UNHCR
The UN Refugee Agency

Annual Public Health Global Review 2019

PUBLIC HEALTH, REPRODUCTIVE HEALTH & HIV, NUTRITION

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
ANM	Anaemia
BSC	Balanced Score Card
CHW	Community Health Workers
GAM	Global Acute Malnutrition
GCR	Global Compact on Refugees
HFUR	Health Facility Utilisation Rate
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IRHIS	Integrated Refugee Health Information System
IYCF	Infant and young child feeding
MAM	Moderate Acute Malnutrition
MC	Measles Coverage
mhGAP	mental health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
NCDs	Non-communicable diseases
PEP	Post-Exposure Prophylaxis
PLHIV	People Living with HIV
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post Natal Care
SAM	Severe Acute Malnutrition
SC	Stabilization Centre
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SGBV	Sexual and Gender-Based Violence
TB	Tuberculosis
U5MR	Under 5 Mortality Rate
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

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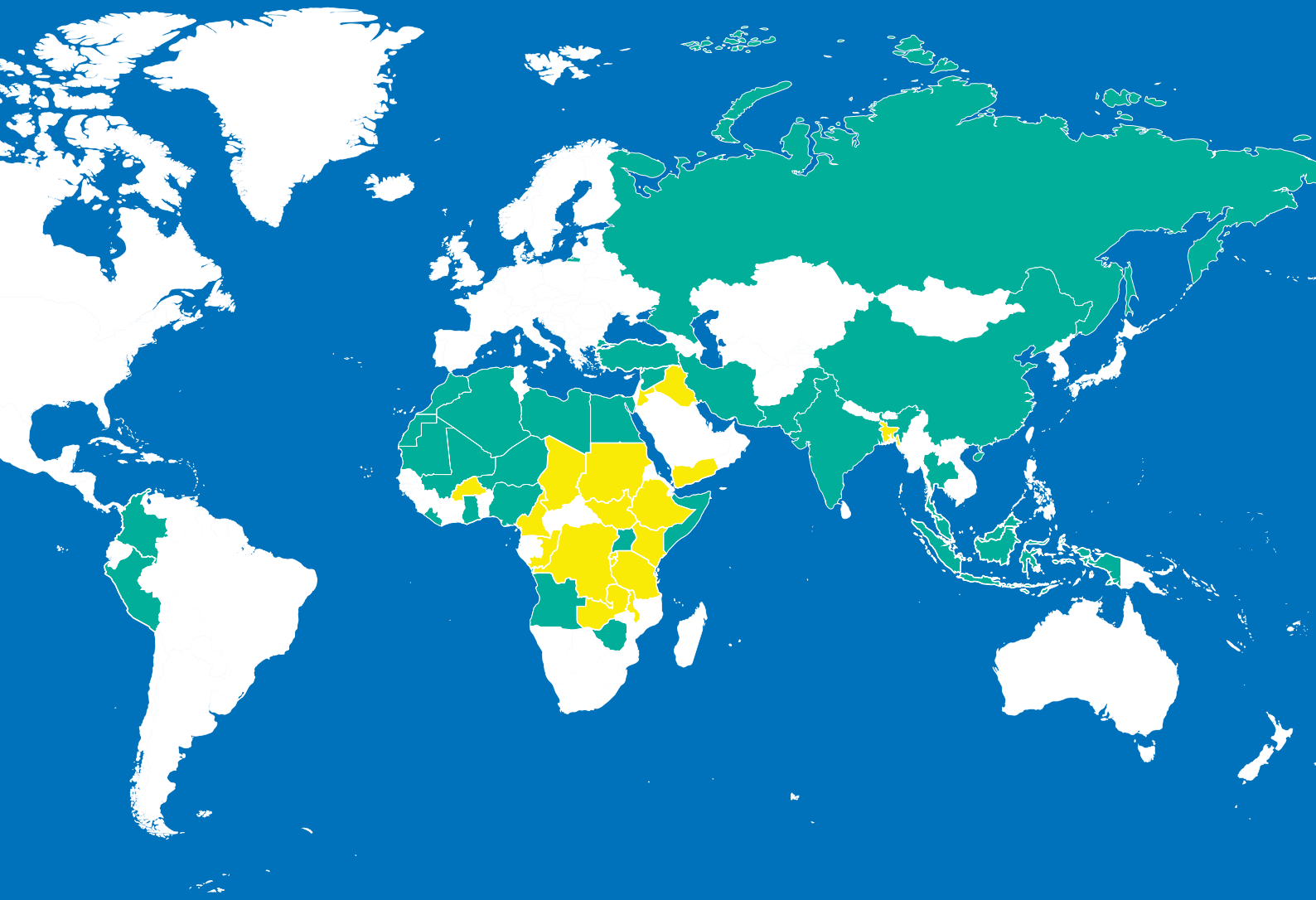
United Nations High Commissioner for Refugees
Public Health Section Division of Resilience and Solutions
Rue de Montbrillant 94 CH-1201 Geneve Switzerland

