UNHCR
The UN Refugee Agency

2025
Public Health Global Review

Public Health Unit | Sustainable Responses Service (SRS), UNHCR, Geneva

2025
Public Health Global Review at a glance

13.5M
refugees

58*
countries with UNHCR supported public health programmes

12.9M
consultations

194,000
referrals

9,856
community health workers

453,670
NCD consultations*

1,077,161
MHPSS consultations

92%
% camps/ settlements** with a mental health professional

84%
coverage of complete antenatal care*

117,000
deliveries supported*

20,861
refugees on antiretroviral therapy

1 in 10
children < 5 yrs with acute malnutrition

1 in 3
children <5 yrs with stunting

198,409
treatment provided to children with acute malnutrition

* Data from 21 countries using integrated Refugee Health Information System
** Camps/settlements with more than 25,000 refugees

Executive summary

In 2025, UNHCR supported public health responses across 58 refugee-hosting countries, operating amid overlapping crises that included conflict, climate shocks, disease outbreaks, and economic pressures. Despite a tightening resource environment, efforts remained focused on reducing preventable mortality and morbidity and sustaining access to essential health services.

Key priorities included primary health care, maternal and newborn health, nutrition, and mental health and psychosocial support, alongside strengthened outbreak preparedness and response. A central strategic objective was advancing the inclusion of refugees in national health systems, which is critical for achieving sustainable and equitable access to quality care for refugees and host communities and strengthening self-reliance. However, funding cuts affected humanitarian service delivery and support to national systems and were further compounded by declines in national health expenditure. While de jure policy inclusion continued to expand, de facto access to health care remained constrained in many contexts, reflecting persistent legal, financial, administrative, and geographic barriers. Efforts to advance inclusion were supported by strengthened evidence and operational learning across health governance, financing, service delivery, workforce capacity, and health information systems.

Constrained resources, combined with increasing need, led in some contexts to reduced services, limited outreach, and declining utilization of health facilities, placing additional strain on already fragile health systems. National health authorities, supported by UNHCR and partners, worked to preserve life-saving care and reinforce system resilience under growing pressure.

While meaningful gains have been achieved in recent years, 2025 marked a critical juncture. Without sustained investment and continued commitment to system-based approaches, hard-won progress toward equitable access, resilience, and health security for displaced populations risks being reversed.

Achievements

- Refugee inclusion is continuing to progress, with 87% of surveyed countries reporting inclusion in national health policies.
- A multi-country study showed pathways to advance refugee inclusion, strengthen health systems, and improve outcomes for refugees and host communities.
- Over 12.9 million health consultations are being delivered globally, demonstrating substantial demand despite reduced capacity.
- Communities are continuing to seek reproductive health services despite service constraints, with 84% of pregnant women completing at least four antenatal visits and 93% of births being attended by skilled personnel.
- Preparedness and response to disease outbreaks are remaining a priority. In Sudan, UNHCR is part of a coordinated multiagency response that is contributing to a major decline in cholera transmission.
- A Spotlight Session at the Global Refugee Forum Progress Review is featuring the 235 pledges on health and Mental Health and Psychosocial Support (MHPSS) and is reporting progress in access to health services in 12 of 15 target countries.

Worrying trends

- Access barriers persist, particularly financial, with UNHCR and partners often supporting insurance premiums or co-financing to enable refugee enrolment and access to essential services.
- Fewer refugee hosting locations are meeting targets for global acute malnutrition (from 65% to 59%), stunting (23% to 20%), and child anaemia (4% to 2%), while treatment coverage for acute malnutrition is declining by 39%.
- HIV testing and treatment are declining significantly, with the number of refugees tested dropping from 573,856 to 365,687, and those on antiretroviral therapy from 24,088 to 20,861.
- Service reductions are affecting critical areas such as safe delivery care leaving many women and girls without access to essential, life-saving or preventive interventions.
- Essential mental health services are being disrupted in several operations due to funding cuts and partner withdrawal, for example Ethiopia, South Sudan and Tanzania.
- Cuts to community health programmes are weakening early detection and care-seeking. Community outreach is declining in 36/49 countries, contributing to delays in treatment.

The way forward

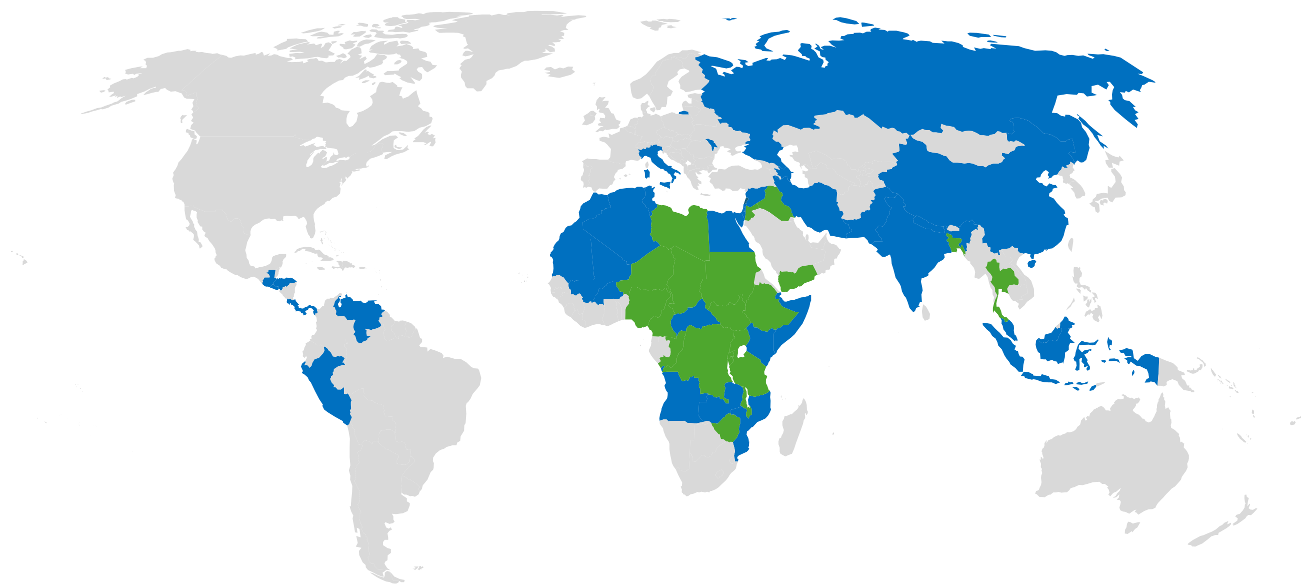
UNHCR will continue to work with host governments, development actors, UN agencies, civil society, refugee communities, and the private sector to advance more resilient and inclusive health responses, anchored in the following key priorities:

- **Prioritize life-saving services and self-reliance** as foundations for human capital development, including through economic inclusion, while reinforcing preparedness and response to mitigate growing public health risks.
- **Tackle barriers to equitable access** by addressing financial, administrative, and geographic constraints to health services.
- **Advance refugee inclusion and strengthen system capacity** by transitioning from parallel service delivery to government-led approaches, while reinforcing national systems across financing, workforce, and service delivery.
- **Bridge financing and multi-stakeholder partnerships** to support coordinated delivery and translate commitments on health inclusion and MHPSS into concrete results for host countries.

