion and, where possible integration, in a sustainable way. This country-level multi-year plan should have periodic milestones (e.g. 6-monthly or annual) working towards inclusion of refugees and integration of services with agreed contributions by other actors. These should be recalibrated yearly based on a multi-agency review led by the government.

Development and/or partnership officers will work closely with public health officers at regional and country level to include refugees and, where relevant, other persons of concern into national development plans and initiatives by the World Bank, other multilateral development banks and development donors. This will especially include contexts where funding is targeted at inclusion of UNHCR's populations of concern such as World Bank's Window for Host Communities and Refugees or the Global Concessional Financing Facility.

Enabling actions

- In the preparedness phase, assess the capacity of the national/local health system and its readiness to include refugees; this includes considerations of the expected impact of an influx of refugees.
- In the preparedness and response phases, advocate for, and catalyse, strengthening of national health systems in anticipated refugee hosting areas through UN partners, development agencies and bilateral support agencies.

- Assess the need for short to medium-term support early in preparedness actions and in response to displacement, to support the capacity of the health system to meet the needs of refugees and hosts. Such support may include, but is not limited to, medicines, supplies and equipment, staffing and capacity building activities.
- Early in displacement and throughout the response assess the extent to which refugee and host community health needs are being met in line with objectives of an emergency health response.
- Identify barriers to inclusion of refugees within, and access to, the national systems including health system capacity, geographical, political, financial and others.
- Catalyse and coordinate the development of medium to long-term plans for support to national health systems to facilitate greater inclusion of refugees in national health systems with agreed milestones, reviewed jointly at least yearly and recalibrated as needed. These are complementary to country operation multi-year strategies.

Result 2: Financing for refugee inclusion and integration into national health systems is established

Inclusion of refugees within national health systems generally requires additional financing that may be supported by humanitarian actors in the short to medium-term but requires medium to long-term financing mechanisms for sustainability. Many host governments will not have domestic resources for this and will require development donor support, including the use of pooled funding mechanisms to which multiple donors can contribute. UNHCR and partners, such as WHO, will need to review different financing mechanisms to support refugee and host community services based on the country context. Many countries are working towards UHC through various mechanisms. Given the diverse contexts and differences in health system capacities and policies towards refugees, extent of donor support and progress towards UHC, a sound country analysis is needed to determine the options in the medium to longer term.

Tools are available to assist country operations to assess available options for financing of inclusion into national social health protection schemes, including health insurance.¹⁵ National health systems can also be funded by tax-based revenue and financing options for refugees in these contexts will need further exploration at country level.

¹⁵ [Handbook on social health protection for refugees: Approaches, lessons learned and practical tools to assess coverage options](#)



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Iran. Salamat Health Insurance brings care and comfort

WHAT IS UNIVERSAL HEALTH COVERAGE:

- UHC does not mean all health services are free of charge but that they are affordable.
- UHC is not only about health financing but encompasses all components of the health system to improve health service coverage and outcomes, i.e., health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation.
- UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.
- UHC is not equal to health insurance. Health insurance is one mechanism of pooling risk and providing access to health services with protection against high out of pocket health expenditure.
- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns and actions. e.g., controlling mosquito breeding grounds.

Universal Health Coverage

Universal health coverage is defined by WHO as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship.¹⁶

Working towards UHC requires strengthening of national health systems and strong financing structures are essential. Pooling of funds from compulsory sources such as mandatory insurance contributions are one way of spreading financial risks of illness across the population.

Taking steps towards UHC means advancing towards equity, development priorities, and social inclusion and cohesion.

Progress towards UHC can be measured by assessing the proportion of a population that can access essential quality health services (SDG 3.8.1)¹⁷ and the proportion of the population that spends a large amount of household income on health (SDG indicator 3.8.2).

¹⁶ https://www.who.int/healthsystems/universal_health_coverage/en/

¹⁷ SDG indicator 3.8.1 measures coverage of essential health services by measuring a mean of 16 tracer indicators of health service coverage. The tracer indicators are organized by four components of service coverage: 1. Reproductive, maternal, newborn and child health 2. Infectious diseases 3. Noncommunicable diseases and 4. Service capacity and access.

Enabling actions

- Assess and understand the financing mechanisms of the national health system and financing towards UHC.
- Ensure that refugees, and where relevant, other populations of concern are included in national developments towards UHC.
- Assess opportunities for inclusion of refugees in national social health protection schemes if existing, such as national health insurance.
- Assess capacity of refugees and, where relevant, and other populations of concern to contribute to their health care costs through contributions to national schemes, if existing, on par with nationals of similar socioeconomic status.
- Catalyse support for additional financing for inclusion of refugees through donor and/or development agency support if domestic capacity is not possible.

Result 3: Inclusion of refugees in national health policies, plans and services is monitored

Progress towards inclusion as well as the extent of inclusion of refugees in national health systems should be monitored. When refugees enjoy full or partial inclusion in national systems, monitoring of access to and utilisation of health services is required including the identification of any barriers to access so these can be addressed.

Enabling actions

- Undertake the UNHCR country inclusion survey in priority countries every two years to assess and monitor the extent of inclusion.
- Joint monitoring of progress on inclusion plans with government, development partners, donors and refugees themselves.
- Monitor the impact of refugee inclusion on national health systems including through changes in proportion of services provided to refugees, bed occupancy, waiting times, and staff/patient ratios.
- Undertake participatory assessments with refugees and immediate host communities including as part of country situation analyses and annual implementation monitoring, to assess health service access, gaps in service provision and satisfaction with health services.
- Conduct household surveys such as UNHCR's HAUS, multisectoral household surveys or integrate refugees into national surveys to assess the level of access to health services, barriers to access and household expenditure on health.

- Advocate for disaggregated data by refugee status and/or nationality in the national health information system and monitor access of refugees with consideration of protection implications.
- Advocate for and support systems for accreditation of refugees who are qualified health providers including nurses, midwives, doctors and laboratory technicians in line with national standards.

STRATEGIC OBJECTIVE 3

Promote and support equitable provision of health care services

In line with Goal 10 of the SDGs to **Reduce inequality within and among countries** UNHCR will work with ministries of health and partners to design and monitor health services that promote and support equitable outcomes for populations of concern.

UNHCR aims to achieve:

- i) Equal access to health care for those in equal need of health care;
- ii) Equal utilization of health care for those in equal need of health care;
- iii) Equitable health outcomes.

This requires well-functioning health services that are accessible and responsive to the needs of all population groups, as well as targeted health services for particular groups.

Efforts will be made to support equitable provision of health and related services for the following groups.

Persons with disabilities

UNHCR strives to ensure that persons with disabilities have access to essential services, adequate accessible living conditions and have opportunities to apply their skills and capacities to benefit themselves, their families and communities. Persons with disabilities “include those who have long-term¹⁸ physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”.¹⁹

¹⁸ A long-term impairment is usually understood as a condition that has persistence over time. Although there is no universal agreement on this time period, UNHCR understands this to be six months.

¹⁹ <http://www.un.org/disabilities/convention/conventionfull.shtml>

Some disabilities may be identifiable through visual cues (such as some physical and sensory disabilities) while others may be less visible, such as psychosocial disabilities (e.g. severe mental conditions and developmental disabilities e.g. autism and other neurodevelopmental conditions). Globally, according to the definition used in the World Report on Disability, persons with disabilities make up an estimated 15% of the population.²⁰ This may be higher in refugee and IDP populations.²¹

All people with disabilities require access to health care as everyone else, including child health services for boys and girls with disabilities, and sexual and reproductive health services for women and girls with disabilities. This may require adaptations of health care facilities and services to ensure access on par with others. Some people with disability have extensive additional health care needs related to their disability but others do not. Additionally, people with disabilities may also require assistive technologies such as glasses, wheelchairs or hearing aids.

Refugees and other persons of concern with disabilities may face particular challenges in accessing services. They are often disproportionately exposed to discrimination, exploitation and violence, and face barriers in accessing humanitarian assistance, including health services. Women and girls with disabilities may face forced sterilisation, abortion and contraception, in addition to other forms of violence, which UNHCR strongly opposes. Assessments in refugee situations identified a number of areas that need strengthening including waiting times for assistive devices; consistent provision of mobility aids; training of health providers, reception and other personnel on disability inclusion; and accessible information and communication on health.

LGBTIQ+ persons

Lesbian, gay, bisexual, transgender, intersex, queer and other diverse identities (LGBTIQ+) persons of concern, as everyone else, require equal access to general health care services.²² They are more likely to experience human rights violations including violence, criminalization, discrimination and stigma. This results in a high rate of physical and mental

health issues and reduced access to health and social services. Men who have sex with men and transgender people are at significantly higher risk of acquiring HIV²³ and require targeted prevention activities, treatment and care.

Within health care settings, incidents of violence against LGBTIQ+ persons have been documented, including denial of medical treatment, verbal abuse, and forced – often medically unnecessary – procedures. This is unacceptable and UNHCR is expected to take action to prevent this.

Discrimination on the basis of sexual orientation or gender identity violates UN human rights standards, and negatively affects individuals, communities societies, and undermines the achievement of the Sustainable Development Goals. These intersecting barriers to health care and social services result in drastic health disparities between those who have access to these essential services and those who do not.

Adolescents

Adolescents (10 to 19 years old) experience rapid physical, cognitive and psychosocial growth. This may affect how they feel, think, make decisions, and interact with the world around them. During this phase, adolescents establish patterns of behaviour – for instance, related to diet, physical activity, substance use, and sexual activity – that can protect their health and the health of others around them, or put their health at risk now and in the future.

While adolescent mortality is generally low, HIV, suicide, and – in sub-Saharan Africa-, maternal mortality are the main causes of death.^{24,25} For example, complications during pregnancy and childbirth are the leading cause of death for 15-19-year-old girls.²⁶ Adolescent mothers face higher risks of pregnancy-related complications such as eclampsia and sepsis than women aged 20 to 24 years; babies of adolescent mothers face higher risks of low birth weight, preterm delivery and severe neonatal conditions.²⁷ Girls who become pregnant before the age of 18 years are more likely to experience violence within an early marriage or partnership.²⁸ Adolescent pregnancy and

²⁰ [World report on disability \(who.int\)](https://www.who.int/world-report-2019)

²¹ [IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action, 2019 | IASC \(interagencystandingcommittee.org\)](https://www.iasc.org/publications/2019/04/24/iasc-guidelines-inclusion-of-persons-with-disabilities-in-humanitarian-action-2019)

²² <https://emergency.unhcr.org/entry/221506/lesbian-gay-bisexual-transgender-and-intersex-lgbti-persons>

²³ https://www.unaids.org/en/resources/presscentre/featurestories/2020/september/20200928_new-hiv-infections-increasingly-among-key-populations

²⁴ WHO: https://www.who.int/maternal_child_adolescent/epidemiology/adolescence/en/

²⁵ The Lancet. Maternal mortality in adolescents compared with women of other ages: evidence from 144 countries 2015: <https://www.thelancet.com/journals/langlo/article/PIIS2214-109X1370179-7/fulltext>

²⁶ https://www.who.int/maternal_child_adolescent/data/causes-death-adolescents/en/

²⁷ WHO. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015. Geneva: WHO; 2016

²⁸ Raj A, Boehmer U. Girl child marriage and its association with national rates of HIV, maternal health, and infant mortality across 97 countries. *Violence Against Women* 2013;19(4)

childbearing, as well as increasing the risk of gender-based violence, including early marriage, often forces girls to drop out of school which jeopardizes their future education and employment opportunities.

Adolescents need age and gender-appropriate health education, opportunities to develop life skills, and to be able to access health services. Too few refugee adolescents have access to information and counselling and to integrated, adolescent friendly services, and especially to sexual and reproductive health services without facing discrimination or other obstacles.

Women and girls, men and boys

Gender is a social determinant of health. Gender as a social construct impacts the social norms and biases that can negatively impact the access and availability of health care. To address this adequately, UNHCR's operations need a good understanding of the differential impact gender has on health-seeking behaviour and health outcomes.

Women and girls

World wide gender inequality and a power imbalance between men and women lead to gender-related health disparities. In many settings, women and girls have little to no access to employment, education and health and nutrition care. Women and girls are disproportionately exposed to the risk of gender-based violence, which is further increased in a situation of forced displacement, and which has severe and often long-term negative health implications. Gender inequality may lead to health risks, suboptimal health behaviours and inferior health and nutrition outcomes for women and girls. For example, the education of girls positively affects their health and well-being as adults, including the chances of their children surviving infancy. A lack of gender representation and diversity amongst health care providers may lead to female patients and their children not having equitable access to health care.

Boys and men

In most parts of the world, men and boys have worse health outcomes than women and girls. The reasons for this include biological differences, but also behaviours associated with male norms of risk-taking and because men are less likely to visit health services when they are ill.²⁹ In countries with generalized HIV epidemics, for example, men are less likely than women to take a HIV test, less likely to access antiretroviral therapy and more likely to die of

AIDS-related illness than women.³⁰ In many refugee populations women are far more likely to access antiretroviral treatment than men: 2019 data on new ART enrolments for refugee women and men over the age of 18 demonstrate that women represent 66% of the new enrolments. Similarly, male TB patients appear to be less likely to seek care. Global suicide mortality rates were 75% higher in men than in women in 2016. In Uganda in 2020, 76% of the completed suicides amongst refugees were among men. Finally, the increasing global burden of non-communicable diseases is affecting more men than women and affecting them at a younger age.

Older persons

An estimated 4% of all displaced populations in the world are older people (over 60 years), though a lack of age-disaggregated data may hide a much higher percentage.³¹ Older persons have the same basic needs as others but face increased risks as a result of ageing, including neglect, discrimination and abuse.³² While they may face particular challenges during displacement, they should not be seen as passive, dependent recipients of assistance. They may be community leaders and involved in transfer of knowledge, culture, skills and crafts. UNHCR and partners must ensure their rights and meet their needs without discrimination.

Older people may have age-related health needs relating to sight, hearing, mobility, and psychosocial support, and they are more likely to have chronic health conditions and specific nutritional needs. In forced displacement situations, impairments that would normally not impact daily functioning, can overwhelm older persons' capacity to cope. For example, older persons with physical impairments, reduced mobility, diminished vision or poor hearing can rapidly become incapable of getting food, accessing basic services such as water and sanitation facilities, or receiving information.³³ Markets or food distribution points can be difficult for them to reach and food assistance packages may not cater for older people's particular nutritional requirements. Older refugees can become socially isolated and physically separated from their families, compounding their vulnerability as well as that of their caregivers. The psychological toll of displacement on older people can be severe.