T: +41 22 739 8433 F: +41 22 739 7344
E-mail: hqphn@unhcr.org www.unhcr.org

Cover photo: Young Rohingya refugees from Myanmar participate in a UNHCR supported workshop to learn psychosocial skills and coping mechanisms at the Kutupalong Refugee camp in Bangladesh© UNHCR/Will Swanson

PUBLIC HEALTH



48* COUNTRIES

179 SITES

20 COUNTRIES USING IRHIS

7,167,197 CONSULTATIONS

CMR
0,12 DEATHS / 1,000 / MONTH

U5MR
0,3 / 1,000 / POPULATION UNDER 5 PER MONTH

*50 countries were requested to complete the annual survey but only 48 countries responded

UNHCR supports Ministries of Health to ensure healthy lives and promote wellbeing of its persons of concern, enabling them to access safe, effective, equitable and affordable health care services. This report provides an overview of UNHCR supported access to comprehensive primary health care services as well as referral to secondary and tertiary care for refugees in 48 countries hosting 16.4 million refugees. Primary care included preventive, promotive and curative care including vaccination, access to clinical consultations and medications, sexual and reproductive health and HIV services, mental health care, and nutrition care.

In 2019 UNHCR's integrated Refugee Health Information System (iRHIS) was used in 20 countries, 179 refugee sites monitoring health activities covering a total population of 4,741,914.

UNHCR worked with 144 NGO and other partners (of which 63% were national partners) in collaboration with and support to national health systems.

Health information for other refugee populations and PoCs were collected through national health systems which mostly do not allow for disaggregated data. Health access and utilization survey (HAUS) and other surveys were conducted in four locations (Uganda, Lebanon, Cameroon and South Africa) to provide additional information on access to health services and health indicators. UNHCR will continue to work to include refugees in national health surveys with disaggregation for refugee or nationality to provide comparable data to nationals.

In the 20 countries where UNHCR and its partners use the iRHIS, 7,167,197 consultations were conducted at health facilities, a health facility utilisation rate (HFUR) of 1.5 visits per person per year (Sphere standard is 1 – 4 visits per person per year). As in 2018 the three most common causes of morbidity were malaria (17%), upper respiratory tract infections (18%), and lower respiratory tract infections (6%).

Data reported through iRHIS shows that the reported **under-5 mortality rates** are within standard (< 1.5 deaths per 1,000 under five population) across 177 out of 179 monitored sites in 20 countries. Sites in Sudan and Chad continued to report the highest under five mortality rates. The weighted average **under-five mortality rate** was 0.3 per 1,000 under five population per month, similar to 2018, while the weighted average **crude mortality rate** was 0.12 deaths per 1,000 total population per month, similar to that reported in 2018 (0.13 deaths/1,000 population). The top 3 causes of deaths overall were neonatal deaths (31%), malaria (8.3 %) and lower respiratory tract infections (5.6%). These proportions are similar to what was reported in the previous 2 years.