Acronyms and Abbreviations

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
CDC	Centers for Disease Control
CHW	Community health worker
DHIS2	District Health Information System version 2
EmONC	Emergency obstetric and newborn care
GAM	Global acute malnutrition
GAVI	Global Vaccine Alliance
HIV	Human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IATT	Inter-Agency Task Team
ILO	International Labour Organization
ILO	International Labour Organization
IOM	International Organization for Migration
iRHIS	Integrated Refugee Health Information System
IYCF	Infant and young child feeding
MAM	Moderate acute malnutrition
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MNS	Mental, neurological and substance use conditions
MUAC	Mid-upper arm circumference
NCDs	Noncommunicable diseases
NGO	Non-governmental organization
PLHIV/TB	People living with HIV and tuberculosis
PM+	Problem Management Plus
QMU	Queen Margaret University
QMU	Queen Margaret University
SAM	Severe acute malnutrition
SBS	Step by Step
SENS	Standardized Expanded Nutrition Surveys
SRH	Sexual and reproductive health
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
WFP	World Food Programme
WHO	World Health Organization
WASH	Water, sanitation and hygiene

Overview of UNHCR's Public Health Response



- Countries with public health programmes
- Countries with public health programmes using iRHIS

Introduction

The 2025 Global Public Health Overview presents key results from UNHCR's response across 58 refugee-hosting countries, drawing on operational data, field experience and insights gathered during an exceptionally challenging year. It outlines major trends, achievements, and persistent gaps across core technical areas, reflecting the evolving realities facing refugees, stateless people, and host communities.

UNHCR intensified efforts to advance refugee inclusion in national health systems, expand access to essential services, particularly in emergencies, and sustain life-saving interventions despite unprecedented budget reductions. Lessons from the current strategy cycle (2021-2025) directly informed the development of the forthcoming Global Public Health Strategy (2026-2030), which calls for more responsibility sharing towards sustainable, nationally led and resilient health systems from the outset of emergencies.

UNHCR's public health priorities centre on reducing preventable mortality and morbidity and ensuring continued access to essential services. This includes primary health care, maternal and newborn health, nutrition support, and mental health and psychosocial services, alongside efforts to reinforce preparedness for and response to disease outbreaks.

A core focus is the progressive inclusion of refugees in national health systems, recognising that sustainable and equitable access to quality health care depends on strong and financially supported nationally led service delivery for both refugees and host communities. To advance this objective, UNHCR strengthened the evidence base for inclusion by working with academic institutions to generate new analysis on governance, financing, service delivery models, health workforce needs, and data systems to guide effective transitions.

Collaboration with host governments, development partners, UN agencies, civil society organizations, refugee communities, and the private sector increasingly shape more resilient and coordinated health responses.

Partnerships such as the Group of Friends of Health for Refugees and Host Communities play a key role in sustaining engagement and translating shared commitments on health inclusion and MHPSS into practical, multi-stakeholder action.

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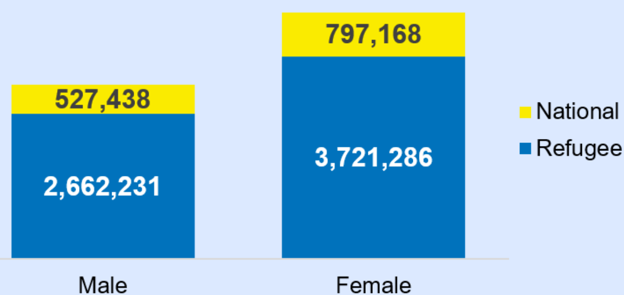
Access to essential health and nutrition services

Globally, 12.9 million consultations were reported across 58 countries in 2025, compared to 15.4 million consultations across 63 countries in 2024, an overall 16% decline. Of the 12.9 million consultations, 7.7 million outpatient visits were reported in 21 countries using the Integrated Refugee Health Information System (iRHIS). These countries experienced shrinking resources and major new displacements, particularly in Burundi, Chad, the Democratic Republic of the Congo, Ethiopia, South Sudan, Sudan and Uganda. This represents an 11.5% decrease from the 8.7 million consultations reported in 2024, driven largely by funding constraints, reduced partner capacity, lower utilization, and pressure on host-country health systems.

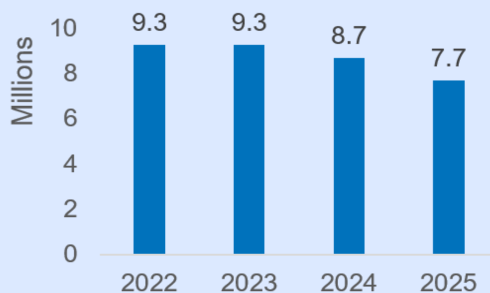
Women and girls represented 59% of all consultations in 2025, compared with 57% in 2024, reflecting a continued pattern of higher service utilization among women. This high service utilization underscores the role women play as primary caregivers, often seeking care not only for themselves but also for children and other family members, a pattern consistent with global evidence showing women disproportionately shoulder informal caregiving responsibilities, particularly in crisis-affected settingssettings.[1,2]

Refugees represented 83% of all consultations, while host-community members accounted for 17%, a pattern consistent with earlier years. New visits also remained steady at 5.8 million, indicating persistent demand for services and suggesting that the decline in total consultations reflects capacity constraints rather than reduced care-seeking among refugees.

Consultations in iRHIS countries, 2025



Outpatient consultations

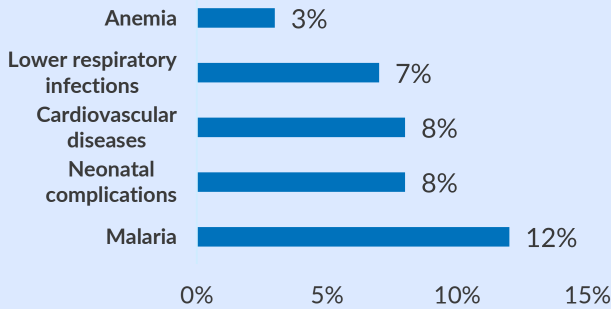


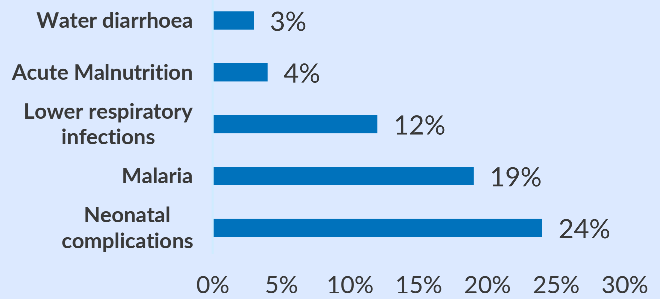
Health facility Utilization Rate

0.87

New visits / refugee / year

5,883,790 New Visits out of **6,807,932** Population





Although the total consultations declined across all operations where iRHIS was used, there is substantial variation between countries. New emergencies and large-scale population movements generated sharp increases in service demand in Burundi, Ethiopia, Rwanda and parts of Uganda, driven by major refugee influxes from the Democratic Republic of Congo (DRC), South Sudan and Sudan. In contrast, conflict related access challenges reduced facility capacity and closure of UNHCR supported services resulted in steep declines in consultations, particularly in South Sudan and Chad and the conflict affected areas of the DRC and Sudan.

The distribution of the leading causes of morbidity remained consistent with 2024 global trends, with upper respiratory tract infections representing 20% of consultations, malaria 19%, lower respiratory tract infections 10%, and skin diseases 6% and watery diarrhoea 5%.

Over 194,000 referrals were made from primary to secondary or tertiary care in 2025, with a global median of 2,070 referrals. This represents an increase from the 183,952 referrals recorded in 2024, indicating a continued upward trend in referral activity. The rise is likely attributable to increased case severity, driven by delays in timely health-seeking behaviour and reduced access to primary health care services following budgetary constraints.