The needs and capacities of older persons are often overlooked. Health interventions must address their specific needs, and plan and implement services in close consultation with them.³⁴

²⁹ <https://www.who.int/bulletin/volumes/92/8/13-132795/en/>

³⁰ Blind Spot: Reaching out to Men and Boys (UNAIDS) 2017

³¹ UNHCR Global Trends: Forced Displacement in 2019, 2020, <https://www.unhcr.org/globaltrends2019>

³² [UNHCR Working with Older Persons in Forced Displacement](#)

³³ <https://www.helpage.org/what-we-do/emergencies/older-people-in-emergencies/>

³⁴ For more information on strategies to ensure access to health services, please see [UNHCR Working with Older Persons in Forced Displacement](#)

Persons of concern who are deprived of their liberties

International standards are clear that persons in detention shall have access to the same standard of health care as is available in the community, and that this applies to all persons regardless of citizenship, nationality or migration or displacement status. Persons of concern to UNHCR who are deprived of their liberty may face specific risks to their health and well-being. For example, in some contexts, asylum-seekers and refugees who are held in detention have restricted access to hygiene, health care and food and in some cases are exposed to torture, gender-based violence, or deprivation. In such situations, people can be expected to have higher rates of malnutrition, communicable diseases and mental health problems. This can be addressed through a combination of advocacy, monitoring and service provision.

Result 1: Disaggregated data allows identification and analysis of disparities in access, utilisation and outcomes

Enabling actions

- Selected health indicators are disaggregated by key stratifiers including demographic characteristics (sex, age, place of residence (urban/rural, subnational), and refugee or nationality status.
- Consult and engage with specific groups such as people with disabilities, adolescents, women and girls, men and boys, older people and LGBTIQ+ persons about their views, needs and access to services.
- Advocate for inclusion of refugees in national health surveys such as DHS, MICS or nutrition surveys with an adequate sample size to allow disaggregated presentation of results by refugee status or nationality.
- Consistently document age and sex disaggregated mortality data including neonatal, maternal and under-five mortality.

Result 2: Gender responsive policies are promoted

Enabling actions

- Acknowledgement of harmful gender norms, roles and inequalities that impact health seeking behaviour and access, whilst advocating for and implementing gender transformative solutions that enhance the power of women and girls to make decisions about their health and health care and contributing to actions that integrate

specific needs for men/boys; women/girls; transgender and other gender identities based on their sex and gender requirements.

- Integrate gender analysis and mainstream gender in health and nutrition policies, strategies, assessments, evaluations, etc.
- Implement actions to increase access and acceptability e.g. option of same-sex providers, alternate venues and/or longer opening hours to reach everyone.
- Promote female medical and nursing staff in contexts where the lack of female staff is a major barrier to access services for women and girls
- Promote gender equality among health providers, including actions to have women in management positions.

Result 3: Barriers to accessing health services identified and addressed

Enabling actions

- Conduct an assessment (including key informant interviews, focus group discussions, review of health utilization data) to identify context-specific barriers to health service access for key vulnerable groups (including those above).
- Develop and support interventions that explicitly address barriers to access and health care adherence for “hard to reach” populations including social, gender and economic barriers
- Ensure information is available to all segments of the population using preferred channels of communication and in accessible formats and languages on entitlements to access health services
- Through the AGD processes, engage specific populations such as adolescent males and females, women and men, girls and boys, LGBTIQ+ people, persons with disabilities, sex workers, people living with HIV, ethnic minorities and other identified groups at risk of being marginalised in the process of determining health priorities, while disseminating information about where to access services and shaping health services
- Train and support health providers on the rights, needs and vulnerabilities of specific populations such as LGBTIQ+ persons, older people, adolescents, people with disabilities, survivors of gender-based violence, other potentially stigmatising conditions and others who may have challenges in accessing health services; help health providers to develop supportive approaches to facilitate access of all people to mainstream health services.



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Colombia. 'A life or death situation' – Angelina Jolie on Venezuelan exodus

- Use community health workers or other forms of outreach based on consultation and preferences, to identify those who cannot reach facilities and consider providing home-based care or transport for those referred to clinics or hospitals.³⁵
- Explore attitudinal barriers, promote supportive attitudes and monitor their application with health service providers on provision of specific services to adolescents and other at-risk groups.
- Promote supportive attitudes, behaviour and practices amongst health workers for engaging men and boys and identifying barriers to them accessing health services.
- Provide space for male partners in health facilities.
- In consultation with male and female older persons and persons with disabilities, design or adapt health centres, distribution sites, water sources, latrines, shelters and other infrastructures so that they are safe, accessible and appropriate. This includes attention to barriers or tripping hazards, ramp access, large doorways, handrails on stairs, non-slippery floors, disability accessible toilets).³⁶

- Ensure and monitor access of older persons and persons with disabilities to food, cash assistance or in-kind distributions. Take steps to facilitate their access where necessary for example, through dedicated distributions, assistance with transport, smaller parcels, or 'home delivery'.

Result 4: Health services are accessible and responsive to the needs of specific population groups including people with disabilities, adolescents, women and girls, men and boys, older people, people with diverse SOGIESC and different ethnic groups

 **Enabling actions**

- Ensure physical accessibility for persons with disabilities and older persons as above.
- Promote capacity amongst health providers and reception staff to communicate in accessible formats such as sign language.

³⁵ Working with Older Persons in Forced Displacement. UNHCR 2013

³⁶ <https://emergency.unhcr.org/entry/251401/older-persons>

- Consider needs of persons with disabilities and persons with low literacy levels in developing information, communication, and education materials such as materials in Braille, pictorial materials, and oral formats; train health care staff in communicating with persons with disabilities with diverse needs.
- Partner with disability-focused organizations to improve UNHCR, partner personnel and health provider knowledge regarding the rights of persons with disabilities, assist in monitoring access of persons with disabilities to quality health services, identify barriers to access and contribute to empowerment of persons with disabilities.
- Work with health and nutrition partners to identify any specific dietary needs of older persons and persons with disabilities.
- In consultation with adolescents, develop programmes ensuring adolescent-responsive health services and including rights to access sexual and reproductive health (SRH) information and services. Key elements include community involvement and empowerment, peer-led approaches and addressing attitudinal barriers, particularly those of health care providers.
- Understand national laws and policies that may present barriers to adolescent access to and self-determination of health, including requirements related to parental consent, particularly regarding HIV testing, contraceptive services and post-abortion care.
- Adapt services provision to facilitate access for men based on an understanding of their needs through, for example, extended clinic hours, separating reproductive health services for men from services for maternal health, outreach in bars, barber shops, workplaces and other venues.
- Identify geographical barriers including distance and adaptation of services to overcome these barriers including mobile clinics.
- Ensure service availability for service providers or interpreters for different nationality or ethnic groups who may not speak the dominant language.
- LGBTIQ+ people may need targeted services which provide a safe environment to discuss and address their health needs without fear of discrimination and rejection (particularly transgender persons).
- Persons with alcohol and substance use disorders may require dedicated services (particularly when the substances they use are socially unacceptable or criminalized).
- Persons with disabilities should have access to assistive devices that are allocated on a needs basis using clear criteria.
- Identify and map implementing and operational partners and national service providers offering rehabilitation services including priority assistive devices to refugees and host communities.
- Expand access to assistive technologies and establish clear procedures to allocate resources for assistive devices.
- In close collaboration with community-based protection, support access to rehabilitation services on the basis of impact on health, functioning and participation or reduction of vulnerability to protection risks.
- Country operations should make specific reference to access to assistive devices in referral protocols and to partners providing other evidence-based and prioritised rehabilitation interventions. These include:
 - Physical therapy sessions (facility and home-based) and follow-up, including community-based rehabilitation.
 - Occupational therapy (facility, community, and home-based).
 - Provision of prioritised assistive devices including hearing aids, eyeglasses and mobility aids.³⁷
 - Strengthened community-based rehabilitation interventions.
 - Training on self-care to beneficiaries.
- Ensuring adolescents' rights to access SRH information and services by³⁸:
 - Providing adolescent sexual and reproductive health information.
 - Improving access to sexual and reproductive health services for adolescents.
 - Increasing adolescents' leadership, engagement, and advocacy for their sexual and reproductive health.
- Map availability of health and related services for men who have sex with men and transgender men and women; consider support to drop-in-centres that provide a range of services including MHPSS, HIV and STI prevention, treatment and care; hormonal treatment; information, education and communication; access to condoms and lubricant, peer-led approaches and outreach, violence mitigation and referral to protection services.

Result 5: Targeted health and related services are provided for groups whose needs may not be adequately met by mainstream services

Enabling actions

- Design service provision in consultation with LGBTIQ+ people, persons engaging in selling or exchange of sex (male, female and transgender), people with alcohol and substance use disorders, adolescents and others.

³⁷ WHO | Priority Assistive Products List (APL)

³⁸ See [Adolescent Sexual and Reproductive Health in Refugee Situations](#)



© UNHCR/Tsvangirayi Mukwazhi
Zimbabwe. Improving water access
at Tongogara refugee camp

STRATEGIC OBJECTIVE 4

Strengthen cross-sectoral collaboration within UNHCR and with partners to create synergies and maximize positive impact on health status, welfare and dignity of refugees and other persons of concern

To improve collective health outcomes of refugees and other populations of concern it is important that the provision of health services and measures to address the immediate causal factors of a disease are complemented by actions to modify the social, economic and environmental determinants of health; promote the mitigation and adaptation to climate change and reduce health vulnerability to climate change. Therefore, a critical element of the work of public health personnel in UNHCR is to raise awareness and foster joint intersectoral actions to improve health outcomes and reduce health inequities. Collaboration with protection, shelter and settlements, food security, livelihoods, WASH and energy personnel are particularly relevant to mitigating health risks.

Result 1: Promote inclusion of health within overall assessment, planning and policy making

💡 *Enabling actions*

- During annual planning processes at country and regional level, explore opportunities for enhancing actions to address priority intersectoral areas;
- Ensure public health and nutrition are considered in the development of UNHCR policies, strategies and guidance notes to ensure they take into account the impact of recommendations, seeks synergies, and avoid harmful health impacts with the aim of improving health and nutrition status and health equity.
- Consider the impact of national non-health policies for refugees, IDPs and other persons of concern on health care access and utilisation including the differential impact based on age, gender and diversity.
- Include health and nutrition considerations in participatory assessments to inform situational analyses, annual implementation reviews and sectoral specific assessments.

PUBLIC HEALTH AND CLIMATE ACTION

Climate change is contributing to poorer health outcomes by increasing the frequency and severity of natural disasters, changing disease patterns, increasing food insecurity and reducing water availability. UNHCR-supported public health programmes will:

1. Support and strengthen the prevention, detection and control of communicable diseases, including through improved disease surveillance, vector control and immunization.
2. Strengthen community health networks to engage in emergency preparedness and response as first responders to climate-induced events, to mobilize communities on adaptation, improve prevention and detection of acute malnutrition and supporting community-based mental health and psychosocial responses.
3. Contribute to reducing carbon emissions through investment in renewable technologies such as solar power generation instead of diesel-powered generators in UNHCR-supported health facilities.
4. Advocate for the inclusion of refugees in national disaster preparedness plans and mitigation and adaptation measures, including health vulnerability assessments at national and local level.

Result 2: Ensure effective intersectoral collaboration to strengthen collective outcomes including reducing health vulnerability and promoting mitigation and adaptation to climate change.

Table 1: Priority areas for intersectoral collaboration with Public Health and Nutrition

Priority Areas	Sector(s)	Activities
Community health and hygiene promotion	WASH	<ul style="list-style-type: none"> • Ensure coordination and complementarity of community health and hygiene promotion using standardized messaging and materials • Ensure that people have access to sufficient and regular hygiene items – through CBI, or in-kind where CBI is not feasible-, to enable people to meet their needs in the most flexible and appropriate manner. <p>At community level</p> <ul style="list-style-type: none"> • strengthen the community health workforce to disseminate hygiene-related messages; • integrate community data collection systems • promote hand washing and other measures to reduce water-borne and communicable disease (such as scabies), including access to drinking water, safe wastewater and solid-waste management at both household and community level.
Vector control	WASH, Shelter and Settlements, Camp Management	<ul style="list-style-type: none"> • Coordinate and implement vector control activities to prevent malaria, dengue and other vector-borne diseases <ul style="list-style-type: none"> - long lasting insecticide treated net distributions and promotion and - shelter designs to allow appropriate net use
Outbreak preparedness and response	WASH, Food Security, Protection, Camp Management	<ul style="list-style-type: none"> • Establish outbreak control teams, develop preparedness plans and manage responses
Ensure adequate WASH and energy for health facilities	WASH, Energy and Environment	<ul style="list-style-type: none"> • Technical input to assess and improve WASH and energy at health facilities including with renewable energy sources together with health and WASH partners
Promote healthy living environments	Shelter and Settlements, WASH, Energy and Environment	<p>Develop approaches to:</p> <ul style="list-style-type: none"> • reduce overcrowding and indoor air pollution • improve cooking options and safe use of clean energy for cooking, heating and lighting, • reduce injury hazards for children • reduce vector breeding sites

Priority Areas	Sector(s)	Activities
<p>Promote and support menstrual hygiene management</p> <p>Accessibility to shelter and facilities</p>	WASH, Protection, Shelter and Camp Management	<ul style="list-style-type: none"> • Ensure access to supplies and materials for menstrual hygiene management, • promote supportive facilities with female friendly toilets and washrooms in schools and public facilities, including waste management; • provide menstrual health and hygiene education. • improve accessibility to private and community facilities for persons with functional impairment
<p>Reduce risk and respond to GBV</p>	Shelter and Settlements, WASH, Energy and Environment, Food Security, Education, Protection	<p>Work in a multisectoral way to:</p> <ul style="list-style-type: none"> • reduce risk of GBV by implementing GBV prevention and mitigation strategies³⁹. • strengthen national and community-based systems that prevent and mitigate GBV, and enable survivors and those at risk of GBV to access care and support;
<p>Strengthen GBV responses</p> <p>Reduce vulnerability of people with disabilities</p> <p>Protection of people subject to discrimination</p> <p>Promote IYCF</p>	Protection	<ul style="list-style-type: none"> • Conduct joint protection and health monitoring and assessment visits to strengthen services for GBV survivors, including clinical management of rape survivors • Work with community-based protection to strengthen supportive social networks, identify safe and secure housing and foster the protection of people with severe mental health conditions, disabilities and others with increased protection risks. • Assess, plan, implement and monitor activities that contribute to addressing the health and protection needs of people who sell or exchange sex. • Develop rights-based approaches for people subjected to discrimination related to specific conditions or identities such as HIV status, COVID-19, disabilities, selling or exchange of sex and diverse SOGIESC. • Promote Infant and Young Child Feeding (IYCF) approaches in child protection policies and actions including development of clear procedures for identification and referral of pregnant and lactating women, and other mothers and caregivers of children 0-23 months • Identify and address the non-health causes of unrecovered acute malnourished children who have been enrolled in treatment programmes, such as family environment and care practices. • Work with community-based protection on referral and interlinkages for all mental health and psychosocial support services.