TABLE 1
OVERVIEW OF KEY HEALTH DATA

Specific data regarding sexual and reproductive health, GBV, HIV, and nutrition is discussed in subsections of the report below and includes relevant references to SDGs

Country	Crude Mortality Rate /1000/ month	Under Five Mortality Rate /1000/month	Total Consultations	Health Facility Utilization Rate	Mental Health Consultations	NCD Consultations
Uganda	0.1	0.2	2,069,304	1.67	50,947	82,352
Bangladesh	0.2	0.2	502,808	1.5	7,580	58,269
Thailand	0.4	0.4	231,560	2.5	7,193	33,459
Ethiopia	0.01	0.1	708,795	1.2	8,732	16,397
Jordan	0.2	0.2	746,190	6.6	29,388	76,185
Sudan	0.17	1.01	673,295	2.1	Not reported	Not reported
DRC	0.20	0.40	116,222	1.3	5,834	5,619
Zambia	0.51	0.59	23,821	1.5	93	0
Cameroon	0.14	0.06	218,022	0.7	34	5,453
Malawi	0.00	0.00	40,381	0.9	2714	Not reported
Tanzania	0.13	0.28	718,497	2.7	16,091	Not reported
Kenya	0.10	0.20	621,133	1.7	8,529	23,427
Rwanda	0.12	1.00	241,093	2.3	6,248	7,732
Burundi	0.00	0.00	19,164	0.3	6043	373
Iraq	0.00	0.00	29,431	0.4	4,082	0
Yemen	0.19	0.10	16,253	1.7	4,677	7,764
Burkina	0.06	0.00	10,025	0.7	75	291
Chad	0.20	1.10	101,946	0.2	2,822	1,132
Republic of Congo	0.04	0.15	452	0.02	0	15
South Sudan	0.25	0.65	78,805	0..4	55	1,296

Dr Joseph examines nine-year-old Syrian refugee, Ghena, at a UNHCR-supported clinic for refugees in downtown Amman. UNHCR/Lilly Carlisle

Mental Health

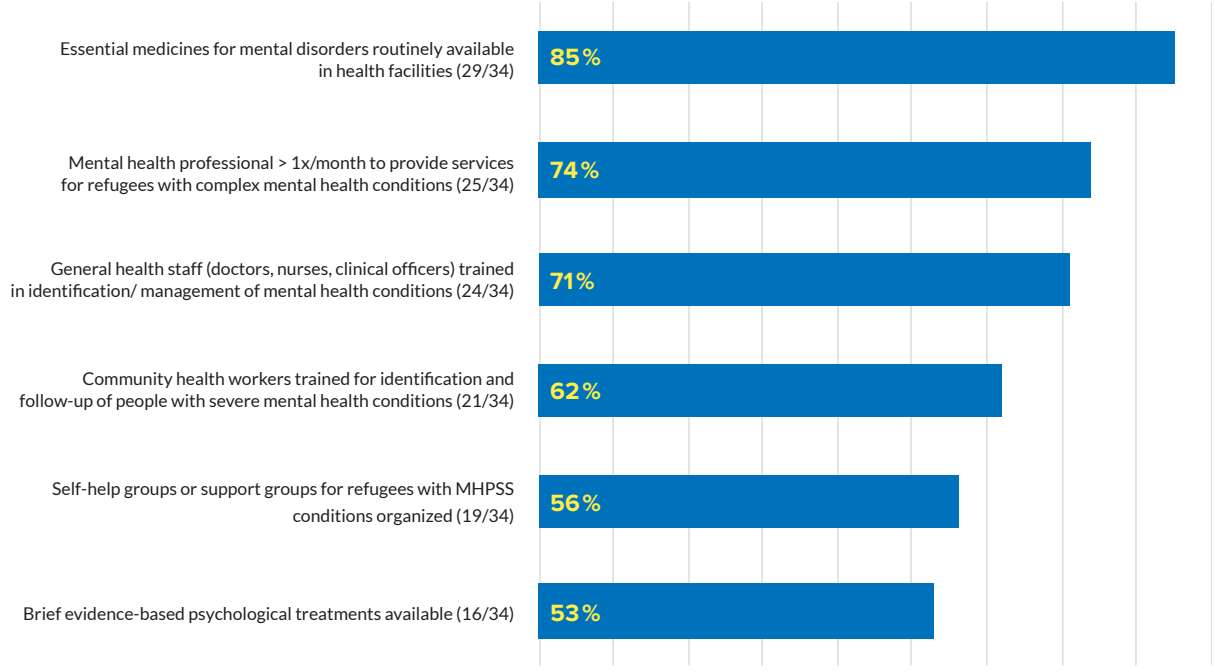
In 2019, the focus on integration of mental health into primary health care continued. In the 20 iRHIS reporting countries, the total number of consultations in the refugee health facilities increased to 161,137 which constitutes 2.2% of the total number of consultations. However, Republic of Congo and Sudan did not separately record mental health consultations.