Crude mortality remained stable at 0.07 deaths per 1,000 population per month in 2025 and 2024. Under-five mortality rate was 0.14/1,000/month in 2025, slightly up from 2024. The leading causes of mortality were malaria (12%), neonatal complications (8%), cardiovascular diseases (8%), lower respiratory infections (7%), and anaemia (3%), underscoring the continued vulnerability of refugee populations to preventable infectious and neonatal conditions. However, community level mortality reporting remains limited and recent funding cuts have reduced surveillance capacity in several operations, limiting the ability to fully detect and

Crude Mortality Rate

Gender	Deaths	Population	< 0.75 / 1000 / month	1000 / month
Female	2,478	3,556,227	√	0.06
Male	2,913	3,251,705	√	0.07
Total	5,391	6,807,932	√	0.07

Under 5 Mortality Rate

Gender	Deaths	Population	< 1.5 / 1000 / month	1000 / month
Female	768	534,961	√	0.12
Male	980	528,290	√	0.15
Total	1,748	1,063,251	√	0.14

interpret mortality trends. Global WHO analyses show that disruption to primary health care, reduced service coverage and weakened surveillance systems in crisis affected settings can contribute to higher mortality risks; yet underreporting and gaps in community-level data mean that potential increases in mortality in 2025 may not be fully captured.[3] [4]

In 2025, neonatal complications remained the primary driver of mortality among children under-five, accounting for 24% of all deaths, similar to 2024. Malaria (19%), lower respiratory infections (12%), and acute malnutrition and watery diarrhoea (each 4%) followed as the next major contributors, reflecting a mortality pattern broadly consistent with the previous years. The persistence of neonatal conditions as the foremost cause of under-five mortality underscores ongoing gaps in maternal, newborn, and early postnatal care, including delays in antenatal attendance, limitations in intrapartum management, and inadequate immediate newborn support. Compared with 2024, these findings reaffirm the continued vulnerability of young children to preventable infectious, nutritional, and neonatal causes, highlighting the need for sustained investments in quality reproductive, maternal, and newborn health services across refugee-hosting settings.

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Disease Outbreaks and Emergency Response

Malaria remained a major cause of morbidity and mortality, with an incidence rate of 173 per 1,000 population per month compared to 214 per 1,000 per month in 2024, while multiple operations reported outbreaks of cholera (10 operations), measles (9), dengue (5) and mpox (4) in refugee sites.

A convergence of extreme weather events, multiple concurrent outbreaks, and severe reductions in humanitarian financing tested UNHCR's capacity to prevent, detect, and respond to communicable diseases in 2025. Refugee-hosting countries continued to face overstretched health systems, with extreme weather-related shocks such as flooding, prolonged drought, and degraded water systems driving increased transmission risks for water and vector-borne diseases. These pressures further compounded gaps in national surveillance systems, service availability, and access to prevention and treatment. For example, in the Democratic Republic of the Congo, severe flooding aggravated outbreaks of several high impact epidemics, including cholera, Ebola, and mpox, with North Kivu experiencing more than 300 mpox cases in a single week in 2024–2025, underscoring the heightened vulnerability of displaced communities to overlapping epidemics. Similarly, the Dadaab Refugee camp in Kenya was affected by El Niño related climatic extremes, with temperatures nearing 50°C and erratic rainfall triggering recurrent droughts and devastating flash floods conditions that significantly increased risks of malnutrition and food insecurity, malaria, diarrhoeal diseases, and WASH-related outbreaks across camp settings.

Across emergencies and protracted settings, disease surveillance was reinforced, essential public health functions sustained, and life-saving outbreak response supported through collaboration with governments, WHO, UNICEF, and other partners. As humanitarian financing contracted, operations adapted to safeguard the most critical services, including immunization, case management, and community surveillance. Central to these efforts was coordination with Ministries of Health to ensure refugees' inclusion in national outbreak preparedness and response plans, in line with UNHCR's shift towards nationally led, sustainable health responses.

Communicable disease outbreaks increased in scale and complexity in 2025. Cholera resurged across several refugee-hosting countries including Burundi, Chad, DRC, Ethiopia, Sudan, and others, driven by floodings, water insecurity and overstretched sanitation systems. In Sudan, cholera affected 17 of 18 states, requiring integrated health and WASH action despite access constraints and degraded infrastructure. Recurrent malaria transmission in emergency settings required strengthened vector control measures and close alignment with inter-agency technical guidance, including updates to the Malaria Control in Emergencies Field Manual. Mpox alert and response capacities were reinforced through WHO's new guidance for camp settings, with UNHCR technical inputs.

UNHCR and partners responded through public health interventions, including case management, vaccination campaigns, strengthened community-based surveillance, temporary treatment sites, and integrated risk communication. Community health systems continued to play a pivotal role, supported by harmonized tools and SOPs developed across 2025. Capacity building remained essential: UNHCR delivered technical webinars, facilitated outbreak-specific training, and collaborated with the US Centers for Disease Control and Prevention (CDC) on mortality surveillance to strengthen detection of excess mortality linked to communicable diseases.

Despite these efforts, reductions in funding and public health staffing constrained outbreak prevention and response. Several operations reported declining immunization coverage, interruptions in NCD and HIV care that further elevated vulnerability to infectious diseases, and reduced access to diagnostics and referral pathways. In several countries, national leadership in outbreak management grew stronger, but continued investment in nationwide disease surveillance, health-system readiness, and inclusive and integrated services are critical to mitigating the growing communicable disease burden in displacement settings.

Cholera outbreak in Sudan

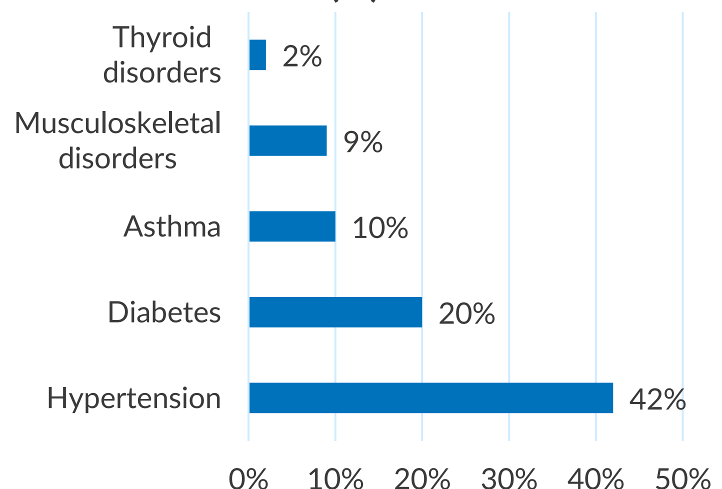
The cholera outbreak that began in Sudan in July 2024 continued into 2025, constituting one of the country's most significant public-health emergencies. By December 2025, the Ministry of Health had reported a total of 123,692 cases and 3,569 deaths nationwide, reflecting the scale of the epidemic. Refugee-hosting areas were heavily affected in the early stages of the outbreak, with 1,450 cases and 29 deaths recorded among refugees since its onset. Despite these challenges, case fatality among refugees remained lower than the national average, demonstrating the effectiveness of UNHCR-supported cholera treatment units. By the end of 2025, transmission had declined markedly, with only one new refugee case reported in December, a 91.7 percent reduction from the previous month.

* Sudan. UNHCR scales up cholera response as second outbreak hits.

The outbreak was driven by a combination of deteriorating WASH conditions, flooding, overcrowding, and substantial shortages of medical supplies, which collectively amplified transmission risks in both refugee camps and surrounding host communities. In response, UNHCR and partners strengthened surveillance systems, enhanced early detection, expanded hygiene promotion and community engagement activities, and supported targeted WASH interventions and case management. These efforts contributed to the sharp reduction in cases observed toward the end of the year.