³⁹ https://gbvguidelines.org/wp/wp-content/uploads/2015/09/2015-IASC-Gender-based-Violence-Guidelines_lo-res.pdf

Priority Areas	Sector(s)	Activities
Prevention of nutritional deficiencies	Food security, Cash, Energy and Livelihoods	<ul style="list-style-type: none"> Promote low-cost nutritious balanced diets to prevent acute and chronic malnutrition, micronutrient deficiencies, especially in vulnerable groups such as children below the age of 5, pregnant women, mothers and caregivers of children under five years. Support diets for people with specific needs such as non-communicable diseases, including diabetes, people living with HIV and with TB. Such approaches may include small scale agriculture, evidence-based income-generating activities, and cash assistance.
Financial protection against catastrophic health expenditure	Livelihoods, Cash, and all other sectors	<ul style="list-style-type: none"> Strengthen measures to ensure financial risk protection for refugees by reducing out-of-pocket expenditure and eliminating catastrophic expenditure on health. Promote access to decent work and labour markets. Consider CBI where it can enhance access to health care and improve health outcomes.
Strengthen collective outcomes	Education	<ul style="list-style-type: none"> Share information and results on strategies, plans, lessons learnt, and outcomes on working with national systems and refugee inclusion. Promote equitable access for refugee children and adolescents to school health programmes on par with nationals including comprehensive sexuality education, prevention and response to GBV and sexual exploitation and abuse. Explore schools as an opportunity to implement health and nutrition interventions in line with national policies, such as sexual and reproductive health; anaemia treatment and prevention in adolescent girls; weight and height monitoring and malnutrition screening; deworming; eyesight and hearing screening; immunization; suicide prevention and MHPSS activities.⁴⁰ Promote access to school feeding programmes to retain children, particularly adolescents. Promote access to drinking water, good sanitation and hand-washing facilities. Develop clear procedures for identification and criteria for referral between education and health and nutrition services.

⁴⁰ <https://www.globalpartnership.org/content/better-education-outcomes-through-school-health-interventions-factsheet>

STRATEGIC OBJECTIVE 5

Actively engage communities in activities to promote and sustain their health

People and the communities in which they are born, raised, live, work and play, are at the heart of delivering people-centred and integrated health services. Communities need to be at the centre of measures to improve the quality of health services, access and equity, and achieving UHC. Within UNHCR's work, focusing on community engagement has become of critical importance because of complex health challenges associated with population displacement and the capacity and resilience of health systems and the populations they serve.

Community health is a critical part of the primary health care continuum to address people's health needs, considering age, gender and other diversity factors.

Community health encompasses⁴¹:

- Health promotion and service delivery activities that occur primarily outside of a health facility such as nutrition screening using family MUAC and community health workers (CHW), supplementary immunization activities and community dialogues relating to health and nutrition.
- Both supply of and demand for health care, including activities that community members undertake as agents of their own health.
- CHW as one of a number of delivery channels.
- CHWs integrated into the formal health system.
- Linkages to a broader multisectoral community system.

A strong community health approach can save lives, increase access to care, contribute to containing disease outbreaks, contribute to responding to other emergencies, keep health care affordable, all while delivering a positive economic return, promoting livelihoods, empowering women and girls, and enhancing community resilience.

One essential element of a strong community health approach is a community health workforce. Tapping into the individual and collective potential of community health workers, including in refugee and IDP situations, can help overcome some of the health workforce challenges and accelerate progress towards UHC as well as contribute to addressing multiple priority health needs with integrated community-level approaches. The community health workforce plays a critical role in adapted service delivery in response to the COVID-19 pandemic.

⁴¹ <https://www.communityhealthroadmap.org/>

ROLES OF COMMUNITY HEALTH WORKERS

- Contribute to emergency preparedness and response for disease outbreaks, disaster preparedness, new influxes or new displacement.
- Contribute to disease control through surveillance at the household level, community education, support to vaccine delivery and distribution of drugs, referral for treatment.
- Provide preventive care, education and hygiene promotion.
- Treating common uncomplicated conditions e.g. acute diarrhea with ORS and zinc.
- Conducting home visits during pregnancy and during the postnatal period for both the mother and the neonate including specific follow-up for mothers practicing kangaroo mother care at home.
- Delivering life-saving interventions early and at low cost (such as community case management of childhood pneumonia and home-based neonatal care).
- Contribute to management of chronic diseases e.g. through supporting adherence for TB, HIV, diabetes and hypertension including COVID-19 related adapted treatment delivery mechanisms.
- Community-based distribution of contraceptives.
- Support to outpatient management of acute malnutrition, CHW follow-up of new enrolments and potential defaulters as well as providing IEC
- Establish referral and counter referral linkages with health facilities.

There is a strong case for investment in CHWs as a component of primary health care. Investment in CHWs yields further benefits to communities by:

- **Empowering women:** the employment of significant numbers of women in the provision of health care can represent a meaningful step towards gender equality and female empowerment, with important economic and social benefits to the woman herself as well as to her family and her community.
- **Reducing costs for households:** CHW systems can reduce costs by bringing much less expensive or free care to households.
- **Supporting data collection including civil registration and vital statistics:** CHWs are a critical workforce for filling data gaps, recording births and deaths in their communities, and feeding into the civil registration system.
- **Enabling expanded non-health service delivery:** CHWs can also be used to spread useful new agricultural practices and to support education (for example by promoting attendance of children in school).

- **Promoting strong, empowered communities:** CHWs can play an important role in building and strengthening the communities in which they operate. CHWs are necessarily a visible part of the communities they serve, and their activities can bring communities together around shared goals of improved health. Further, CHWs can function as the voice of the community in the health system, serving as sources of two-way communication between higher-level health authorities and communities.

In the past UNHCR has focused on community health in refugee camp and settlement settings. Recent experience has shown the importance of sound, well-supported community health activities in non-camp, including urban, settings. With this strategy, UNHCR will strengthen refugee community health systems in a range of settings in line with national community health policies and strategies, build refugee capacity and promote resilience.

Result 1: Strengthened participation, consultation and empowerment of refugees and other persons of concern

Enabling actions

- Continue to develop and support consultative processes that enable refugees and host community members to assist in designing appropriate, accessible and inclusive responses.
- In line with Accountability to Affected People continue to support effective two-way communication with communities and safe and effective complaints and feedback mechanisms.
- In line with Age, Gender and Diversity ensure assessment of the diverse needs of women, girls, men, boys, persons with disabilities, LGBTIQ+ people, adolescents, young people and youth and subsequent programming to consider these needs, including through links with community-based protection mechanisms.
- Promote community participation for refugees and other populations of concern in assessment, design, implementation, monitoring and evaluation with appropriate safeguards against sexual exploitation and abuse.
- Community health workers are drawn from and representative of the communities they serve with gender balance and sensitivity to nationality, ethnic, language and religious diversity.
- Refugees and other populations of concern are actively included and involved in health service management committees where possible.

COMMUNITY HEALTH WORKFORCE- GOOD PRACTICES

- CHWs are considered part of integrated community-based primary health care teams and of a broader, equity-focused health system, rather than standalone agents.
- CHWs and lower-level facilities have sufficient referral capacity so people can be appropriately and reliably treated at higher-level facilities when required.
- In line with national health approaches ensure appropriate remuneration and incentives for community health workers and supportive supervision of CHWs.
- Ensure quality and effectiveness of community health programs through providing a minimum number of CHWs based on the context (e.g. 1:1000 population) and CHW supervisors (e.g. 1 per 10 CHWs) with regular training and supportive supervision.
- Peer educators may be effective for adolescent and youth health, HIV, and other areas, particularly in their ability to link to formal health services.
- Mobilizing respected members of the community to promote healthy behaviours or health seeking, such as retraining traditional birth attendants to be safe motherhood promoters; or recognizing 'model' mothers who promote breastfeeding or facility-based delivery, for example.
- Support community groups working towards a common goal, such as developing community kitchen gardens, linking livelihood and social support to health promotion messages.



© UNHCR/David Azia
Bangladesh. Community health worker undertakes household visits

Result 2: Refugee communities are engaged in and benefit from a strong community health approach adapted to the context (urban, rural dispersed, camp settings, low and middle-income settings)

Enabling actions

- Develop, design and support a community health approach based on known good practices⁴².
- Consider community mobilization through Participatory Reflection and Action groups.
- Community health worker roles adapted to the main causes of morbidity and mortality, national priorities and health system capacity.
- Community health workforce has knowledge of the priority public health, sexual and reproductive health, MHPSS and nutrition messages to promote integrated approaches.

Result 3: Refugee and other population of concern settings have functional systems for communication of health-related risks and promoting health and behaviour change

Enabling actions

- Where sector specific community health workers do not exist use other community outreach workers to – at a minimum – provide information on available health services and a system for feedback.
- Develop and maintain a system for Health and Social Behaviour Change Communication that includes consultation and engagement with communities to better understand social, cultural and power dynamics, identify barriers to adopting desired behaviors and identify key influencers.
- Establish behavioural and communication objectives.

⁴² [WHO guideline on health policy and system support to optimize community health worker programmes 2018](#)

- Emphasize two-way communication and use of multiple communication channels adapted to the context and the preferences of the audience such as: social media, hotlines, WhatsApp trees, Short Message Service (SMS), traditional media, local art, music and dance.
- Adaptations (linguistic, literacy level and cultural) to facilitate effective communication with refugees. For example, use of translators, health messages in appropriate languages, levels of literacy, format and preferences.
- Promote the use of existing community feedback mechanisms so that community beliefs, concerns, and suggestions are heard; ensure to update the community on any action taken or reasons for not taking action based on feedback received.

Result 4: Monitoring of community health programmes including community-based data collection systems strengthened

Enabling actions

- At a minimum, information on births and deaths are collected, collated, analysed and reported with full engagement of community members, including where relevant, to feed into the health information system or national data collection systems.
- Utilize technologies such as mobile phones and SMS to enable CHWs to accurately store and rapidly transmit information to relevant recipients with consideration to data protection principles.
- Develop a set of key indicators for community health programmes. Monitor outputs and outcomes of community health activities including through regular supervisor sessions and results-based data monitoring, community feedback and performance indicators.

Monitoring of the Global Public Health Strategy

UNHCR will monitor the implementation of the strategy through its existing monitoring systems including measuring progress against baseline data. A mid-term and final review will be carried out on the global implementation of the strategy.

UNHCR offices plan and monitor health-related results as part of their multi-year strategy. As part of each strategy, offices design a country results framework that specifies health related impacts, outcomes and outputs that UNHCR intends to achieve in partnership with key stakeholders and in line with UNHCR's Strategic Directions and the Global Public Health Strategy. Where relevant,

offices formulate their results to reflect the intended inclusion and integration into national health systems and services.

Country health results are measured at impact, outcome as well as output levels for countries with health programming. UNHCR offices use results indicators to establish a baseline for measuring progress, monitor achievement of targets as well as support oversight and accountability to affected populations and UNHCR's governing body. Results are reviewed systematically and reported on an annual basis.

For standardized measurement and to contribute to targets and leaving no one behind, UNHCR's impact and outcome indicators are aligned with SDG 3 goals and indicators on good health and well-being.

Output and process indicators are also aligned to good practice indicators including those in SDG 3 and the Sphere Handbook. Monitoring of the health status of populations of concern and access to services is based on in-depth information from a variety of sources including UNHCR's Integrated Refugee Health Information System where it is in use, nutrition surveys (SENS), Health Access and Utilization Surveys, protection monitoring and participatory assessments with persons of concern.

Recognizing the importance of emergency responses, UNHCR will systematically monitor the effectiveness of health responses in L2 and L3 refugee emergencies through the health information system, relevant core indicators and an accountability framework. As of 2022, offices will plan their emergency response, including their health response through UNHCR's RBM tool, COMPASS.

Recognizing the importance of the role of national health systems in providing care for refugees and asylum seekers and of supporting such systems, UNHCR will systematically measure and monitor the status of inclusion, and progress over time (every 2 years), of persons within national health systems.

UNHCR will undertake a mid-term review of the strategy as well as an end of strategy review to assess the overall contribution to improving health outcomes for refugees and other persons of concern and progress towards the objectives as well as documenting lessons learnt and informing future strategic direction.



© UNHCR/Kamrul Hasan
Bangladesh. UNHCR centres treat refugees and Bangladeshi Covid-19 patients

ANNEX 1

DEVELOPMENT OF PUBLIC HEALTH RESPONSE PLANS IN REFUGEE OPERATIONS

Public health, including sexual and reproductive health, nutrition and MHPSS, will be an integral part of UNHCR's operation level results-based management planning processes including the situation analysis, development of multi-year strategic plans, monitoring and annual implementation reviews. In some operations, there may be a need for more detailed response plans to guide interagency public health responses to support medium to long-term inclusion and integration plans with governments and other stakeholders. These are to be fully aligned with the interim or multi-year strategies developed through UNHCR's results-based management processes and reporting would remain within the results-based management reporting requirements. There are three situations where specific health response plans may be considered:

1. New onset refugee emergencies L2 and L3

In refugee emergency situations in low and middle-income countries consider the following:

- In refugee emergency situations and especially refugee emergency level 2 or 3, a specific public health emergency response plan may be considered to guide the overall coordinated interagency public health response
- The response plan would be updated as the situation evolves and per the direction of the ministry of health and health sector coordination group
- The response plan would inform the health, nutrition and MHPSS components of key documents such as the refugee response plan (RRP)
- Emergency plans developed in Compass will also include the components of the public health response plan
- Beyond the acute phase of the emergency the public health plan will be integrated into the country operation multiyear strategic planning processes.

2. Multi-year country-level/national public health response plan

The development of multi-agency, multi-year country-level/national public health response plan, including sexual and reproductive health, nutrition and MHPSS,¹ in coordination with ministries of health, health/nutrition partners and the beneficiaries can be considered in the following situations:

- Countries/operations with a reported total expenditure greater than USD 1,000,000 under the Healthy Lives outcome area at the end of the previous year **AND** with more than 50,000 refugees or people in refugee-like situations, as of the end of December of the previous year.
- The implementation of the response plan is recommended to be monitored yearly as part of and in conjunction with, the annual implementation review and updated as needed (and ideally at least every three years), unless there is a significant change in operational context not adequately covered by the existing plan and that cannot be addressed by a supplementary plan e.g. new onset emergency.
- The country-level plan may include the various sub-national operational contexts and priorities and actions in camp and out-of-camp situations, including urban and rural dispersed locations
- Sub-national plans for specific situations or where specific operational aspects of the situation, such as new onset emergencies, are not adequately covered by the country-level plan may be considered

3. Medium to long-term inclusion and integration plans

Multi-year, multi-stakeholder health inclusion and integration plans may be considered where there are significant opportunities to advance the inclusion of refugees and, where relevant, other persons of concern into national development plans, policies, strategies and/or integration into service delivery in a sustainable way. These may be part of a multisector country inclusion and integration plan.

- In countries where it is considered feasible (for example, national political support, humanitarian and development donor support, health system capacity and geographical reach are both favourable, protection risks considered), UNHCR could catalyse the development of a five to seven-year plan at country level in conjunction with the ministries of health, ministries of finance, other UN agencies such as WHO, ILO, UNICEF, national and international NGO partners, the World Bank, regional development banks, humanitarian and development donors to move towards greater inclusion into national policies and strategies and integration into service delivery.
- The aim is to enhance inclusion and improved access and, where possible, integration, of refugees into national policies, plans, strategies and health service delivery systems.
- The country level multi-year health inclusion/ integration plan is recommended to have periodic milestones (e.g. six-monthly/ annual) with agreed contributions by UNHCR and other actors supported by policy or service delivery advances.
- These milestones are to be recalibrated based on a recommended yearly multi-stakeholder review led by the relevant line ministry.

¹ For example, [Jordan Health Sector Humanitarian Response Plan 2019-2020](#).