Trainings for the integration of mental health into primary care (mhGAP trainings) were organized in Burundi, Ethiopia, Iraq, Tanzania, Uganda and Zambia. In 2019, a total of 307 medical staff and 738 refugee volunteers and community workers were trained in these countries, using the WHO/ UNHCR mhGAP Humanitarian Intervention Guide.

In the preliminary analysis of the survey on inclusion of persons of concern into national health policies, systems and services, in 34 out of 49 countries responding (69%) mental health activities were implemented as part of the public health programming for refugees. In those 34 countries, the most common components were the routine supply of essential medication for mental disorders to the health centres in 29 countries (85%), followed by the availability of a mental health professional in the refugee setting (at least once per month) to manage people with complex mental health conditions in 25 countries (74%). In 24 countries (71%) at least one general health staff had been trained in the identification and management of mental disorders. The least often reported activities were the training of community health workers to do follow-up for people with severe mental health conditions in 21 countries (62%), the facilitation of support groups /self-help groups for refugees with mental health conditions in 19 countries (56%) and the provision of evidence-based brief psychological therapies in 18 countries (53%). See figure 1 for a visualization of the data. These findings show that the health facilities in most of the reporting countries have integrated mental health within their facility-based primary health care activities, but there is a need to strengthen the community mental health component and the provision of psychological therapies.

FIGURE 1

MENTAL HEALTH ACTIVITIES IN THE 34 COUNTRIES WITH A MENTAL HEALTH PROGAMME AS PART OF PUBLIC HEALTH



Non-Communicable Diseases (NCDs)

UNHCR continued capacity building of staff to improve care for persons with NCDs integrated within primary health care services with a focus on cardiovascular diseases, diabetes and chronic respiratory conditions. Training of clinical staff and training of the trainers on management of NCDs was done in Cameroon, Burundi and Ethiopia in order to improve care for people with NCDs at primary health care level. Since the start of this capacity building initiative in 2014, 12 countries have received training and introduction of treatment protocols reaching approximately 300 participants from UNHCR, NGO and government partners. Further cascade training has been done in all of the countries reaching approximately a further 1,000 persons. Monitoring has shown an improvement in knowledge of staff. The UNHCR essential medicines list was updated and included additional medicines for the management of NCDs. UNHCR continued to lead the informal interagency group on NCDs in humanitarian settings which has worked on guidance (clinical and operational) on NCD care in such settings to be released in 2020.

Inclusion

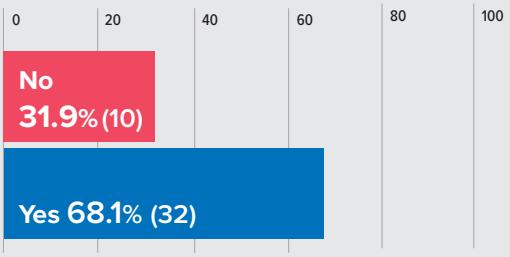
Inclusion of refugees in national policies, strategies and plans and inclusion in functional national health systems continues to be part of UNHCR's approach to ensuring equitable access to health care. In the preliminary analysis of an inclusion survey done in January 2020, of 49 responses from 48 countries (two were provided for different populations in Thailand), approximately 68% reported that refugees were included or covered in the national health plan, policy, or other health legislative framework, while 3 (6%) countries reported that refugees were explicitly excluded or not included. A total of 48 (98%) reported that refugees have access to national primary health care facilities, while 47 (96%) reported access to national secondary health care facilities This access was under the same conditions as nationals in 44 (92%) for primary health care and 36 (77%) for secondary health care.

A total of 33 countries (67%) reported having a national health insurance scheme with 9 of those (27%) including refugees in these schemes, mostly for refugees living out of camp and in urban areas. Inclusion was mostly under the same conditions as nationals with contributions mostly subsidized by UNHCR.

As part of the Expanded Programme on Immunization (EPI), a total of 46 (94%) reported that refugees have access to all relevant vaccines under the same conditions as nationals. In Malaysia, services are available but for a fee, in China there are differences at municipal levels with it being free of charge in some but not all. In Thailand, most antigens are provided free by the government excluding rotavirus and influenza vaccines.