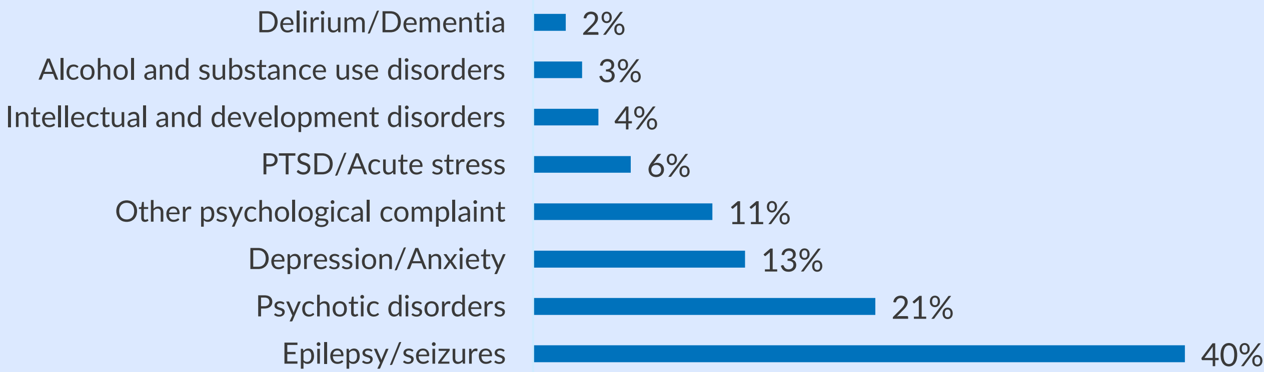
Noncommunicable diseases

Non-communicable diseases (NCDs) accounted for 6% (453,670) of all outpatient consultations in reported in iRHIS in 2025, a proportion consistent with 2024. Within the NCD caseload, hypertension (42%), diabetes (20%) and asthma (10%) remained the predominant conditions. This distribution reflects the growing chronic disease burden observed in protracted refugee settings, where lifestyle, environmental exposures, ageing populations, and limited access to long-term continuity of care all contribute to rising NCD prevalence. The continued dominance of these conditions highlights the need to further strengthen integrated NCD services at primary-care level, including routine screening, improved case management protocols, and reliable access to essential medicines for long-term treatment and control.



Mental Health and Psychosocial Support Services

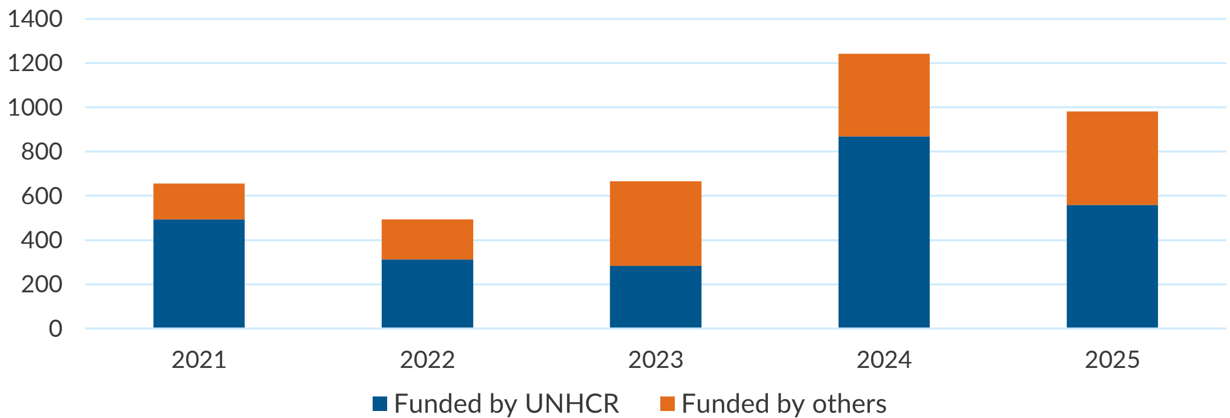
Mental, neurological, and substance-use (MNS) conditions accounted for 3% (178,473) of all outpatient consultations reported in iRHIS in 2025, a proportion similar to 2024. Within this caseload, epilepsy and seizures remained the most frequently reported conditions (40%), followed by chronic psychotic disorders (21%), depression/anxiety (13%), other psychological complaints (11%), and post-traumatic disorder (PTSD)/acute stress (6%). The predominance of complex conditions reinforces the importance of integrating Mental health and psychosocial support (MHPSS) into primary health care where early identification, follow-up, and continuity of care can be ensured. Strengthening mhGAP-aligned service delivery, securing a reliable supply of essential psychotropic medicines, and reinforcing referral pathways to and supervision by secondary-level psychiatric care remain essential components of the response.



In 2025, 822 doctors and nurses working in refugee settings received training to identify and manage priority mental, neurological and substance use conditions with the mhGAP Humanitarian Intervention Guide, which is an increase compared to 2024 but still lower than the years before when more funding in UNHCR and partners (including governmental partners) was available for capacity building.

Similarly, trainings for non-specialized staff both within and outside health facilities were trained in scalable psychosocial interventions: in 2025 almost 1,000 people in refugee settings were trained (57% funded by UNHCR, 43% funded by others), mostly in the five-session approach of Problem Management Plus. The number of trainees reduced with 21% compared to 2024.

Number of doctors and nurses who participated in trainings to identify and manage mental, neurological and substance use conditions with mhGAP (2021-2025)



Additionally, community-based psychosocial support is essential in promoting treatment adherence, preventing relapse, and supporting long-term care for individuals living with chronic mental, neurological, and substance-use disorders. Almost 5000 community health workers and other community workers received training in Psychological First Aid and or basic psychosocial helping skills.

MHPSS requires multi sectoral action including within our work in protection and education. This will be described in detail in the forthcoming report 'Strengthening Mental Health and Psychosocial Support in UNHCR Annual Report 2025.'

Supporting Rohingya adolescents with psychological distress

Mental Health and Psychosocial Support (MHPSS) services in the Rohingya camps in Bangladesh have faced challenges in adequately responding to adolescents experiencing emotional and internalizing problems. To address this gap, UNHCR Bangladesh introduced the Early Adolescent Skills for Emotions (EASE) intervention, which aims to equip adolescents and their caregivers with practical skills to reduce psychological distress. Before implementation, all EASE tools, manuals, and Information, Education and Communication (IEC) materials, as well as workbooks, were translated and contextualized to ensure cultural and contextual relevance. UNHCR EASE master trainers conducted a 10-day training programme, complemented by supportive supervision, for 28 refugee community para-counsellors and psychologists from partner organizations. As part of the certification process, all EASE helpers conducted two practice sessions prior to delivering the intervention. In 2025, trained EASE providers collectively delivered services to 83 adolescents experiencing emotional and internalizing problems, along with their 83 caregivers in Cox's Bazar and Bhasan Char. This successful implementation provides a strong foundation for scaling up the EASE intervention in 2026 and beyond.

Sexual and Reproductive Health

Despite ongoing resource pressures and foreclosures of several health facilities, sexual and reproductive health (SRH) were sustained by UNHCR's continued prioritization of SRH services.

Antenatal care (ANC) performance remained strong in 2025 with 84% of pregnant women completing at least four ANC visits-an improvement from previous years. This high completion rate reflected continued, consistent utilization of ANC services, mirroring stable patterns observed in 2024.

UNHCR supported facilities recorded over 117,000 deliveries in 2025, a decrease from 138,248 reported globally in 2024. Skilled birth attendance (SBA) remained stable at 93%, consistent with trends reported since 2022. Neonatal complications accounted for 24% of under-five deaths in 2025: continued efforts to strengthen quality maternal and newborn care remain therefore essential. Close monitoring and targeted investments are critical to safeguard these gains and accelerate reductions in neonatal mortality across refugee hosting settings.

Maternal mortality remained a significant public health concern with 148 deaths reported in 2025, lower than the 180 deaths recorded in 2024 but still representing a substantial preventable burden. When interpreted against fluctuating delivery volumes and persistent constraints in emergency obstetric and newborn care (EmONC), these deaths highlight critical systems gaps consistent with the WHO 'Three Delay' model: delays in seeking care, delays in reaching care, delays in receiving timely, quality intrapartum and emergency obstetric services.