ANNEX 2: PROGRAMMATIC GUIDANCE

A) TECHNICAL SHEET: NUTRITION

ACRONYMS

ANC	Antenatal Care
BSFP	Blanket Supplementary Feeding Programme
CMAM	Community-based Management of Acute Malnutrition
ECD	Early Child Development
FAO	Food and Agriculture Organisation
FBM	Food Basket Monitoring
GAM	Global Acute Malnutrition
GAP	Global Action Plan
GFD	General Food Distribution
GMP	Growth Monitoring and Promotion
HAUS	Health Access and Utilisation Survey
iRHIS	Integrated Refugee Health Information System
HIV	Human Immunodeficiency Virus
IPT	Intermittent Preventative Treatment
IRS	Indoor Residual Spraying
IYCF	Infant and Young Child Feeding
JAM	Joint Assessment Mission
LLIN	Long-Lasting Insecticidal Net
LNS	Lipid-based Nutrient Supplements
MAM	Moderate Acute Malnutrition
MPG	Multi-Purpose Cash Grant
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organisation
PDM	Post-Distribution Monitoring
PHC	Primary Health Care
PLW	Pregnant and Lactating Women
PNC	Post-Natal Care
RUTF	Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goals
SENS	Standardised Expanded Nutrition Survey
SQ-LNS	Small Quantity Lipid-based Nutrient Supplement
TB	Tuberculosis
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation



© UNHCR/Sebastian Rich
Kenya. Caring for refugee children on a Kakuma paediatric ward

1. INTRODUCTION

Ensuring adequate nutrition throughout the life cycle and eliminating all forms of malnutrition are recognized as integral to fulfilling UNHCR's protection mandate. Undernutrition encompasses stunting, wasting and micronutrient deficiencies as one form of the condition known as malnutrition, with obesity or over-consumption of specific nutrients as another form. In low-income and middle-income countries, the growing problem of obesity and overweight co-exists with undernutrition in populations. This is referred to as the 'double burden of malnutrition'.

In 2019, 47 million children under five years of age were wasted, 144 million were stunted, and 124 countries had anaemia prevalence higher than 20% in children under 5 years, highlighting the most prominent global health and economic development¹. In an effort to rally the international community around improving nutrition, the World Health Assembly (WHA) endorsed in 2012 the first-ever global nutrition targets, focusing on six areas: stunting, anaemia, low birthweight, childhood overweight, breastfeeding, and wasting. In 2015, the world committed to eliminating all forms of malnutrition by 2030 as part of the Sustainable Development Goals (SDG 2 – End hunger, achieve food security and improve nutrition, and promote sustainable agriculture). In 2019, WHO, FAO, UNHCR, UNICEF, and WFP developed the Global Action Plan (GAP) which outlines priority actions on the prevention and treatment of child wasting.

The COVID-19 pandemic, which started in December 2019, continues to threaten food and nutrition security worldwide. The 2020 Global Humanitarian Overview forecasted 235 million people in need of humanitarian assistance and protection in 2021, the highest figure in a decade. While there is limited data on 2020 nutrition outcomes due to COVID restrictions, available data indicates increased food insecurity, economic vulnerability and health concerns which are likely negatively impacting refugee nutrition.

Displacement is a major shock, associated with a restriction on rights, rupture of livelihoods and limited access to national systems often leading to food insecurity and undernutrition. In refugee operations, protection, food security and nutrition are closely intertwined. Refugees often do not have the right to land, employment, ability to develop businesses, or freedom of movement, which severely limit their ability to develop livelihoods and access income. As such they often remain dependent on humanitarian assistance to meet their basic needs. Child and maternal undernutrition are a key challenge in many refugee situations.

In 2019, 61% of the 77 sites that carried out nutrition assessments had less than 10% global acute malnutrition (GAM), while 13% (10 sites) registered GAM prevalence equal to or above the emergency threshold of 15%. 50% (38 sites) registered stunting prevalence above or equal to the critical level of 30%. The prevalence of child anaemia was critical- above 40%- in 32% (20 sites). This highlights a multiple

¹ UNICEF, WHO, and World Bank Group Joint Child Malnutrition Estimates, 2020

burden from the various forms of malnutrition including wasting, stunting and micronutrient deficiencies. Malnutrition and micronutrient deficiencies can lead to irreversible developmental delays, stunting, and death with impacts on short-term survival and long-term economic and productive capacity.

UNHCR is actively working to reduce undernutrition in refugee populations, alongside host governments and partners. In line with the Global Compact for Refugees, UNHCR advocates for refugee inclusion into national health systems and supports access to quality health and nutrition services. Addressing the underlying causes of malnutrition requires a multi-sectoral approach.

Within UNHCR, Nutrition and Food Security Officers or Public Health Officers (where no nutrition and food security officer position exist) engage with livelihoods, cash, development, shelter, protection, education and data management colleagues to ensure links and alignment in programming for nutrition outcomes. They are also responsible for the coordination between all partners and amongst other sectoral refugee coordination groups such as health, WASH, child protection or Nutrition and Food Security Clusters and various national nutrition technical working groups to ensure a strong link between all sectors to achieve food and nutrition security for refugees.

Refugee contexts are very different and challenges in accessing and supporting nutrition and essential services exist, especially when refugees are hosted

within local communities. Treating malnutrition can also be challenging where malnutrition is viewed as shameful and an indication of not being able to ensure the family's food security. This stigma becomes an obstacle to health care access as it could prevent patients from seeking health care services.

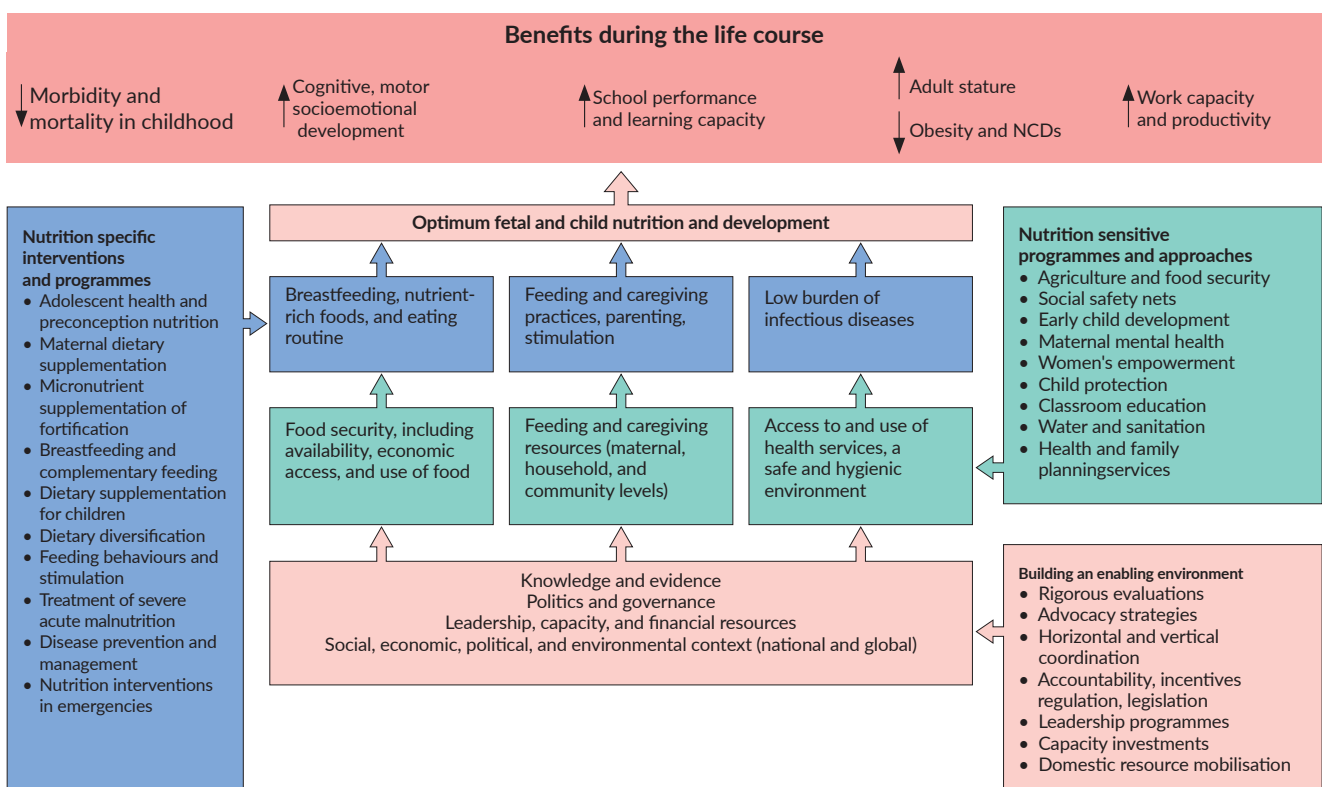
2. GUIDING FRAMEWORK FOR OPTIMAL NUTRITION OUTCOMES

Given the multiple causes of maternal and child malnutrition, the range of actions to achieve optimal nutrition is wide and very context specific. The possible interventions are described in the framework of action below summarised in the 2013 Lancet series based on a review that covered 36 countries (Figure 1).

Based on the three levels of action in the framework above, UNHCR has defined five priority areas, for programming in refugee settings, including:

- Prevention of all forms of malnutrition by supporting access to healthy and affordable diets and basic services.**
- Improvement of Infant and Young Children Feeding (IYCF).**
- Management of acute malnutrition.**
- Management of anaemia and other micronutrient deficiencies.**
- Prevention of obesity and link to chronic diseases.**

Figure 1 – Framework for actions to achieve optimum foetal and child nutrition and development



3. PRIORITY ACTIONS FOR NUTRITION

a) Prevention of all forms of malnutrition by supporting access to healthy, and affordable diets and basic services

UNHCR and WFP collaboration ensures adequate, sufficient, and timely provision of food and complementary non-food assistance as per the Memorandum of Understanding (2011). Both organisations are committed to supporting sustainable efforts to refugee food security and nutrition through greater [self-reliance and economic inclusion](#).

The key element to preventing all forms of malnutrition is to achieve nutrition and food security. This requires multisectoral collaboration and long-term efforts to address short term gaps while engaging with wider stakeholders for greater inclusion and sustainable nutrition and food security.

Broader, the root causes of malnutrition are addressed through a multi-stakeholder strategy including but not limited to food security, livelihoods, Water, Sanitation, and Hygiene promotion (WaSH), health and protection sectors.

Key actions include:

Support and promote short and long-term food security

- [Jointly assess refugee food security and basic needs with WFP](#) and [target](#) food and other basic assistance to those most in need.
- Advocate for in-kind food assistance that provides an adequate quantity and quality food basket and fortified food commodities to ensure nutritional needs are met.
- Advocate for the cash transfer value to cover nutritional needs where multipurpose is used as a modality of assistance/support.
- Advocate for the inclusion of refugees and other persons of concern in national food, nutrition, and social assistance programmes.
- Support the development of context-specific [livelihoods](#), and [nutrition-sensitive](#) and climate smart² agriculture.
- Promote opportunities for women to participate in income generation activities.
- Support access to financial services (savings and loans).

Prevent malnutrition in at risk groups

- Promote Blanket Supplementary Feeding Program (BSFP) for children aged 6-23 months

- using a nutrient-dense supplement when adequate diet is not possible and widen the age group to 6-59 months, when GAM prevalence is $\geq 15\%$ or GAM is $>10\%$ with aggravating factors.
- Advocate for the inclusion of pregnant and lactating women, and consider adding HIV and TB patients, chronically ill, elderly or adolescents when their nutritional status of is of concern.
- Provide nutrition education and cooking demonstrations to support consumption of a healthy diet and appropriate food preparation to optimize nutritional intake.
- Identify and promote access, availability, and utilisation of nutrient dense foods.

Support and promote nutrition support in health clinics/centres

- Improve access to health care and treatment as disease and malnutrition have a synergistic vicious cycle.
- Advocate for systematic screening for malnutrition among children 0-59 months, pregnant, and lactating women, and all patients at risk of malnutrition at the various health facility contact points.
- Advocate for preventive activities in children 0- 59 months such as immunization, deworming, bi-annual [vitamin A](#).
- Advocate for the supplementation of [iron and folic acid](#) and [calcium](#) for pregnant women and provision of [iron supplements to adolescent girls and adult women](#) in high anaemia prevalence areas ($\geq 40\%$).

Support and promote water, sanitation, energy, and shelter interventions that advance positive nutrition outcomes

- Advocate and provide access to safe, quality and quantity of water and sanitation.
- Provide education on safe food handling, preparation, and storage.
- Provide education on good hygiene and safe sanitation practices at all levels to promote clean environments that protect nutrient utilisation.
- Advocate and provide access to clean energy for cooking where applicable
- Advocate and provide appropriate shelter and prioritize household with nutritionally vulnerable members.

Support and promote nutrition through protection and education

- Advocate for the right to food and nutrition for refugees to avoid increasing vulnerability to protection risks associated with displacement and food insecurity
- Advocate for an overall conducive protection environment to address any protection gaps that could affect food and nutrition security.

² Climate-Smart Agriculture: is an agricultural system that sustainably increases productivity, enhances resilient to climate induced risks, reduces/removes GHG where possible, and enhances the achievement of national food security and development goals (FAO 2013)

- Advocate for the provision of essential nutrition services through the various education platforms including school feeding, nutrition education and micronutrient deficiency prevention.

b) Improvement of Infant and Young Children Feeding (IYCF)

Improving IYCF practices can have significant impact on preventing and treating malnutrition. IYCF interventions aim to protect and support the nutritional needs of both breastfed and non-breastfed infants and young children as well as that of the mother with the understanding that the nutrition of a child begins at conception as per the First Thousand Days approach. Multi-sectoral coordination and shared objectives are essential to improve IYCF and care practices. Detailed information on this can be found in the UNHCR IYCF in refugee settings – A multi-sectoral framework for action guidelines.

Key actions include:

Advocacy

- Advocate to the relevant stakeholders to protect, promote and support [IYCF](#) and Early Child Development (ECD) activities. This is to be integrated into nutrition programming including during emergencies and within other sectors.
- Advocate for the IYCF multisectoral framework for action roll out.

Public health linkages

- Promote maternal nutrition by ensuring appropriate quantity, quality, and diversity of food for pregnant and lactating women (see section 1).
- Promote exercise and optimum weight gain according to the stage of pregnancy or lactation.
- Promote appropriate breastfeeding and complementary feeding practices, hygiene and ECD care to caretakers of sick children or children attending preventive activities.
- Implement sensitisation campaigns, cooking demonstrations or other education interventions such as baby and child-friendly spaces and community-based support networks to promote, protect and support breastfeeding and appropriate complementary feeding and minimise the risks of artificial feeding and optimise children survival.
- Ensure high coverage of antenatal (ANC) and post-natal care (PNC) programmes to promote among other prevention of malnutrition activities, birth spacing, delayed cord clamping, kangaroo mother care to pre-term, low birth weight and new-borns.
- Provide psychosocial support to mothers of young children.