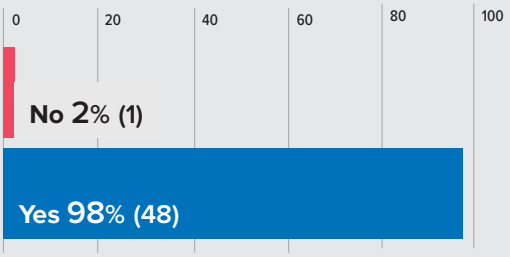
Are refugees included or covered in the National Health Plan/Policy or other legislative regulatory framework?

Percent of responses (%)



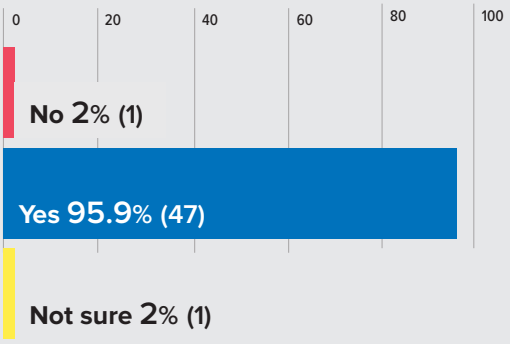
Are refugees able to access National Primary Health Care facilities?

Percent of responses (%)



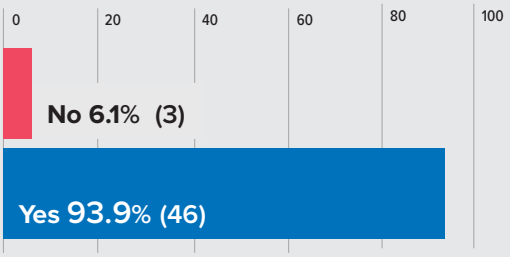
Are refugees able to access National Secondary Health Care facilities?

Percent of responses (%)



As part of the Expanded Programme on Immunization, do refugees have access to all relevant vaccines under the same conditions as nationals?

Percent of responses (%)



Case Studies

In Bangladesh - UNHCR has been working to scale up mental health and psychosocial support services for Rohingya refugees through a multi-level and integrated approach. Integration of mental health services into primary health care centres has been successfully implemented in UNHCR-supported facilities, and the trained medical professionals provided a total of 7,580 clinical mental health consultations in 2019. This was achieved through mental health trainings of health staff[1], introduction of innovative scalable psychological interventions[2] and training community psychosocial volunteers.[3]

In Rwanda, the Ministry of Health has recently integrated the refugees into the national hepatitis B vaccination program, which will contribute greatly to lowering the prevalence of the disease and associated complications for refugees. UNHCR worked with the International Labour Organization (ILO), to accelerate the inclusion of refugees in national social health protection systems with approximately 6,000 urban refugees being included.

In response to the Ebola outbreak in the Democratic Republic of the Congo (DRC), UNHCR and partners developed and implemented preparedness and response plans in DRC itself and surrounding countries including Rwanda, Burundi, South Sudan and Uganda, Tanzania, Republic of the Congo (ROC), Angola and Zambia. These plans included strengthening of point of entry screening, infection prevention and control, surveillance, risk communication and community engagement and capacity building of health care workers. While no cases were reported among refugees, these activities improved the capacity of the refugee health systems in these countries to be able to detect and respond to other public health emergencies/outbreaks.

1 Tarannum, et al. (2019). Integrating mental health into primary health care in Rohingya refugee settings in Bangladesh: experiences of UNHCR." Intervention 17 (2), 130- 139.

2 Mahmuda, et al. (2019). Contextual adaptation and piloting of Group Integrative Adapt Therapy (IAT-G) amongst Rohingya refugees living in Bangladesh. Intervention 17 (2), 149-159.