Regionally, the Eastern Horn & Great Lakes and Southern Africa region accounted for the highest proportion of reported maternal deaths concentrated largely in the Democratic Republic of Congo, Ethiopia, Sudan, Tanzania. Significant reports also came from Cameroon and Chad in Western and Central Africa. These patterns reflect a complex interplay of factors, including insecurity during periods of displacement and funding constraints. To mitigate preventable causes such as post-partum haemorrhage, UNHCR-supported operations routinely implement standardized postpartum haemorrhage (PPH) management bundles, including timely uterotonic administration, rapid stabilization and resuscitation, referral to EmONC alongside the continued use of Kangaroo Mother Care. Sustained investment, strengthened systems and close monitoring are essential to further reduce maternal mortality in these high-risk settings.

93%
Skilled birth attendance rate

Birth Attended	109,166
Live & Still Birth	117,151

84%
Coverage of complete antenatal care

Pregnant Women >= 4 visits	96,482
Live Birth	115,525

Adolescent pregnancies also remained a concern in 2025. While proportions varied by country, adolescent deliveries continued to represent a notable share of total births (13%), mirroring the 12% level observed in 2024. This highlights the need for a multisectoral approach in refugee operations. Rising displacement, conflict and economic instability in 2025 increased adolescents' vulnerabilities to unintended and early pregnancies by disrupting protective systems and limiting access to essential SRH services. Restricted mobility, prolonged school closures and weakened family and community support contributed to earlier sexual debut. They also reduced access to contraceptives and accurate SRH information. UNHCR complements adolescent sexual and reproductive health programming with child protection interventions that address underlying protection risks associated with adolescent pregnancy. These include prevention of and response to child marriage and sexual violence against children, support to adolescent-responsive programming, strengthening of child protection case management/best-interest procedures, and community engagement to address harmful social norms affecting girls. However, humanitarian funding cuts further reduced the availability of adolescent-friendly SRH services. At the same time, gaps in clinical management of rape, weak GBV prevention structures, limited SRH commodities, and insufficient mental health support heightened adolescents' exposure to sexual violence and exploitation. These intersecting factors elevate the epidemiological risk of rising adolescent pregnancies, which is associated with higher maternal morbidity, mortality, and long-term social vulnerabilities. Adolescent SRH must be initiated early and sustained in crises. However, ongoing resource constraints threatens these essential services and may exacerbate preventable harms.

In 2025, a total of 365,687 individuals were tested for HIV, representing a notable decline compared to 573,856 tests conducted in 2024. The reduction in testing volume may be attributed to service disruptions observed in early 2025, including interruptions in HIV testing and counselling services within refugee operations. During ANC visits, 187,059 pregnant women were screened for HIV in 2025, reflecting a slight decrease from 195,517 screened in 2024. While the decline is relatively small, it may indicate access challenges during reporting period. In contrast, the number of individuals maintained on antiretroviral therapy (ART) decreased substantially from 24,088 in 2024 to 20,861 in 2025, indicating significant pressure on continuity of care, treatment access and follow up.

Case study Algeria: Ensuring maternal and child health services in Boujdour camp, Sahrawi refugee camps, Tindouf-Algeria

Boujdour Camp Hospital is a lifeline for Sahrawi refugee women, providing essential maternal and child health services to about 300 people each week. With midwives and nurses trained from within the community, women can access safe antenatal, delivery, and postnatal care without travelling long, risky distance outside the camp. Yet these services remain fragile. Persistent shortages of supplies, medications, and staff threaten the hospital's ability to provide consistent, quality care.

Photo Credit: El Khansa Tadjine / UNHCR 2025

Sustained support from partners is urgently needed to protect mothers and newborns and ensure continued access to safe, dignified health services in Boujdour camp.

Nutrition

At the end of 2025, data from the Standardized Expanded Nutrition Surveys (SENS) was available in 113 refugee hosting locations across 16 countries, down from 19 countries in 2024, mainly due to declining funding and reduced operational capacity to plan and implement surveys. Drawing on results from these locations, multiple forms of malnutrition continued to affect refugees: 1 in 10 refugee children suffering from acute malnutrition, 1 in 3 from stunting and nearly 1 in 2 from micronutrient deficiencies. Micro-nutrient deficiencies were also widespread among women with 1 in 3 being affected. The prevalence of Global Acute Malnutrition (GAM) reflects short-term deficiencies in nutrient intake and recurrent illnesses, while high levels of stunting indicate chronic nutrition deprivation and underlying social economic vulnerabilities. Widespread micro-nutrient deficiencies, particularly among women and children, highlight inadequate diet diversity. While global averages suggest the nutrition situation remained broadly comparable to 2024, findings indicate some deterioration, with the share of locations meeting the GAM target falling from 65% to 59%, those meeting the stunting target from 23% to 20%, and those meeting the child anaemia target from 4% to 2%, underscoring the persistence of structural drivers of malnutrition and the need to sustain both treatment and prevention efforts.

Across the 113 refugee hosting locations:

- 59% of locations met the Global Acute Malnutrition (GAM) target of <10%,
- 32% had a GAM prevalence 10-15% indicating a serious situation,
- (9%) were above the emergency threshold of ≥15% indicating a critical situation.

Stunting amongst children aged 6-59 months remained of concern:

- Only 20% of the locations met the UNHCR target (<20%),
- 22% of the settlements reported high levels, and
- 58% had stunting prevalence above the critical level of ≥30%.

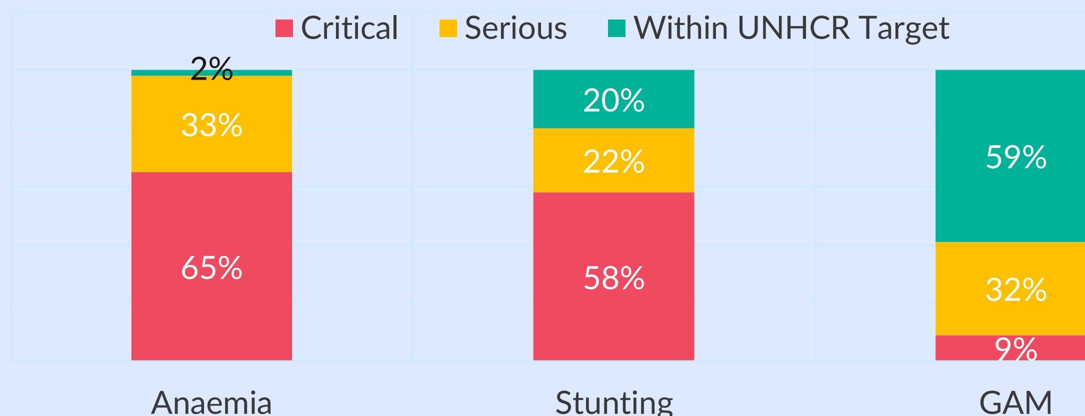
Anaemia in children aged 6-59 months, a measure of iron deficiency and general micronutrient status showed that:

- Only 2% of the locations met the UNHCR target (<20%)
- 33% reported medium levels, and
- (65%) had critical levels of ≥40%.

Among women 21% of locations met the UNHCR target (<20%), 62% had medium levels, and the rest (17%) had critical levels of ≥40%.

In 2025, funding reductions constrained the delivery of nutrition and related health services in several operations, including reduced outreach, lower geographic coverage and interruptions in the availability of key supplies. In contexts where baseline levels of wasting, stunting and anaemia remained high, these operational constraints increased the risk of delayed detection and treatment of acute malnutrition and reduced access to preventive services.