- Promote use of context specific IYCF guidance for HIV-positive mothers and exposed infants, to minimise risk of HIV transmission.
- Integrate IYCF practices into broader public health messages delivered by other sectors such as WASH, shelter, protection etc.

c) Management of acute malnutrition

In 2019, of UNHCR's 77 refugee sites where acute malnutrition (wasting and nutritional oedema) was measured. 47 sites (61%) met the UNHCR standards of less than 10% Global Acute Malnutrition (GAM), while 10 sites (13.0%) showed GAM levels equal to or above the emergency threshold of 15%. Treatment options for acute malnutrition exist either through services provided in refugee camps



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Sudan. Nivasha is one of several refugee settlements in the outskirts of the Sudanese capital Khartoum.

or through national programmes. Treatment of acute malnutrition in refugee situations should be managed using the principles of community-based management of acute malnutrition (CMAM), according to relevant national treatment guidelines or WHO protocols where there are no recent CMAM treatment guidelines. Treatment of severe acute malnutrition (SAM) will be provided through inpatient and outpatient platforms and, wherever possible, in collaboration with UNICEF, in order to secure the supply of severe acute malnutrition treatment products and training. Treatment of moderate acute malnutrition (MAM) will be provided, with WFP normally providing the food products required for the treatment of moderate acute malnutrition as per the UNHCR-WFP MoU. Community involvement and awareness in the identification of malnourished individuals, and their inclusion and retention in the treatment of acute malnutrition is crucial in the success of this programme, as well as in obtaining effective coverage. Establishing and maintaining strong linkages between the different components of the CMAM programmes, as well as with health and preventative services are key features of any effective treatment programme.



Key actions include:

Integration and coordination

- Advocate for the inclusion of refugees into the national treatment programmes, especially for refugees living in out-of-camp.
- Link with national systems and structures from the very start and strengthen collaboration with government, UNICEF and WFP when establishing a treatment programs for refugees.
- In emergencies where GAM prevalence is high (>10%), ensure optimal coordination among all partners and communication with the refugee population to raise awareness
- Include Growth Monitoring and Promotion (GMP) for children below the age of 5 years as compulsory preventive actions under primary-health care.
- Establish and maintain strong linkages between CMAM, community and preventives PHC activities for key preventive actions such as immunisation programmes, intermittent preventative treatment (IPT) of malaria, deworming campaigns in young children following the relevant [protocol](#) or food supplementation for PLW and children to prevent acute malnutrition.
- Establish psycho-social support platforms for caretakers and cognitive development activities for children in CMAM.

Early detection of malnutrition for referral and enrolment in treatment

- Screen under 5 years children for acute malnutrition on arrival at all entry points, reception centres and camps and in the long term by establishing community health/nutrition workers/volunteers' outreach networks. Where possible the family MUAC approach to be rolled out.
- Screening of malnutrition at the facility level to be established at all contact points using both MUAC and weight for height for children aged 6 to 59 months.
- Screening for malnutrition among adults to include BMI in adolescents, adults, and ill patients and MUAC for PLW during general health consultations, ANC, PNC, transversal HIV, TB or NCDs programmes.

Community based Management of Acute Malnutrition (CMAM)

- Implement CMAM according to the relevant CMAM protocol (national or international).
- Establish early detection and referral mechanism in emergencies as noted in the last section.
- Provide treatment of Severe Acute Malnutrition (SAM) and the treatment of Moderate Acute Malnutrition (MAM). Collaborate with UNICEF/ MOH and WFP, to secure the supply of therapeutic treatment and supplementary feeding products and staff training.
- Timely needs forecasting, procurement and prepositioning is key to prevent pipeline breaks of CMAM nutrition supplies.
- Strengthen community involvement and awareness of the importance to access services provided, to allow optimal coverage of all referred malnourished children.
- Collaboration with health and WASH to ensure that necessary hygiene measures and infection prevention control (IPC) are integrated into the CMAM program.
- In areas with HIV prevalence greater than 1%, promote counselling and testing of all SAM children or their mothers when the child is below 18 months old, for HIV to provide adapted counselling and treatment.

d) Management of anaemia and other micronutrient deficiencies

Micronutrient deficiencies can easily develop during an emergency or worsen when already present. In the context of refugee populations, [anaemia](#) is a great concern, especially in young child and women. It can be caused by lack of iron, folic acid, and vitamin B12, malaria, hookworms, and schistosomiasis³.

³ <https://www.unhcr.org/protection/health/4b8e854d9/unhcr-strategic-plan-anaemia-prevention-control-reduction-reducing-global.html>

Other micronutrients of concern are Vitamin A, C, B1 and B3. They can result in life threatening diseases such as beriberi or severe disabilities such as xerophthalmia.

 **Key actions include:**

Screening and treatment

- Monitor the occurrence of specific micronutrient deficiencies and provide treatment for at least anaemia (iron and folate deficiency), Xerophthalmia (vitamin A deficiency), Beriberi (vitamin B1 deficiency), Pellagra (vitamin B3 deficiency), and Scurvy (vitamin C deficiency) using national or international protocols.
- Establish systematic screening and referral of anaemia among children, girls, and women of childbearing age, PLW and other high-risk groups.
- Equip laboratories with the appropriate means to diagnose anaemia.
- Document the likelihood of hemoglobinopathies (e.g. sickle cell anaemia, thalassemia) in the population through secondary data sources to guide anaemia treatment protocols.
- Prevent malaria outbreaks by establishing and maintaining strong linkages between community and preventives activities to promote key preventive actions such as providing long-lasting insecticidal net (LLINs) for the whole family and as part of the ANC programme in malaria endemic areas or implementing indoor residual spraying (IRS) campaigns every 6 months or prior to the rainy seasons, or intermittent preventative treatment (IPT) of malaria and deworming campaigns in young children following the relevant protocol.

e) Prevention of overweight and obesity, and link to chronic diseases

There is a growing problem of overweight and obesity in low- and middle-income countries. In 2019, 38.3 million children were overweight globally. Maternal overweight and obesity are associated with maternal morbidity, preterm birth and increased infant mortality. Being overweight or obese are major risk factors for cardiovascular disease, diabetes, and premature death in adulthood and both have direct physical and mental health implications for a child or adolescent.

 **Key actions include:**

- Promote healthy diets and physical active lifestyle in all [prevention activities](#) and in PHC.
- Track trends in [childhood overweight prevalence](#) in refugee operations by including reporting of childhood overweight prevalence in all SENS surveys in children 6-59 months.
- Promote routine GMP for children and BMI for adults in PHC.
- Screen for diabetes as part of ANC and PNC programmes.
- Ensure diagnosis, treatment, care, and counselling for [non-communicable diseases](#) including hypertension and diabetes mellitus.

4. CROSS-CUTTING ISSUES

a) Capacity building

Having staff trained when they are hired and throughout their career allows accountability in terms of quality delivery of services. Providing refugees with information, education and communication on actions that promote optimal nutrition throughout the life cycle is likely to result in better nutrition outcomes, to rebalance gender relations and to enable people to be actors in their own lives.

 **Key actions include:**

- Provide capacity building to equip UNHCR, implementing partners or ministry of health staff and community workers with the most up-to-date and contextualized knowledge to ensure quality programming and service provision.
- Use innovative training methods in addition to face to face training such as E-learning, webinars or community of practice discussions and integrate specialists' group discussions.
- Provide education to mothers/fathers and extended family members on various preventive health and nutrition issues preventing occurrence of malnutrition such as appropriate feeding behaviours, ECD for young children, family MUAC, ANC, PNC, hygiene, immunization etc.
- Implement sensitisation campaigns, cooking demonstrations or other education interventions such as baby and child-friendly spaces and community-based support networks to promote, protect and support breastfeeding and appropriate complementary feeding to reduce malnutrition and optimise children survival.

b) Monitoring Framework and nutrition information analysis

A core set of indicators are to be systematically tracked across all operations to monitor the nutrition situation, to track the trend, to measure outcome of programmes, and to allow for evidence-based decision making and advocacy.

Key actions include:

- Ensure systematic inclusion of treatment programme quality monitoring with documentation through an improved nutrition module in iRHIS and the balanced score card approach (nutrition supervisory checklist).
- Monitor and document the delivery and performance of programmes for context dependent indicators, such as supply inventory, staff capacity, number of staff trained, etc.
- Conduct regular SENS surveys measuring nutritional status (GAM, stunting, etc.) among children aged 6-59 months, anaemia among children aged 6-59 months and women of reproductive age, indicators for IYCF practices, CMAM and BSFP coverage, food security, health, WASH, and mosquito net coverage.
- Promote rapid assessments and regular coverage surveys in high GAM situations (>10%).
- Promote effective use and analysis of data from various resources to inform action, such as UNHCR/WFP joint assessments, data coming from GMP, post-distribution monitoring (PDM) and WFP food basket monitoring (FBM), etc.
- Advocate for the inclusion of refugees (as a representative sample) in national data collection efforts including nutrition surveys, food security and vulnerability assessments, etc.

Nutrition programmes aims to save lives of the most vulnerable refugees and children below 5 years. Educating mothers and fathers on optimal nutritional will allow progress along the humanitarian development nexus and change attitudes in the long-term resulting in healthier lives.

5. KEY REFERENCES

a) Guidelines

- [Guidelines for Selective Feeding: The management of Malnutrition in Emergencies 2011](#)
- [UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations](#)
- [Guidelines for the inpatient treatment of severely malnourished children](#)
- [Infant and young child feeding practices: Standard Operating Procedures for the Handling of Breastmilk Substitutes \(BMS\) in refugee situations for children 0-23months](#)
- [UNHCR Policy related to the acceptance, distribution and use of milk products in refugee settings](#)
- [Guideline: updates on HIV and infant feeding](#)
- [Guideline for nutrition surveys](#)
- [Nutrition Assessment Counselling and Support guidelines, FANTA](#)

b) MoU/LoUs

- [UNHCR-WFP Global MoU 2011](#)
- [WFP/UNHCR Global MoU addendum on cash assistance 2017](#)
- [WFP/UNHCR Global MoU addendum on data sharing 2018](#)
- [Model tripartite agreement WFP/UNHCR 2016](#)
- [UNICEF, LoU, template and guidance notes 2015](#)
- [Strengthening the cooperation between FAO and UNHCR](#)

c) Trainings

- [Introduction to nutrition, Global Health learning centre](#)
- [Nutrition in emergencies, ENN resources](#)
- [Nutrition in emergencies, e-learning, UNICEF resources](#)
- [Infant feeding in emergencies, ENN resources](#)
- [Training guide for Community based Management of Acute Malnutrition, FANTA](#)
- [General nutrition and breastfeeding videos, Global Health Media](#)
- [SMART and UNHCR Standardised Nutrition Survey Guidelines \(SENS\) Training](#)

ANNEX 2: PROGRAMMATIC GUIDANCE

B) TECHNICAL SHEET: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)

ACRONYMS

CBST	Community-based Sociotherapy
CETA	Common Elements Treatment Approach
GBV	Gender-based Violence
HIS	Health Information System
IASC	Inter-Agency Standing Committee
IAT	Integrated Adapt Therapy
IPT	Interpersonal Therapy for Depression
IPV	Intimate Partner Violence
iRHIS	integrated Refugee Health Information System
mhGAP	Mental Health Gap Action Programme
mhGAP-HIG	Mental Health Gap Action Programme Humanitarian Intervention Guide
MHPSS	Mental Health and Psychosocial Support
MNS disorders	Mental, neurological and substance use disorders
PM+	Problem Management Plus
POC	Persons of Concern
PTSD	Post-traumatic stress disorder
SDG	Sustainable Development Goals
SH+	Self Help Plus
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
WHO	World Health Organization

1. INTRODUCTION

MHPSS

Mental health is an inseparable part of health that must be addressed in an integrated way throughout the public health programmes of UNHCR and partners. Within humanitarian assistance, the broader term 'mental health and psychosocial support' (MHPSS) is commonly used to refer to 'any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders'. This technical sheet will mainly focus on what health actors in refugee setting should do with regards to MHPSS and how to coordinate around MHPSS with other sectors. However, MHPSS is not restricted to the health sector and requires multisectoral action with interventions in programmes for protection (community-based protection, child protection and GBV) and education. Coordination with other sectors is therefore essential. For more guidance on MHPSS outside the health sector consult the following documents:

- [Operational guidance, mental health & psychosocial support programming for refugee operations](#)
- [Strengthening Mental Health and Psychosocial Support in 2021](#)

Terminology

Within UNHCR, we use the term 'mental disorders' when referring to a therapeutic context (for example the number of consultations for mental disorders in the HIS). We use the term 'MHPSS problems/conditions' when referring to a broader spectrum of issues including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities. For historical and pragmatic reasons, epilepsy and dementia are included in MHPSS work. Some actors use other terms such as 'mental, neurological and substance use (MNS) disorders'¹ or 'psychosocial disability'.²

Prevalence

Around 22% of adults in conflict settings have mental health disorders. This is much more than in non-conflict settings. Reasons for the increased prevalence of mental health conditions include adverse experiences in country of origin, on the way and in refugee settings and lack of supportive social systems. Many more are distressed, but there are no global data.

The mental health and psychosocial well-being of displaced communities is determined by

- events in the past that lead to their displacement or on the way to safety
- current conditions including the adequacy of the assistance and protection in place
- how refugees perceive their future: solutions and real prospects to get a better life.

Multifactorial aetiology

Without good mental health, people feel unable or less able to carry out activities of daily living, including self-care, education, employment and participation in social life. There is a bidirectional relation between mental health and poverty, loss of livelihoods: (1) People who drift into poverty, marginalization, who lost their livelihoods and future, have more mental health issues; (2) Pervasive states of depression, hopelessness, being overwhelmed by memories of the past and being full of negative thoughts, hinders people to use their potential to find solutions.

Sustainable Development Goals

Mental health is explicitly mentioned in the Sustainable Development Goals.

- SDG 3.4: 'By 2030, reduce by one third premature mortality from non-communicable disease through prevention and treatment and promote mental health and well-being'.
- SDG 3.5 'Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol'.

MHPSS is also relevant for other goals such as SDG 16 on Justice, Peace and Stronger Institutions.