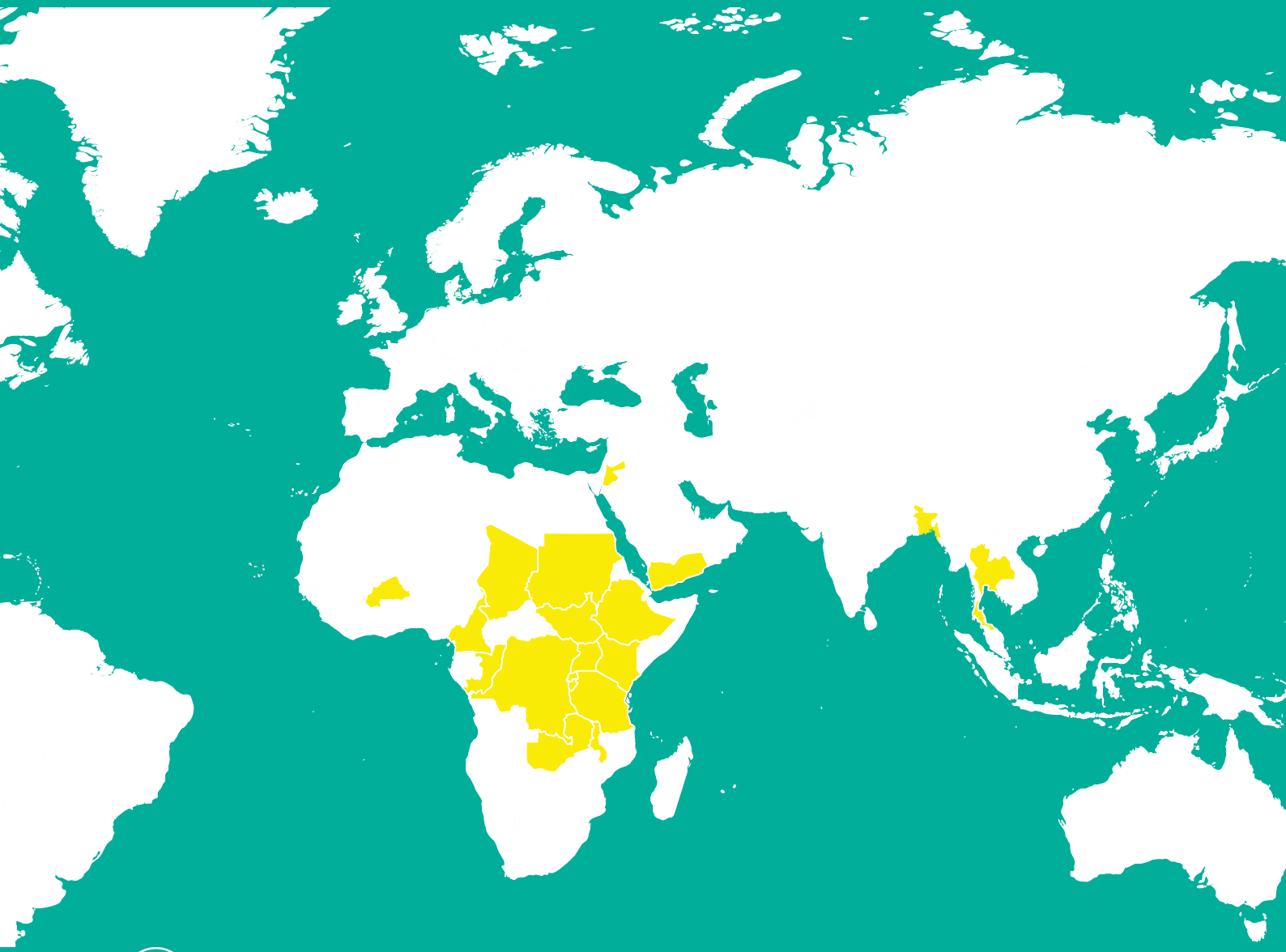
3 Uddin, A., & Sumi, H. (2019). The story of a Rohingya refugee: becoming a community psychosocial volunteer. Intervention, 17(2), 296.