Global acute malnutrition, stunting and anaemia prevalence, children aged 6-59 months



Source: SENS data from 113 settlements in 16 countries

In 23 refugee hosting countries, a total of 2,4 million individuals were screened for acute malnutrition in 2025, a slight drop from the 2.6 million in 2024. Nutrition service delivery in these settings continued to rely on integrated primary health care systems, complemented by community outreach platforms that linked households, community-based screening and facility-based care. UNHCR and partners prioritized early identification and referral of individuals affected by malnutrition through community outreach and health facility services. Screening efforts targeted children under five years of age, pregnant and breastfeeding women (PBWs), and people living with HIV and tuberculosis patients (PLwHIV/TB).

As a result, the acute malnutrition management programme provided treatment to 55,071 refugee children with severe acute malnutrition (SAM) and 143,338 with moderate acute malnutrition (MAM). Without these interventions, these children would have faced increased risks of mortality and slowed development. In addition, 37,132 pregnant and breastfeeding women and 649 PLwHIV/TB affected by acute malnutrition were supported. Compared with 2024, the number of reporting countries declined from 26 to 23. Within the reporting countries, coverage of targeted children in need of acute malnutrition management declined by 39%.

Pregnant women experiencing malnutrition are at higher risk of adverse birth outcomes, including low birth weight (LBW), which was 4.4% in 2025, a slight decrease from 4.8% in 2024.

The nutrition programmes also extended support to host communities, assisting 19,354 children, 2,920 pregnant and breastfeeding women, and 71 PLwHIV/TB. The programmes maintained high recovery rates (target >75%), with over 91.5% children successfully rehabilitated.

Notably, partnerships with UNICEF and WFP remained central to service delivery through the provision of essential nutrition supplies, and collaboration with governments and operational partners supported programme continuity and strengthened integration of nutrition into broader primary health care and community systems.

Support for maternal, infant and young child feeding remained central to prevention efforts, with continued promotion of maternal nutrition, early initiation and exclusive breastfeeding, and improved complementary feeding practices to support child growth and development. SENS results showed that only 51% of the 113 surveyed refugee locations met UNHCR's recommended breastfeeding proportion of 75%. While progress has been made in establishing support systems, the annual public health survey covering 26 operations shows that skilled Infant and Young Child Feeding (IYCF) support was available at health facilities in 81% of operations and community-level support mechanisms in 65%, pointing to the need for further scale up. In line with this, strengthening staff capacity remained a priority: 774 health and nutrition personnel were trained on the IYCF multisectoral framework. In operations where skilled support was available, IYCF services were integrated into routine health care to maximize reach.

In 2025, 380,846 refugee women attending antenatal care in 20 countries received IYCF counselling. Among newborns delivered in health facilities, 98,523, or approximately 85% of recorded live births, were breastfed within the first hour of birth. Community-level support was reinforced through 616 mother-to-mother support groups and community health workers, who provided practical breastfeeding guidance and strengthened peer support networks. Breastfeeding remains a high-impact, low-cost prevention measure, particularly when sustained through routine facility counselling and practical community support.

Preventing micronutrient deficiencies among women and children remained important because such deficiencies can have serious consequences, including weakened immunity, impaired cognitive development and increased risk of pregnancy complications. Targeted interventions to prevent and address micronutrient deficiencies were implemented in 19 of 26 surveyed countries (73%). Preventative iron and folic acid supplementation for pregnant women was provided in all 19 countries. Haemoglobin monitoring during antenatal care was available in 17 countries, enabling earlier detection of anaemia. Among screened women at antenatal care clinics, 21% were diagnosed with low haemoglobin, facilitating timely treatment and follow-up.

Child-focused interventions included biannual vitamin A supplementation campaigns in 18 countries and deworming campaigns in 15 countries helping prevent micronutrient deficiencies and support healthy development.

Additional nutrition-specific interventions targeted vulnerable groups, including PLwHIV/TB and individuals with noncommunicable diseases, with services implemented in 17 and 8 of the 26 operations respectively. Blanket supplementary feeding programmes using micronutrient-fortified products were implemented in 12 countries. School feeding programmes operated in 11 of 26 operations (42%), primarily reaching primary school children, with six countries also covering secondary students.

Nutrition-sensitive interventions complemented nutrition treatment and prevention programmes in 2025. Implemented across 17 countries, these interventions included cooking demonstrations, vegetable demonstration gardens, and cash or fresh food voucher programmes to promote diversified diets. Some operations established mother-and-babyfriendly spaces to provide integrated psychosocial and nutrition support, while others introduced nutrition-sensitive agriculture initiatives to strengthen household food availability. These efforts helped address underlying drivers of malnutrition by aligning with food security, livelihoods, health, education and protection systems.

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Sustainable public health responses: working in partnerships and supporting national health systems

According to the 2025 Public Health Inclusion Survey, 87% of surveyed countries (39 out of 45) include refugees within national health plans or regulatory frameworks, up from 80% in 2023, reflecting continued progress toward inclusive policy frameworks. However, inclusion in policy does not consistently translate into effective access in practice. Significant access barriers remain, including health service fees, limited coverage or access to health insurance schemes, geographic constraints, and documentation barriers, which continue to restrict refugees' access to services. UNHCR continues to reinforce this progress by strengthening national systems in partnership with governments, UN agencies, NGOs, and development partners.

In addition, the private sector played an increasingly influential role across health, nutrition, and MHPSS responses, contributing technical expertise, financial support, and innovative delivery models. UNHCR's private-sector partners including philanthropic foundations, corporate partners, and social-impact actors supported expanded access to essential health services, nutrition interventions, and community-based MHPSS programming. Private-sector collaboration is a growing pillar of UNHCR's approach. In 2025, the Greentree Acceleration Plan was launched. This is a new partnership between the United Nations and the Wellcome Trust to elevate and expand humanitarian mental health responses. Implementation is expected to start in Chad and Lebanon in 2026.

The cooperation with philanthropic foundations such as the Novo Nordisk Foundation (NNF) and World Diabetes Foundation (WDF) are part of a broader trend of expanded private-sector engagement supporting non-communicable diseases, national health inclusion, nutrition programming and scalable MHPSS interventions, aligned with the multi-stakeholder pledges on national health inclusion and mental health and psychosocial wellbeing.

Together, these public-private collaborations contribute to strengthening national service delivery systems, fostering innovation, and advancing long-term, sustainable access to quality health, nutrition, and MHPSS services for refugees and host communities.

Strengthening Health Systems

Strengthening national health systems in refugee hosting countries remains a core component of UNHCR's public health strategy. UNHCR continues to play a catalytic and operational role working closely with the WHO, UNICEF, World Bank and other development partners and the private sector. In 2025, this support extended to 429 national primary health care facilities and 1,636 national secondary health care facilities, helping host countries meet increased demand for services. The support includes training healthcare workers, improving infrastructure, and ensuring the availability of essential medicines and supplies to local health facilities, enabling them to cater for the needs of host communities and refugees.

In addition, UNHCR continued to support national health systems through targeted in-kind contributions and infrastructure investments. In Afghanistan, UNHCR supported the Ministry of Public Health through the construction of 11 national community health centres and 17 additional health facilities, alongside the provision of medical equipment and supplies, representing a total investment of over USD 8 million, all fully embedded within national systems. In Iran, due to a significant shortage of TB medicines affecting the country, of which 25% of total TB cases countrywide are among Afghan refugees residing in Iran, UNHCR intervened through the donation of internationally sourced TB drugs, with a total value of approximately EUR 224,000. This intervention was critical to ensuring continuity of care for patients in urgent need. In 2025, UNHCR Egypt significantly supported the Ministry of Health and Population (MOHP) in strengthening the national health system's preparedness and response to the increased numbers of people fleeing to Egypt due to the Gaza and Sudan crises. This included the donation of essential medicines, critical medical supplies, and diagnostic equipment with a total value of nearly USD 2.5 million, reinforcing the Egyptian MOHP's capacity to meet growing humanitarian health needs.