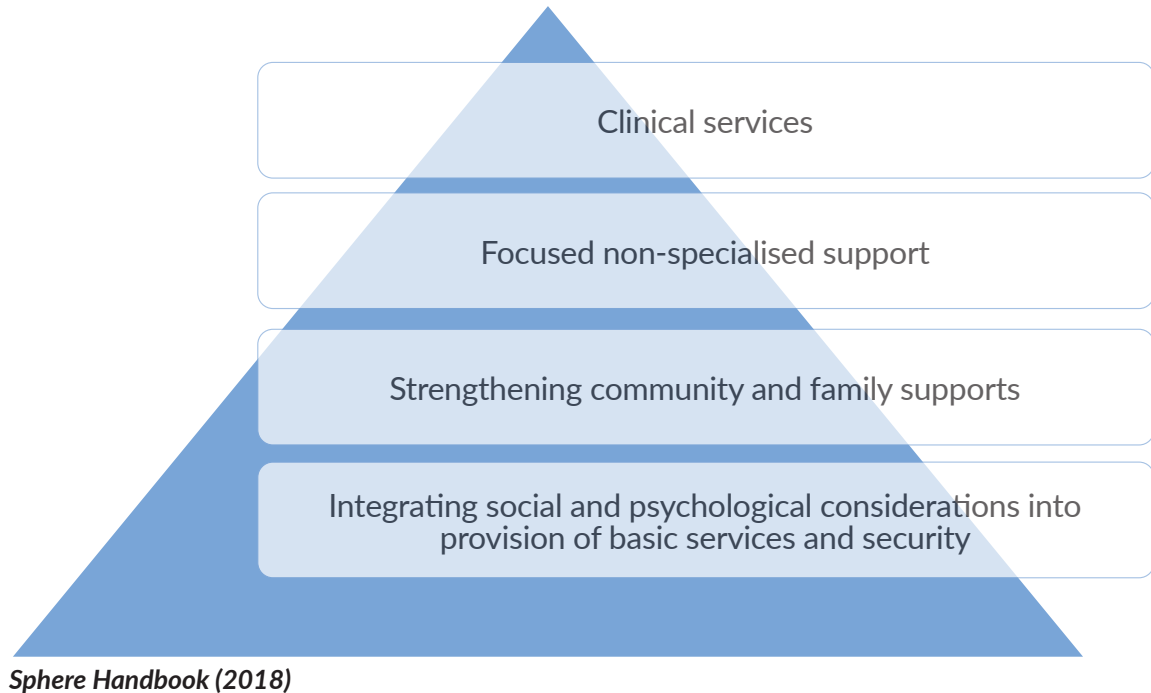


© UNHCR/Haidar Darwish
Lebanon. Ten years into Syria crisis, refugee family struggling with poverty and mental health issues

¹ The World Health Organization uses the term 'Mental, neurological and substance use (MNS) disorders' to refer to mental disorders, alcohol/substance use disorders, epilepsy and dementia.

² Disability advocates use the term 'psychosocial disability' to refer to forms of disability related to people who have received a mental health related diagnosis (or who self-identify with this term) and who experience participation restrictions due to social and environmental barriers, often related to discrimination and exclusion. The term captures the notion of disability as being the result of physical and social barriers preventing a person with an impairment from participating equally in community and social life.

Figure 1: Multi-layered MHPSS services and supports



2. GUIDING FRAMEWORKS FOR MHPSS

IASC Guidelines on MHPSS in Emergencies (2007)

This interagency guidance provides a consensus framework for MHPSS in humanitarian settings that forms the basis of agency-specific guidance including that of UNHCR. Key notions in the guidance are (1) that MHPSS is not something that can only be done by mental health specialists, (2) that a multisectoral approach is needed and (3) that services and supports can best be seen as a multi-layered system (see figure 1).

Layer 4: Clinical mental health and psychosocial services for those with severe symptoms or whose intolerable suffering rendering them unable to carry out basic daily functions. Such interventions are usually led by mental health professionals but can also be done by trained and supervised general health workers.

Layer 3: Provision of focused psychosocial support through individual, family or group interventions to provide emotional and practical support to those who find it difficult to cope within their own support network. Non-specialised workers in health, education, community-based protection or child protection usually deliver such support, after training and with ongoing supervision.

Layer 2: Strengthening community and family support. This is not so much about ‘outsiders’ delivering ‘interventions’, but about enabling people to preserve and promote their psychosocial well-being through activities that foster social cohesion and through enabling communities to restore or develop mechanisms to protect and support themselves.

Layer 1: Provision of basic services and security in a manner that protects the dignity of all people, including those who are particularly marginalized or isolated and who may face barriers to accessing services and deliver the response in a participatory, rights-based way.

(Adapted from IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings, 2007)

In the [Sphere Handbook](#), MHPSS is mentioned throughout the document, in addition to a specific Mental Health Standard ‘People have access to health services that reduce mental health problems and associated impaired functioning’ with the following key actions:

1. Coordinate mental health and psychosocial supports across sectors.
2. Develop programmes based on identified needs and resources.
3. Work with community members, including marginalised people, to strengthen community self-help and social support.
4. Orient staff and volunteers on how to offer psychological first aid.
5. Make basic clinical mental health care available at every health care facility.

6. Make psychological interventions available where possible for people impaired by prolonged distress.
7. Protect rights of people with severe mental health conditions in the community, hospitals and institutions.
8. Minimise harm related to alcohol and drugs.
9. Take steps to develop a sustainable mental health system during early recovery planning and protracted crises.

[UNHCR Operational Guidance for MHPSS in Refugee Operations \(2013\)](#)

This document informs the MHPSS response in different sectors. An important concept is the difference between and MHPSS approach and MHPSS interventions:

- Adopting an *MHPSS approach* means providing humanitarian responses in ways that are beneficial to mental health and psychosocial well-being. This is relevant to everyone who assists refugees. Humanitarian actors should not necessarily do different things; rather do things differently. This has become clear within the COVID-19 pandemic.
- *MHPSS interventions* consist of activities with an explicit goal to improve the mental health and psychosocial well-being of refugees, usually implemented by health, protection, education actors.

3. PRIORITY ACTIONS FOR MHPSS WITHIN HEALTH PROGRAMMES

Many refugee hosting countries do not have a functional mental health system to integrate refugees into, while the needs are often extremely high. Therefore, UNHCR uses a twin track approach: (1) support direct service provision through partners and (2) working towards integration through strengthening national services. Below is a list of activities that can be considered, depending on available resources.

a) Integration of mental health into general health care facilities for refugees

Mental health is an intrinsic part of health care. Among patients visiting general health care, a disproportionate number has mental health conditions that can be identified and managed. Therefore, each health facility needs to integrate mental health into its services.

1. Ensure that mental health is part of the Project Partnership Agreement with health providers.
2. Arrange for a routine supply of essential medication for mental disorders to health centres.

Tools:

- Psychotropic Medication on [UNHCR Essential Medicine list May 2021](#)
- Calculation tool for quantities of psychotropic medication (in development)

3. Ask partners to regularly organize training for general health staff in identifying and managing mental health conditions. Such trainings usually take 3-5 days and need to be followed by supportive supervision and refresher trainings.
 - Tools: WHO/UNHCR (2015) [mhGAP Humanitarian Intervention Guide](#)
 - Tools: WHO/UNHCR (2021 in press): Facilitation Manual mhGAP Humanitarian Intervention Guide
4. Arrange for a mental health professional (dependent on the context this can be a psychiatrist, psychiatric clinical officer, psychiatric nurse or clinical psychologist) to manage people with complex conditions and provide clinical supervision to the general health workers. This can be a part time function. Minimum frequency of visit is once per month to each health centre, but more frequent visits are preferable.
5. Ensure that consultations for mental health conditions are registered in the health information system. In case mental health consultations are done by a separate MHPSS partner they shall be asked to enter their data in iRHIS.
 - Tool: MNS Categories in the iRHIS. See also [here](#).

b) Integration of MHPSS into community health work

The community health workers are a bridge between communities and the health facilities. Mental health needs to be a part of their training curriculum and they should be regularly supervised on mental health issues. In some operations more specialized community MHPSS volunteers are trained to do more focussed work.

1. Train community health workers in identification and follow up of people with severe or complex mental health conditions.
2. Train community health workers in Psychological First Aid and Basic Psychosocial Skills.
3. Consider using community workers in facilitating of support groups for refugees with mental health conditions.
Tools
 - [Psychological First Aid: Guide for field workers](#)
 - [Basic Psychosocial skills: A Guide for COVID-19 Responders](#)
 - Sample curriculum for MHPSS training for Community volunteers (in development)
 - [mhGAP community toolkit](#)

c) Provision of evidence-based brief psychological therapies

Mild and moderate mental health conditions can be effectively addressed through brief scalable psychological interventions (5-8 sessions) that can be delivered by non-specialized staff after a brief training and with supportive clinical supervision by a mental health professional. There are several of such methods.

The choice is dependent on what the programme wants to achieve, costs, availability of trained staff and versions that are contextually and linguistically adapted. Important is to choose a method that is evidence-based. The most widely used methods are Problem Management Plus (PM+) which has been developed by the World Health Organization and group Interpersonal Therapy for Depression (IPT) which has been developed by Columbia University New York and was published by the World Health Organization. Table 1 contains an overview of scalable psychological interventions.

Table 1: Overview of scalable psychological interventions

<i>Intervention (+ link)</i>	<i>Description</i>	<i>For whom?</i>	<i>Where has it been used?</i>
Problem Management Plus (PM+) Individual version Group version	Based on Cognitive Behavioural Therapy. Participants learn to use four techniques: stress management, problem solving, behavioural activation and strengthening support. Basic training 7 days + regular supervision. <ul style="list-style-type: none"> • Individual version: 5 sessions of 90 min. • Group version (6-8 participants): 5 sessions Researched through RCTs in Pakistan, Kenya (non-refugees) and with Syrian and Venezuelan refugees	For adults with depression, anxiety and stress, including people who do not have a diagnosis.	Widely translated and used by UNHCR partners in <ul style="list-style-type: none"> • Middle East and North Africa: (Iraq, Jordan, Lebanon, Syria) • East and Horn of Africa and Great Lakes: (Ethiopia, Kenya, Uganda) • West and Central Africa (Chad, CAR) • Asia (Bangladesh) • Europe (Greece, Turkey, Switzerland, Netherlands) • Americas (Colombia, Equador, Panama)
Interpersonal Therapy for Depression (IPT) Group version Individual version (in development)	Aims to reduce depression by improving interpersonal skills to address: 1) loss, 2) role transitions. 3) interpersonal conflicts and 4) social isolation. Basic training 4-7 days + refresher and weekly clinical supervision. <ul style="list-style-type: none"> • Group version: 8 sessions • Individual version: 8-12 sessions • ‘Interpersonal Counselling’: Brief 3 session version as first line treatment by community workers 	For adults with mild, moderate or severe depression. Can be effective for other conditions such as PTSD.	<ul style="list-style-type: none"> • Implemented through UNHCR in Bangladesh, Tanzania and Peru. • Used by partners in Lebanon, Syria.

Intervention (+ link)	Description	For whom?	Where has it been used?
Self Help Plus (SH+) Group version	Guided self-help for emotional distress using a self-help book and audios in 5 weekly sessions for groups up to 30 people. Research with South Sudanese refugee women showed small and transient effects. Research among refugees in Turkey and Europe showed a preventive effect on the development of mental health problems.	For adults with distress or mild-moderate depression anxiety	<ul style="list-style-type: none"> • South Sudanese women in Uganda (Juba Arabic version) • Refugees and migrants in Europe (Farsi, Arabic and English)
Integrated Adapt Therapy (IAT) Not yet in public domain	6 session model (individual or group), using elements of Cognitive Behavioural Therapy, that are 'packaged' specifically for refugees with attention to how the refugee experience is connected to psychological symptoms. Research with refugees in Malaysia and Bangladesh showed satisfactory results.	For refugee adults	<ul style="list-style-type: none"> • Myanmar refugees in Malaysia and Bangladesh • Refugees in Australia
Community-based Sociotherapy (CBST) Not yet in public domain.	15 group sessions of 2-3 hours with 8-12 persons from the same community ('area- based approach' facilitated by two facilitators from the same community. Participation in the group is based on social issues (marginalization, mistrust) not only on psychopathology. Goal is strengthening social connectedness, interpersonal support and mutual trust. Research in Rwanda shows improvements in mental health and civic participation.	Adults	<ul style="list-style-type: none"> • Conflict-affected populations in Rwanda, Burundi, DRC, Ethiopia and Liberia • Currently research with Congolese refugees in Rwanda and Uganda
Common Elements Treatment Approach (CETA) Not yet in public domain.	8-12 individual one-hour sessions based on Cognitive Behavioural Therapy with a modular approach for treatment of depression, anxiety, substance use and trauma and stress related disorders. Briefer versions and group versions are possible. More information here	Adults and Adolescents	<ul style="list-style-type: none"> • IDP in Iraq and Ukraine • Refugees in Thailand • Refugees in Ethiopia • Nationals in Zambia and Myanmar
Thinking Healthy Group version	15 group sessions for with perinatal mental health issues. Published by WHO	Women with perinatal depression	<ul style="list-style-type: none"> • Pakistan/India (non-refugees) • Yemen (non-refugees)
Friendship Bench Not yet in public domain	Individual Therapy (3 or more sessions) for people with mild/ moderate mental based on Problem Solving Therapy, activity scheduling followed by peer led group support. More info here .	Adults	<ul style="list-style-type: none"> • Zimbabwe

d) Promote access to mental health professionals for people with complex problems

With the steps above, access to essential MHPSS services can be greatly increased. But the emphasis on integrated treatment by non-specialists does of course not make the role of mental health professionals such as psychiatrists, psychiatric nurses and clinical psychologists redundant. They are especially important for training/ supervision and to help people with more complex problems. In many low- and middle-income countries it can be challenging to find specialist care or referral facilities that are of acceptable quality. A brief assessment should take place before considering a facility adequate for referral with a particular view on the use of evidence base treatments and respect for human rights.



© UNHCR/Will Swanson
Bangladesh. Mental health project helps Rohingya youths discuss anxieties

e) Take steps to address neglected MHPSS issues such as alcohol and other substance use and suicide prevention

Standard packages for MHPSS do not sufficiently address two problem areas that are explicitly mentioned in the Sustainable Development Goals with an indicator to which all national governments have to report.

- Addiction and misuse of substances such as alcohol, illegal drugs and prescription medication.
 - SDG Indicator 3.5.1: Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
 - SDG Indicator 3.5.2: Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol
- Suicide and suicidal behaviour
 - SDG Indicator 3.4.2: Suicide mortality rate

UNHCR has commissioned systematic reviews on [suicide prevention](#) and [alcohol and substance use conditions](#) which make clear that i) there are limited evidence-based interventions that have been tested in humanitarian settings and ii) that these problems can only be tackled through long term multi-sectoral approaches that combine community-based interventions with focused individual interventions.

A package for suicide prevention could consist of

- Improved and consistent data collection
- Review of cases of completed suicide and severe attempts
- Public awareness raising and community engagement, including information how and where to seek help
- Restriction of access to methods
- Training of gate keepers and community support persons in identifying people with increased risk for suicide, and in using emotional crisis management and de-escalation techniques
- Training frontline staff from health and protection partners in brief interventions and safety planning
- Opportunities for staff care after crises have occurred
- Standard Operating Procedures and referral pathways to specialized services (e.g. local mental health providers).

A toolkit for suicide prevention and response in refugee setting is being developed by UNHCR. A package to address alcohol and substance use problems should consist of

- Awareness raising and access control
- Brief interventions on community level
- Individual psychotherapeutic interventions
- Clinical interventions

In 2021, a toolkit to address substance use in humanitarian settings is expected to be released by UNODC in cooperation with UNHCR.

f) Coordination around MHPSS

This technical sheet focussed on the MHPSS intervention within the health sector. However, MHPSS interventions should also be implemented in programmes for protection (child protection, GBV and community-based protection), education and nutrition.

Therefore, multisectoral coordination within a Technical Working Group (TWG) for MHPSS is important. These groups are ideally linked to both the health and protection sector and are co-chaired by actors from health and protection. MHPSS is not a subsector of health or protection. Given the technical nature of TWG involvement of MHPSS experts of NGO partners and government is advisable.