Social Health Protection

Ensuring financial protection and equitable access to health services is central to UNHCR's advocacy efforts. In 2025, 67% of surveyed countries (31/46) reported having a national health insurance scheme. Among these, 65% (20/31) indicated that refugees are included or covered within the national health insurance system, making steady progress toward inclusion in national health financing mechanisms. However, financial barriers persist in many contexts, requiring UNHCR to support premium payments or co-financing arrangements to enable refugee enrolment and ensure access to essential health services. UNHCR currently supports premium payment for some refugees including in Burkina Faso, the Central African Republic, Costa Rica, Ethiopia, Ghana, Iran, Kenya, Mali, Nepal and Rwanda, where out of pocket costs would otherwise prevent refugees from accessing essential health services.

UNHCR and UNICEF advanced collaboration on social health protection, including in northern Ghana where a €2.7 million EU-funded project upgraded health facilities and enrolled over 2,000 displaced people and host community members into the National Health Insurance Scheme, transitioning support from temporary humanitarian aid to sustainable national systems.

UNHCR also strengthened its collaboration with ILO on social health protection through a jointly funded regional position based in Nairobi. The role provides technical support to advance refugee inclusion in national health financing reforms, for example in Ethiopia and Kenya. This partnership reinforces government led, inclusive and financially sustainable social health protection systems, helping ensure refugees gain equitable access to national health insurance schemes.

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Data Integration, Research and Publications

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Effective data integration is essential for planning and monitoring refugee health outcomes. UNHCR is aligning its integrated Refugee Health Information System (iRHIS) with national platforms, prioritizing full interoperability through the adoption of DHIS2 (District Health Information System), which is an open source software platform used by ministries of health in more than 80 refugee-hosting countries. This creates a unified platform, ensuring that refugee health data can flow seamlessly into national HIS frameworks, reducing duplication. The move to DHIS2 enhances compatibility with government systems, improves real-time data accuracy, and supports joint monitoring and analysis between UNHCR, national authorities, and partners.

Joint research with Queen Margaret University (QMU) examined the governance, financing, service delivery, health workforce, and data-system enablers needed to support sustainable inclusion of refugees in national health systems. Six multi-country case studies, provided evidence on contextual factors that facilitate or hinder inclusion: national legal frameworks, health financing arrangements, data interoperability, political will, and development-partner engagement.[5 6 7] Policy briefs and technical summaries informed the development of sequenced transition roadmaps, national-level inclusion dialogues, and the formulation of the Global Public Health Strategy 2026–2030. This collaboration provided analytical foundations for advocacy with governments, WHO, the World Bank, ILO, and others for scalable, sustainable inclusion.

In collaboration with CDC, UNHCR published an updated analysis on the burden of anaemia in displaced women and children in refugee settings.[8] This study updated a previous global review.[9] The study confirms that anaemia is still a critical public health concern among refugee women and children, with median prevalence of 42% in children and 28% in women of reproductive age. The burden is highest in West and Central Africa. Levels are lower in East and Southern Africa and South Asia. Since the onset of COVID-19, trends have diverged: childhood anaemia rose sharply in West and Central Africa but declined in East and Southern Africa, showing progress is possible even in difficult contexts. The strong correlation between anaemia in women and children suggests shared underlying drivers. These findings highlight the need for sustained context-specific action through national systems and integrated responses across food, health, WASH, education, and social protection.

WHO, the World Innovation Summit for Health, IOM and UNHCR published an article on tuberculosis (TB) the world's deadliest infectious disease, disproportionately impacting refugees and migrants who face barriers to diagnosis, treatment, and healthcare.[10] It builds on a 2024 WHO-Qatar Foundation report that outlines innovative solutions and policy actions for TB elimination, while warning that funding cuts and geopolitical tensions now threaten progress. The article calls for urgent political commitment, adequate resourcing, and equitable access to sustain and scale up efforts to end TB.

UNHCR was part of a WHO led interagency group of authors of a field manual on Malaria Control in Emergencies. The manual serves as a comprehensive resource that consolidates consensus on the core elements and key content for malaria interventions in humanitarian emergency and post-emergency contexts. It is grounded in current WHO recommendations and incorporates best practices, lessons learned, and practical solutions to address the main challenges in malaria management during crises. UNHCR also contributed to the WHO-led Guidance on safe and supportive care in community care centres for individuals living with mild mpox in camps for internally displaced persons or refugees.

UNHCR staff coauthored several publications on MHPSS. For example, among ultra-poor refugees and Mozambican nationals, strong associations were documented between poverty, disability, and mental health. These patterns underscore the importance of strengthening mental and public health services for both refugees and hosts, with particular attention to women and people with disabilities.[11]

A qualitative research with Venezuelan refugees and migrants in Peru showed the importance cultural concepts of mental health such as *duelo migratorio* ('migratory grief') to understand the how displaced populations conceptualize their suffering and distress.[12] A joint article with the Think Tank of the Olympic Refuge Foundation conceptualized how MHPSS activities and sport/physical activities can reinforce each other and be programmatically combined.[13] UNHCR personnel co-authored an individual participant data meta-analysis of scalable psychological interventions such as Problem Management Plus (PM+) and Step by Step (SbS) among Syrian refugees, based on the work of the STRENGTHS consortium. The analysis showed small effects in reducing symptoms of psychological distress with stronger for individuals with more severe symptoms. These findings support scaling-up of PM+/SbS for displaced populations with limited access to mental health care, particularly to persons with high levels of distress indicative of depression.[14]

Interagency cooperation

The Group of Friends of Health for Refugees and Host Communities continued to serve as an innovative platform to promote inclusion in national health systems. The Group is led by the Kingdom of Morocco, the Netherlands, the European Commission, Germany, UNICEF, the Global Fund, GAVI and the Amal Alliance, and co-convened by WHO and UNHCR. The Group of Friends shared experiences on implementing multistakeholder pledges on health system inclusion and fostering Mental Health and Psychosocial Wellbeing. In 2025, additional pledges were received bringing the total number of new commitments linked to the Global Refugee Forum (GRF) to 235. In preparation of GRF Progress Review 2025, two stocktaking events were organized by the Group of Friends:

In March, a roundtable in Geneva, gathered over 55 participants from 20 states, including representatives from the European Union and co-hosted by UNHCR and WHO. Participants reaffirmed that sustainable refugee health inclusion requires a whole-of-government and whole-of-society approach, linked to efforts to promote refugee self-reliance. Discussions underscored transformative partnerships among UN agencies, civil society, and refugee-led organizations. Presented innovations included capacity building in Peru to enable non-specialists to deliver scalable psychological interventions. Legal reforms in for example Colombia, Kenya, and Iraq supported refugee inclusion in national health systems. Sustained donor support, context-adapted health system strengthening, inclusive capacity development across the humanitarian-development-peace nexus, and data-driven approaches were identified as urgent priorities.

An online stocktaking event in June brought together 94 participants from governments, refugee-led organizations, NGOs, UN agencies, the private sector and academia to review progress on pledge implementation, and to share good practices and innovative approaches. Among the key recommendations that emerged from the discussions: 1) fostering a favourable policy environment for inclusion; 2) diversifying and optimising health financing mechanisms; 3) advancing government-led transitions away from parallel services; 4) strengthening multi-level partnerships by combining government stewardship with community health networks and local NGOs to ensure last-mile delivery; 5) integrating refugee community health workers into national systems; 6) promoting inclusive, culturally tailored community engagement; and 7) mainstreaming MHPSS across education and protection systems. The event demonstrated shared commitment to implementing pledges on health inclusion and MHPSS, and to achieving tangible progress, enabling refugees and host communities to strengthen their health and psychosocial wellbeing within resilient and sustainable health systems.

Subsequently, at the GRF 2025 Progress Review a plenary Spotlight Session on health, MHPSS, social protection and digital identity management, reported progress in access to health services in 12 of 15 countries.