- Terms of Reference for a Technical Working Group for MHPSS ([Sectoral Coordination Toolkit: Public Health in Emergencies Toolkit](#))
- In emergency settings, requests for short term deployment to support coordination and inter-agency capacity building can be done through mechanisms such as the [Dutch Surge Support for MHPSS](#)

A new interagency Minimum Services Package for MHPSS in Emergency Settings is being developed by WHO, UNICEF, UNHCR and UNFPA which is expected to become available in 2022.

4. KEY REFERENCE DOCUMENTS

UNHCR Guidance on Mental Health and Psychosocial Support for Persons of Concern

- UNHCR (2013) [Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations](#)
- UNHCR (2021) [Strengthening Mental Health and Psychosocial Support in 2021](#)
- UNHCR (2018) [Mental health and psychosocial support](#) entry in Emergency Handbook

Technical documents with WHO

- WHO & UNHCR (2015) [mhGAP Humanitarian Intervention Guide \(mhGAP-HIG\): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies](#)
- WHO & UNHCR (2013) [mhGAP module Assessment Management of Conditions Specifically Related to Stress](#)
- WHO & UNHCR (2012) [Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings](#)
- WHO & UNHCR (2021). Training manual for mhGAP-HIG.

Related Protection Documents

- Global Protection Cluster (2020) [MHPSS and protection outcomes](#)
- UNHCR (2014) [Child protection Issue Brief: Mental health and psychosocial well-being of children](#)
- UNHCR (2017) [Community-Based Protection & Mental Health & Psychosocial Support](#)
- UNHCR (2020) [UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence.](#)

ANNEX 2: PROGRAMMATIC GUIDANCE

C) TECHNICAL SHEET: SEXUAL AND REPRODUCTIVE HEALTH (INCLUDING HIV)

ACRONYMS

BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal care
FGM	Female Genital Mutilation
GBV	Gender-based Violence
HIV	Human immunodeficiency virus
IATT	Inter-Agency Task Team
IPV	Intimate Partner Violence
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, and queer and other diverse identities
MISP	Minimum Initial Services Package
PEP	Post Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
PoC	Persons of Concern
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization



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1. INTRODUCTION

Sexual and reproductive health (SRH), including specific attention to gender-based violence (GBV) related care and the prevention and treatment of HIV, has received increasing attention as part of humanitarian assistance over the past years.

Despite these advances, it continues to be a challenge to ensure the availability of essential and quality SRH services at the onset of a humanitarian crisis as well as the expansion of these services to comprehensively address SRH needs of all refugees and other persons of concerns (PoCs). This technical sheet outlines objectives to enhance access to quality SRH care, seeking alignment with international SRH and HIV standards, and recognizing the important contribution this work can have for the reduction of maternal and newborn morbidity and mortality in fragile and humanitarian settings and in contribution to the Sustainable Development Goals (SDG), specifically SDG 3.

While women and girls are the centre of the current SRH strategies, boys and men have likewise SRH, including HIV-related needs, which require a targeted response. Further, this technical guidance emphasizes the need for particular attention to persons and communities that are known to encounter difficulties accessing and/or accepting the available SRH and HIV services including adolescents, people who sell or exchange sex and LGBTIQ+ persons.

Background

Women and girls are disproportionately affected by humanitarian crisis and in humanitarian settings. Their sexual and reproductive health needs do not stop when a crisis starts and may increase when a humanitarian situation becomes protracted over years. In any given population, 4.5 to 5% of women will be pregnant at any given time and require preventive and clinical obstetric care. The likelihood to encounter pregnancy and birth related complications are the same for woman everywhere: 15% of pregnant women experience complications that may become life-threatening in absence of adequate medical care. **Maternal mortality** is often the result of lack of adequate care: the lifetime risk to die from pregnancy and childbirth related complications is 1 in 37 women in Sub-Saharan Africa compared with 1 in 6 500 women in Europe¹. Most of maternal and newborn deaths can be averted, either through preventive action including high impact approaches or targeted evidence based clinical interventions. **Skilled birth attendance** is recognized to be the most effective intervention to reducing maternal and newborn deaths, but not all women have access. It is estimated that 60% percent of preventable maternal mortality and 45% percent of newborn mortality occur in contexts of conflict, displacement, and natural disasters².

¹ WHO. September 2019. More women and children survive today than ever before <https://apps.who.int/iris/bitstream/handle/10665/327596/WHO-RHR-19.23-eng.pdf?ua=1>

² S. Zeid et al; The Lancet, Vol. 385, 9981, P1919-1920; For every woman, every child, everywhere: a universal agenda for the health of women, children, and adolescents [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)60766-8/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)60766-8/fulltext)

The **reduction of maternal and newborn death** is central to UNHCR sexual and reproductive health ambitions for refugees and other persons of concern in all phases of displacement and crisis.

SDG 3.1. By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

SDG 3.2. By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under 5 mortality to at least as low as 25 per 1,000 live births

Contraceptive coverage in many humanitarian contexts is low, nevertheless an important number of women and girls who have previously chosen a modern method of contraception, are deprived of access once the crisis starts. Globally 214 million women of reproductive age in developing countries have an unmet need for contraception, these unmet needs result in unintended pregnancy and related suffering and may result in unsafe abortion³. The SRH survey UNHCR undertook in four refugee areas in Chad and Cameroon, reflects contraceptive coverage rates ranging from 4% to 32% and averaging 25% for Chad and 10% for Cameroon⁴.

SDG 3.7. By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

The commitment to increase access to modern methods of contraception and narrow the unmet need gap is reflected in interagency commitments for humanitarian assistance and is symbolic of human rights and the respect of women's sexual and reproductive rights.

A high percentage of **adolescent pregnancy** in a population is an indicator reflecting shortcomings in several areas: access to contraception, a power imbalance of girls to negotiate contraceptive use, traditional practices involving child marriage, potential abuse of power and lastly GBV. It also highlights shortcomings in other sectors including a lack of access to education for adolescents and

the non-consideration of adolescent SRH needs in directives and laws, often penalizing young people, at the onset of their autonomous lives. A recent maternal mortality audit study on UNHCR data collected for 2017-2019 in Eastern Africa operations reflects 13% of the 191 audited maternal deaths among refugees to be girls under 20 years of age.

Intersecting vulnerabilities and lack of health services in low income and humanitarian settings also result in morbidity and suffering resulting from **obstetric fistula**.

Sexually Transmitted Infections (**STIs**) in general, **Human Papilloma Virus**, **HIV** infection and **cervical cancer** have important intersecting challenges and present opportunities for action. Globally 37.9 million people live with **HIV** and the infection is responsible to close to 690,000 death per year⁵. Data from 2016 reflects that 1 in 14 person living with HIV was in a humanitarian context in 2016⁶, highlighting the need for emergency responses to address prevention and treatment of HIV from the onset, to avoid treatment interruptions, any related morbidity and mortality as well as new infections resulting from lack of standard precautions for infection control and preventive health action.

SDG 3.3. By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

Gender-based violence including rape exists in all societies and in all contexts at any time. Globally, around one in three women will experience physical and/or sexual violence by a partner or sexual violence by a non-partner⁷. Destabilization of contexts often results in increased levels of violence, including sexual violence. Women and girls represent the large majority of GBV and rape survivors, but men and boys are not spared and while reported incidence in males is much lower, the impact on their health and well-being may be just as devastating. LGBTIQ+ persons, people with disabilities, children and adolescents are also often at increased risk of violence. Needs of survivors are multiple and should be considered as part of all UNHCR operations with specific focus on health care and protection.

³ Evidence Brief Contraception 2019. WHO. <https://apps.who.int/iris/bitstream/handle/10665/329884/WHO-RHR-19.18-eng.pdf?ua=1>

⁴ A population-based survey examining key indicators relating to maternal, newborn, family planning and HIV in selected refugee settings in Chad and Cameroon. 2018-2020. Internal document

⁵ UNAIDS factsheet World AIDS day 2020 https://www.unaids.org/sites/default/files/media_asset/UNAIDS_FactSheet_en.pdf

⁶ Information note: HIV in humanitarian contexts. UNHCR and WFP 2019. https://hivinemergencies.org/sites/default/files/inline-files/Final_HIV%20Data%20Doc%20UNHCR_WFP_May%202020.pdf

⁷ WHO, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO; 2013. https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf;jsessionid=65D035338E4C7740EAB6F9B5644FACD8?sequence=1

2. GUIDING FRAMEWORKS

The [Minimum Initial Service Package \(MISP\) for Sexual and Reproductive Health in crisis situations](#) is a set of lifesaving actions required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. The MISP is developed by the Inter-Agency Working Group for Reproductive Health in Crisis (IAWG). The key objectives are that there is no unmet need for family planning, no preventable maternal deaths and no gender-based violence or harmful practices, even during humanitarian crises. The [SPHERE standards 2018](#) highlight the same priority actions in emergencies. UNHCR priorities in the emergency phase focus on providing the MISP (Section 3.1. below) while planning concurrently for comprehensive SRH services.

3. PRIORITY ACTIONS

UNHCR's Global Public Health Strategy 2021-2025 proposes an inclusive approach with **early priority action in emergencies** while rapidly expanding services to ensure **comprehensive SRH and HIV care** to all refugees and where relevant other PoCs. The development of these services aims to benefit the host communities, refugees and other PoCs, and to support national host governments in enhancing access for sexual and reproductive health and HIV services.

Evidence from past humanitarian interventions has informed guidance on priority health action that most significantly reduces morbidity and mortality in emergencies, post-emergency, and in humanitarian settings at large. UNHCR health action is based on available evidence. UNHCR concentrates efforts on primary health care, ensuring referral for secondary and tertiary health needs as relevant.

A. Priority SRH and HIV actions in emergencies

In line with interagency guidance, UNHCR priorities in the emergency phase focus on providing a Minimum Initial Service Package (MISP) for reproductive health in emergencies. Below summarizes the key objectives and the action which UNHCR supports and monitors.

Objective 1: Reduce maternal and newborn morbidity and mortality

- Availability of skilled birth attendants and facility-based deliveries for all women under the agency's responsibility, with primary focus

to supporting and monitoring access to Basic Emergency Obstetric and Newborn Care (BEmONC), whilst ensuring timely referral options for Comprehensive Emergency Obstetric and Newborn Care (CEmONC)⁸

- Monitoring of EmONC signal functions performed in health facilities to ensure that the complications can be addressed in a timely and adequate manner
- Implementation of evidence-based high-impact practices for neonatal care including initiation of breathing and resuscitation, thermal protection, essential newborn care including delayed umbilical cord clamping and early initiation of exclusive breast feeding
- Provision of information to the community about the availability of safe delivery services and the importance of seeking care
- Reporting of all maternal and neonatal deaths
- Review/audit of every maternal death using the national audit forms or, when indicated, the [UNHCR – Maternal death review guidance and data collection form 2020](#)

Definitions and key information

Maternal death describes the death of a woman during pregnancy or in the period of 42 days following the end of a pregnancy. Severe bleeding (mostly bleeding after childbirth), infections, high blood pressure during pregnancy (pre-eclampsia, eclampsia), complications from delivery and unsafe abortion are the main direct causes of maternal death that make up for 75% of all maternal deaths.

Neonatal death is the death of a live born infant in the first 28 days of life. 99% of the world's newborn mortality happens in low- and middle-income countries. The majority of all neonatal deaths (75%) occurs during the first week of life, and about 1 million newborns die within the first 24 hours. Preterm birth, intrapartum-related complications (i.e. birth asphyxia), infections and birth defects cause most neonatal deaths in 2017. Evidence reflects that newborns who die within the first 28 days of birth suffer from conditions and diseases associated with lack of quality care at birth or skilled care and treatment immediately after birth and in the first days of life.

Maternal and newborn mortality is highest during and immediately around the time of childbirth, making skilled birth attendance the most effective measure to reducing both.

⁸ BEmONC : treatment of Infection (antibiotics), treatment of pre-eclampsia/ eclampsia, treatment of PPH, manual vacuum aspiration of retained products of conception / complications of abortion, vacuum assisted delivery / delivery through skilled personnel, manual removal of the placenta, newborn resuscitation CEmONC : BEmONC + surgical capability (inc. obstetric eg. C-Section) and blood transfusion

Objective 2: Prevent HIV and other STIs and reduce related morbidity and mortality

- Implementation of standard precautions in all health facilities
- Rational use of safe blood transfusion
- Provision of free lubricated condoms
- Provision of ART to all people on ART prior to the emergency, including women enrolled in prevention of mother to child transmission (PMTCT)
- Syndromic treatment approach for STIs
- Provision of Post-exposure prophylaxis (PEP) for survivors of sexual violence and occupational exposure
- Provision of co-trimoxazole prophylaxis for patients diagnosed with HIV

Objective 3: Prevention of unintended pregnancies

- Provision of a range of long-acting reversible and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception]
- Information, including using existing information, education, and communications (IEC) materials
- Community awareness of available contraceptive services

Objective 4: Prevention of sexual violence and clinical management to prevent or mitigate the consequences of sexual violence

- Preventative measures at community, local and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence
- Timely access to clinical management for survivors of rape and intimate partner violence. This includes wound care, post-exposure prophylaxis for HIV, emergency contraception, pregnancy testing, pregnancy options information, presumptive treatment of STIs, vaccination for tetanus, Hepatitis B, MHPSS, and referral to specialized services (health, protection, socio-economic, legal) as relevant and consented by the patient
- Respect of the confidentiality and privacy of all survivors
- Capacity building of health and protection staff to ensure supportive communication with all survivors; compassionate and confidential care and counselling, history and examination and understanding of the medico-legal system and forensic evidence collection

Objective 5: Coordination, collaboration and planning⁹

UNHCR health staff ensure and actively participate in the establishment of SRH and HIV coordination mechanisms at the onset of the emergency and engage in early planning for an expansion to more comprehensive SRH and HIV services once the initial emergency needs are met and a more comprehensive assessment of the SRH and HIV situation has been ensured.

UNHCR health and protection staff collaborate particularly in all aspects fostering non-discriminatory access to SRH and HIV services for all persons in need and with specific concern for the diverse needs of women, adolescents, people with disabilities, people who sell or exchange sex, and LGBTIQ+ persons.

UNHCR WASH, shelter and camp management staff work together to enable safe and hygienic behaviour during menstruation by ensuring access to supplies and materials for menstrual hygiene management (MHM); promote supportive facilities with female friendly toilets/ washrooms in schools and public facilities including waste management; and provide menstrual health and hygiene education.

HIV: The Inter-Agency Task Team (IATT) on HIV in Humanitarian Emergencies is co-convened by UNHCR and WFP and has members from 29 organizations. The role of the IATT is to strengthen the coordination, technical and operational capacity of national/regional and global level actors to prevent, prepare for, and to ensure a quality and timely response to HIV in emergencies. At country level, within the UN joint team on HIV, UNHCR and WFP are responsible within the division of labour for addressing HIV in humanitarian situations. This includes technical and operational support in response to refugee and migrant crises to support the HIV response. Key areas of joint engagement include amongst others advocacy work for e.g. inclusion of refugees in national programs and funding opportunities and ensuring refugees and other populations of concern in humanitarian settings are well reflected in country level processes, interventions and reporting mechanisms

COVID-19 context

In the context of the COVID-19 pandemic, support to the continuity of SRH care is a particular concern and requires ongoing monitoring and support. More information on continuity of care in face of the COVID-19 related challenges is available through [Guidance on Continuity of health and Nutrition](#)

⁹ In the Inter-Agency MISP guide this corresponds to objective 1 and 6



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Uganda. Help is at hand for South Sudanese refugees living with HIV.