During the GRF 2025 Progress Review, UNHCR and Queen Margaret University (QMU) co-organized a workshop with researchers, practitioners and policymakers to discuss emerging evidence and advance a shared research agenda on refugee health inclusion. This contributed to strengthening academic partnerships as it brought together governments, civil society, private sector and academia.

In 2025, UNICEF and UNHCR strengthened their strategic collaboration to improve health and nutrition outcomes for refugees and host communities, combining emergency response with systems strengthening and advocacy for inclusion in national systems. Anchored in the Strategic Cooperation Framework, the partnership advanced priorities such as vaccination access for zero-dose children (aligned with Gavi 6.0), joint emergency response, and integrated service delivery, supported by aligned planning, supply chains, capacity building, and coordinated policy engagement across regions. This collaboration delivered results across contexts. In Moldova, services for refugee children were integrated in national systems to ensure continuity of care. In Ethiopia, over 140,000 women and children accessed integrated primary healthcare. Joint outbreak responses reached over 1.4 million people with cholera vaccination in Bangladesh while measles and malaria prevention in Tanzania and Malawi were reinforced. Integrated approaches also expanded MHPSS in Uganda, strengthened linkages between protection and health in Colombia, and informed joint health, nutrition, and WASH responses in Chad.

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Through its partnership with the Food and Agriculture Organization (FAO), UNICEF, the World Food Programme (WFP) and WHO via the Global Action Plan on Child Wasting, UNHCR supported efforts to strengthen the prevention and treatment of maternal and child malnutrition. This collaboration supported increased refugee inclusion in national child-wasting plans, with 13 refugee operations reporting advocacy and monitoring outputs.

UNHCR is an active member of the SRH task team, a coalition of SRH partners under the Global Health Cluster. The SRH task team developed an interagency training curriculum on clinical management of rape and intimate partner violence in emergencies (CMRIPV). The toolkit is designed to equip health workers with the skills and resources needed to deliver survivor-centred care in humanitarian settings.

In 2025, UNHCR, together with WFP, UNAIDS and partners, advanced revision of the 2010 Inter Agency Standing Committee (IASC) Guidelines for Addressing HIV in Humanitarian settings. Coordination on HIV in humanitarian settings was sustained through the Inter Agency Task Team (IATT) on HIV in Emergencies enabling advocacy, progress review, knowledge exchange, and operational alignment despite significant institutional and financial constraints. The IATT partners sustained coordinated advocacy in response to major funding cuts disrupting HIV services in 2025, while scaling up advocacy and operational efforts to underscore the critical need to integrate HIV into emergency preparedness and humanitarian responses to end AIDS as a public health threat by 2030. The IATT collaboration extended to global strategic processes, including consultations with over 300 stakeholders to inform the Global AIDS Strategy 2026–2031, particularly as it relates to HIV in emergencies. Technical contributions of the IATT leadership strengthened key analyses and policy briefs, while targeted resource mobilization and country-level support, including successful funding applications and proposal development, were complemented by a dedicated mission to Burundi to reinforce HIV integration in the humanitarian emergency response.

Together with the United Nations Office on Drugs and Crime (UNODC) and WHO, UNHCR continued to cochair the Thematic Group on Substance Use in Emergencies.

Actively engage communities in activities to promote and sustain their health

The active engagement of refugee communities is essential for promoting and sustaining their health. Community health workers (CHWs) serve as central pillar of this effort. Across 23 reporting countries, a total of 9,856 CHWs (52% males and 48% females) supported community level health promotion, disease prevention and service outreach activities. Community-based reporting systems are now established in 82% of operations (14/17), strengthening early detection, follow-up, and linkage to care. CHWs received training across a wide range of essential topics, including hygiene and sanitation, MUAC screening, community-based case detection, psychological first aid, family planning, and newborn care, ensuring they are equipped to address diverse health needs within their communities. These investments expand frontline health capacity and, importantly, reinforce community ownership and participation, enabling refugees to play an active role in improving and maintaining their own health and wellbeing.

This translated into tangible results at country level. In Bangladesh, CHWs made over 1.2 million referrals to health facilities and conducted more than 72,000 community sessions, contributing to near-universal vaccination coverage in camps/settlements. In Uganda, 2,600 village health teams delivered over 77,000 community case management consultations, while in Pakistan, nearly 140,000 people participated in health promotion sessions. However, funding cuts reduced community workforce coverage and outreach, weakening preventive services and contributing to delayed care-seeking and worsening health and nutrition outcomes.

UNHCR has recently launched a dashboard that maps community-based organizations (CBOs) and organizations led by displaced and stateless people, aiming to strengthen engagement and ensure their meaningful inclusion in decision-making and coordination processes.

Impact of funding cuts on access to essential health services

Severe funding cuts and escalating displacement in 2025 sharply reduced access to essential health services for refugees and displaced people. UNHCR and partners struggled to sustain basic care, including SRH and HIV services, nutrition services, mental health support, community outreach and continuity of treatment, amid growing food insecurity and overstretched health systems. UNHCR's mid-2025 survey on funding cuts showed significant impact: among 49 countries, 41 (84%) reported reduced services or partial programme closure. SRH services were cut in 63% of countries, while mandate-critical care also declined including safe delivery (47%), clinical management of rape (33%), contraceptive services (37%) and HIV services (43%). The effects of funding cuts underscore that, despite increasingly inclusive policies, access to health care remains constrained even as governments, communities and partners adapt. Financial, administrative and geographic barriers — including out-of-pocket costs, limited access to insurance schemes, documentation barriers and distance to services — further restrict access. It is too early to assess the full impact of reduced access to services on actual health outcomes, but it is clear how these reductions increased the vulnerability of millions of refugees in hosting countries.

Funding cuts and the need for more sustainable nutrition responses for refugees: Evidence from Uganda, Niger and Algeria

Across Uganda, Niger and Algeria, the 2025 refugee nutrition response illustrates a consistent pattern in which funding shortfalls translated into operational constraints and worsening nutrition risks. Reduced resources led to ration cuts, narrower programme coverage, service discontinuities and reduced capacity to prevent and treat malnutrition at scale. In Uganda, reductions in food assistance and the discontinuation of moderate acute malnutrition services in several settlements coincided with rising severe acute malnutrition admissions.

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Survey data in the refugee sites show that global acute malnutrition increased to 7.8% in 2025, a 44% increase compared to 2024, while child anaemia rose to 42.5%, a 38% increase compared to 2024.

In Niger, reduced programme continuity occurred alongside a serious nutrition situation identified in the 2025 SENS survey. Global acute malnutrition reached 13.0% in 2025 compared to 2021, representing roughly a 44% increase over the period. Stunting increased from about 41% in 2021 to above 50% in 2025, while anaemia affected more than 70% of children, indicating a very high burden of micronutrient deficiencies.

In the Sahrawi refugee camps in Algeria, prolonged ration reductions and limited dietary diversity were also accompanied by worsening nutrition indicators. Global acute malnutrition increased to 13.6% in 2025, a 27% increase compared to 2022, while severe acute malnutrition rose to 2.2% compared with 0.6% in 2022, and child anaemia increased to 65%, an increase of about 20%.

Taken together, these case studies illustrate a clear pattern in 2025: funding cuts reduced programme delivery and access to assistance, while refugee children experienced measurable deteriorations in acute malnutrition and micronutrient deficiencies across multiple contexts. They highlight the vulnerability of nutrition responses that rely primarily on short-term humanitarian funding.

Strengthening health outcomes for refugees will require more predictable and sustained investment, alongside expanded efforts to support self-reliance, strengthen national health systems, and improve access to integrated services. These approaches are essential to ensuring continuity of care, reducing long-term dependency, and enhancing resilience in increasingly constrained humanitarian contexts.

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Public Health Unit | Sustainable Responses Service (SRS), UNHCR Geneva. Contact: hqphn@unhcr.org