[Services in the Context of COVID-19](#) and IAWG [Programmatic Guidance for SRH in humanitarian and fragile settings during the COVID-19 pandemic](#)

B. Comprehensive SRH and HIV care

Comprehensive SRH care builds on the MISP. It expands to cover all persons in need; builds pathways for multisector support; develops preventive care, rehabilitative, curative and palliative care; ensures active outreach, community engagement and empowerment; and meets the specific needs of different groups, including adolescents, people who sell or exchange sex and LGBTIQ+ persons.

“Providing comprehensive, high-quality SRH services in humanitarian settings requires a multi-sectoral, integrated approach. Protection, health, nutrition, education as well as water, sanitation, and hygiene and community service personnel all have a part to play in planning and delivering SRH services. The best way to ensure that SRH services meet the needs of the affected population is to involve the community in every phase of the development of those services; only then will people benefit from services specifically tailored to their needs and demands and only then will they have a stake in the future of those services.”

Source: Inter Agency Field Manual 2018

[Comprehensive SRH for women and girls](#) seeks to align, to the extent feasible, with the concepts of the [Life course approach to Sexual and Reproductive Health](#). The reduction of maternal and newborn mortality stays a central objective for UNHCR public health action. In this sense, ensuring skilled birth

attendance, health facility-based deliveries and adequate and timely referral pathways to secondary health care, continue to be of central importance. In addition, related preventive, promotive and curative action at other points in the life course (adolescent and women’s sexual reproductive health and nutrition; antenatal and postnatal care; newborn and child health) are necessary to adequately meet the SRHR needs of refugees and other people of concern to UNHCR.

Planning for comprehensive SRH services, integrated into primary health care, should begin as soon as possible. Working with the health sector partners to utilize the six WHO health system building blocks as a framework for the comprehensive SRH planning process is encouraged. Key objectives and the action which UNHCR supports and monitors regarding the Comprehensive SRH programming include:

- Ensuring programming of comprehensive SRH services is addressed as part of the MISP
- Ensure SRH services meet international standards, including the ‘Availability, Accessibility, Acceptability, and Quality’ framework of the right to health

[Community outreach and health services](#) must be tailored to meet the specific needs of different communities.

- Promote meaningful community engagement with women, men, adolescents and LGBTIQ+ persons throughout the project cycle. Engage community leaders, including religious leader, in dialogues and the promotion of SRH services.
- Ensure adequate deployment, training and supervision of the community health workforce. In accordance with national policies, engage

Traditional Birth Attendants in non-clinical activities such as promotion of uptake of SRH services and referral to health facilities.

- Ensure monitoring is in place and sensitive to identifying accessibility and acceptance of services for people with special needs

Maternal and Newborn Health Services

In addition to above mentioned objectives for minimum initial services, and in line with WHO recommendations, UNHCR will support and monitor:

- Access to skilled birth attendance and use of BEmONC and CEmONC health facilities for all women and girls in need of care.
- Adherence to principles of respectful maternity care.
- Essential newborn care at birth (includes initiation of breathing and resuscitation where needed; thermal care including skin-to-skin, delayed cord clamping and hygienic cord care; promotion of early and exclusive breastfeeding using the baby friendly initiative; vitamin K and eye prophylaxis, and vaccination) and special care for the sick and small newborn.
- Access to post abortion and safe abortion care to the full extent of the law
- Ante- and post-natal consultation, including diagnostics for anaemia, malaria, malnutrition, syphilis HIV and other infections, and treatment/prevention scope including iron folic acid supplementation, nutritional support, intermittent preventive malaria treatment in pregnancy and bed-net provision, PMTCT.
- Additional high-impact intervention relevant to the specific contexts (e.g. Kangaroo mother care).
- Access to mental health and psychosocial support by building SRH staffs' capacity through e.g. inclusion in mhGAP training to identify and manage women in need of support and facilitate referral of relevant mental health conditions to integrated MHPSS services.
- Continued capacity building of health providers through low-dose-high-impact training programmes

Comprehensive contraception and Family Planning services

aim to fulfil and increase the demand of modern methods of contraception. High-quality contraceptive services meet individuals' and couples' needs at every stage of their reproductive lives through clinical competence of providers, counselling skills, including the information provided, method choice, interpersonal skills, support for continuation of method use, and integration with other health services.

Health providers should ensure accurate and complete information, allowing women, men, and adolescents to voluntarily select a method that suits their needs. In moving for MISP to comprehensive contraception and family planning UNHCR should support and monitor:

- Development of a trained provider workforce (including attitude development)
- Community outreach, involvement and empowerment, with outreach to all relevant communities
- Development of adapted information, education, and communication materials
- Advocacy

HIV prevention and treatment as well as prevention and treatment of other STIs are increasingly integrated into primary health care generally and sexual and reproductive health care specifically. To the extent possible, comprehensive HIV care should align with the UNAIDS [Global Strategy for HIV](#)

In moving from MISP to comprehensive HIV care, UNHCR aims to support and monitor HIV awareness action, prevention and treatment in accordance with the context and the characteristics of the epidemic in the refugee context. This includes:

- **HIV awareness action, prevention and treatment** in accordance with the context and epidemic characteristics in the refugee population and including particularly:
 - Understanding of the epidemic (prevalence, population size, key populations at higher risk of HIV, health care barriers, legal and stigma related considerations) for refugee and host population.
 - Addressing stigma and discrimination, with priority for service providers and, if feasible, general population.
 - Health and protection action responding to the most at-risk persons/communities by working with and for these populations including people selling or exchanging sex, men who have sex with men, transgender men and women and injecting drug users
 - Combination prevention tailored to the epidemic profile and particularly at-risk populations:
 - » Biomedical prevention measures: testing (including self-testing), condoms and lubricants, PMTCT including follow-up on infants born to HIV positive women and early infant diagnosis, PEP, STI treatment and Pre-exposure prophylaxis (PrEP), Voluntary Medical Male Circumcision and needle and syringe exchange where relevant

- » Behavioral change & communication: public campaigns, educational/ awareness materials, peer-led approaches
 - » Interventions addressing contextual factors contributing to vulnerability and risk.
- Access to comprehensive care, treatment and support, including:
- » Patient information and education
 - » Adherence support including alternative service delivery models
 - » ART for all HIV positive persons, monitoring of viral load, treatment of opportunistic infections
 - » Testing for viral hepatitis and tuberculosis
 - » TB preventive therapy in accordance with national guidelines
 - » Social protection, food and nutrition considerations, livelihoods
 - » Peer support and community empowerment including community-led responses by people living with HIV, key populations and women and girls.
 - » Offer HIV testing to all newly diagnosed TB cases
- At policy level, UNHCR will advocate for
- » Inclusion of people living with HIV in national programmes (prevention, testing, treatment and social protection) at the same level as nationals
 - » Strengthened national supply lines for HIV related diagnostics and treatment
 - » No discrimination, stigmatization, criminalization and/or refoulement based on HIV status and no mandatory HIV testing for refugees and other PoCs to UNHCR

GBV Prevention and Response

Survivors of rape and intimate partner violence (IPV) and other forms of GBV often face exclusion, stigma and blame, limiting their access and availability to health care and treatment. Women and girls are the focus of attention, but services should be tailored to ensure access for male survivors to be sensitive to their needs as well as the specific needs of LGBTIQ+ persons.

GBV response must be survivor-centered with a rights-based approach, considering the needs and decisions of the survivor and contributing to reduce discriminating and stigma. All concerned actors must be aware of relevant national laws and policies, both regarding the crime itself (sexual violence and

especially rape are considered crime under most national legislation), but also mindful of contexts in which specific characteristics of the assault may result in the survivors of GBV and IPV to be criminalized.

UNHCR, together with UNFPA and WHO has developed a [Guide for Clinical Management of Rape and Intimate Partner Violence](#) and which focuses on a survivor-centered approach, commitments to confidentiality, establishment of pathways to protection, social and legal support and detailed directives regarding the physical examination and treatment of survivors.

In particular, UNHCR should support and monitor:

- Access to clinical management of rape and IPV for all survivors.
- Survivors right to be provided a medical-legal certificate of the assault are known and honoured
- UNHCR and partner staffs respect of the guiding principles for working with GBV survivors. Community involvement to address and reduce the discrimination and stigma attached to GBV and IPV. Special attention and care must be given to children and adolescents who become survivors of GBV and sexual violence, where health care must be provided to the same extent as for adults and health care staff must be trained to communicate with child survivors and provide safe spaces.
- Active outreach to people specific with needs and different communities
- SoPs and pathways for specialized medical care and other assistance including protection, economic support, legal advice

Other SRH Activities

- Access to **cervical cancer** screening, treatment of pre-cancerous lesions and referral for treatment of advanced forms of cervical and breast cancer in line with national protocols
- Awareness and prevention efforts in relevant contexts for **female genital mutilation/cutting**
- Access to accurate information and counselling on sexual and reproductive health, sexual function, including evidence-based, comprehensive sexuality education
- Access to information on menstruation, menstrual hygiene management, management of severe pain during menstruation
- Access to prevention, management, and treatment of infertility in line with country operation referral protocols

Where services are not available locally, UNHCR should act as a catalyst and support referral pathways and service establishment to the full scope of relevant SRH and HIV care.

C. Specific needs of different communities

Adolescents

Adolescents face additional barriers with accessing SRH and HIV services in humanitarian settings and are at additional risk. Younger people have different needs due to their physical and psychological stages, are experimenting with more risk-taking behavior, and often have inadequate knowledge on SRH and HIV. Simultaneously community attitudes, policies and laws may restrict the access of adolescents to information and services. Often health systems are not geared towards serving adolescent SRH and HIV needs.

UNHCR has developed [Practical guidance to launching ASRH interventions in public health programs: Adolescent sexual and reproductive health in refugee settings](#), a 10-Step approach to launching ASRH interventions.

Specific attention should be brought to pregnant and lactating adolescents to ensure additional assistance and support (including protection) on issues including:

- Child protection: the [UNHCR Framework for Child Protection](#) applies to all adolescents including pregnant and lactating girls.
- Female Genital Mutilation (FGM): FGM is condemned by several international treaties and conventions, as well as by national legislation in many countries. FGM is regarded as prejudicial to the health of children and is, in most cases, performed on minors, thus violating the [Convention on the Rights of the Child](#). An [interagency statement on FGM](#) was issued in 2008 and highlights that re-infibulation is considered at equal level with initial FGM and thus rejected as a medical practice. UNHCR will ensure that health care providers are aware of their obligations in this regard.
- Obstetric Fistula is the result of obstructed labor, particularly prevalent in girls and young women during their first delivery. Underlying factors include child marriage and adolescent pregnancies. The main health actions regarding obstetric fistula are preventive: primary prevention being the delay of the first pregnancy (contraception) and skilled birth attendance, secondary prevention consists in early identification of obstetric fistula post-partum and conservative treatment. Finally, fistula repair should be made available to all women in need.

People who sell or exchange sex

People in humanitarian settings are frequently faced with disruptions to basic needs, livelihoods and community support mechanisms. As a result, people may engage in the sale or exchange of sex. People who sell or exchange sex have particular health and protection needs which remain often unmet because of de-prioritisation, stigma or discrimination.

UNHCR and UNFPA have developed the [Operational Guidance: Responding to the health and protection needs of people selling or exchanging sex in humanitarian settings](#) to support project planning and implementation.

The overriding goal of the guidance is to **improve health, well-being and security** for people who sell or exchange sex in humanitarian settings. Specific health objectives can be summarized as follows:

- Strengthen safety, and health knowledge and skills of people selling or exchanging sex;
- Reduce transmission of HIV and other sexually transmitted infections and improve the health of people living with HIV;
- Reduce the number of unintended pregnancies;
- Ensure medical care and protection for survivors of GBV and IPV and implement prevention activities;
- Enhance community empowerment amongst people selling or exchanging sex;
- Combat stigma and discrimination against people who sell or exchange sex, as well as against their families.

LGBTIQ+ Persons

UNHCR highlights the need for equitable access to care for LGBTIQ+ persons in any humanitarian setting, including access to sexual and reproductive health services, comprehensive support for all survivors of GBV, PrEP for those at increased risk of HIV infections such as MSM and transgender, and if available, hormone supplementation for transgender persons.

UNHCR's Need to Know Guidance: [Working with Lesbian, Gay, Bisexual, Transgender & Intersex Persons in Forced displacement](#) highlight the intersecting vulnerabilities and health needs. UNHCR will ensure partners are aware and actively promote needed action across sectors.

For transgender person, access to **hormone supplementation** is a very specific need that is not available in many national programmes. UNHCR's forthcoming updated referral guidelines will include guidance on the management of transgender persons in need of hormonal supplementation.

4. ADDITIONAL KEY REFERENCES

UNHCR guidance documents

- UNHCR maternal and newborn care: operational guidance (revision underway)
- Adolescent sexual and reproductive health in refugee situations: A practical guide to launching ASRH interventions in public health programmes. UNHCR 2019. <https://www.unhcr.org/5d52bcbd4>
- Operational guidance: responding to the health and protection needs of people engaged in selling or exchanging sex. UNHCR and UNFPA 2021 <https://www.unhcr.org/60dc85d74>
Clinical management of rape survivors and intimate partner violence (IPV). WHO, UNFPA, UNHCR 2020. <https://apps.who.int/iris/bitstream/handle/10665/331535/9789240001411-eng.pdf?ua=1>
- UNHCR Policy on the Prevention of, Risk Mitigation and Response to Gender-based Violence. 2020 <https://www.unhcr.org/5fa018914/>
- Additional resources: <https://www.unhcr.org/reproductive-health.html>

Technical documents IAWG

- Inter-Agency Field Manual for Reproductive health in Humanitarian Settings IAWG 2018. <https://iawgfieldmanual.com/manual>
- Programmatic guidance for sexual and reproductive health in humanitarian and fragile settings during the COVID-19 pandemic 2020. IAWG 2020 <https://iawg.net/resources/programmatic-guidance-for-sexual-and-reproductive-health-in-humanitarian-and-fragile-settings-during-covid-19-pandemic>
- Adolescent Sexual and Reproductive health tool kit for Humanitarian Settings. IAWG 2020. <https://iawg.net/resources/programmatic-guidance-for-sexual-and-reproductive-health-in-humanitarian-and-fragile-settings-during-covid-19-pandemic>
- Roadmap to Accelerate Progress for Every Newborn in Humanitarian Settings 2020 – 2024. Save the Children, WHO, UNICEF, UNHCR. 2020. <https://www.healthynewbornnetwork.org/resource/newbornroadmap/>

Trainings

- MISP training (IAWG) <https://iawg.net/resources/minimum-initial-service-package-distance-learning-module>
- E-Learning CMR-IPV (WHO, UNFPA and UNHCR) <https://who.csod.com/>



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