South Sudanese women wait to register their babies at Jewi refugee camp, Ethiopia UNHCR/Eduardo Soteras Jalil

The Integrated Refugee Health Information System (iRHIS)

As part of enhancements to the iRHIS, UNHCR launched a new electronic application that will replace the paper/Excel-based reporting system. Data is collected through tablets, aggregated on a web application, and directly made available on a weekly basis to the front-line health workers and managers at all levels. This will improve timeliness, accuracy, and utilization of public health information at all levels. So far 16 out of 20 countries have fully transitioned to the new reporting system, while 4 others will be included in 2020. Where feasible the updated iRHIS ensures interoperability with the Ministry of Health systems. Additionally, UNHCR continued to use the electronic health facility quality assessment tool (Balanced Score Card (BSC)) to standardize quality of service monitoring, identify gaps and take corrective action and provide additional information beyond the indicators reported in iRHIS. So far, assessments have been conducted in 12 countries and Health Access and Utilisation Surveys (HAUS) in two countries in 2019.

SEXUAL AND REPRODUCTIVE HEALTH (SRH) & HIV



19
COUNTRIES

171
SITES

108, 545 (90,7%)
NUMBER OF LIVE BIRTHS ASSISTED BY SBA

Women's and girls' health and wellbeing are disproportionally affected by conflict and forced displacement and UNHCR gives particular attention to ensuring access to comprehensive sexual and reproductive health services (SRH) including maternal and newborn health and access to contraception / family planning.

In 2019 a total of **108,545 live births** were reported from 171 refugee settlements in the iRHIS 19 countries (excludes Iraq) , similar to 2018 (109,492 live births) and similar population under surveillance.

In 2019, 83.3% of 18 countries reporting on SRH achieved the standard of at least 90% of reported deliveries occurring in health facilities, similar to 2018 (81.3%). 91% of the women delivering in health facilities were attended by skilled birth attendants (an SDG indicator), a similar result to 2018. While this reflects overall a positive trend, population and antenatal care data indicate that a number of births, as well as maternal and newborn deaths may go unreported. All of the above highlights an important need for further investment in strengthening community health work and maternal perinatal death surveillance and response to strengthen programming.

With regards **antenatal care** (ANC), only 20% of operations reached more than 90% coverage of four or more antenatal visits (slightly less than in 2018). A total of 462,694 antenatal visits were reported, with a weighted global antenatal coverage reported as 69.6%. Only 14.2% of operations reached >90 % coverage of three postnatal visits within 6 weeks of delivery compared to 31.25% in 2018. **Postnatal care** coverage is lower than antenatal coverage, a common challenge which persists despite the significant contribution postnatal care can have in reducing maternal and newborn death. Important efforts are being made to improve awareness of, and access to both ante and post-natal care, particularly at community level, through involvement of men and a strengthened home visit approach. Strengthening links between the community and the health facility can increase utilisation of services and impact maternal and neonatal mortality as well as stillbirths.

TABLE 2
OVERVIEW OF KEY REPRODUCTIVE HEALTH DATA

	Total ANC Visits	ANC Coverage	Live Births	Attended by Skilled Health Worker	SBA Rate	PNC Coverage	Contraceptives (Number, New plus continued)	Condoms (for HIV/ Number)	ART (Number)	PMTCT Test	PMTCT coverage	Number of Rape	PEP
Uganda	**149.687**	86,0%	28.700	26.870	93,6%	75,2%	60.876	2.613.341	6.857	40.576	91%	1540	95%
Bangladesh	**30.098**	635,5%	4.798	1.439	30,0%	80,3%	53.217	151.021	0	1.044	6%	30	33%
Thailand	**14.414**	95,1%	1.796	1.671	93,0%	73,6%	8.378	41.914	105	1.912	99%	7	100%
Ethiopia	**34.602**	61,8%	12.388	11.740	94,8%	79,8%	20.347	908.714	1.691	14.697	81%	32	100%
Jordan	**11.148**	82,9%	4.225	4.184	99,0%	115,7%	21.862				0%	4	100%
Sudan	**24.778**	65,8%	6.109	5.290	86,6%	30,0%			9	1.214	5%		
DRC	**9.037**	76,9%	2.412	2.386	98,9%	79,6%	16.015	632.428	549	2.645	94%	109	90%
Zambia	**0**	0,0%	690	585	84,8%		959	29.379	114	214			
Cameroon	**2.810**	5,8%	5.470	4.821	88,1%	4,0%	1.003	4.864	87	485	41%	6	100%
Malawi	**2.992**	0,0%	784		0,0%		1.110	139.261	36				
Tanzania	**48.520**	73,8%	13.087	12.739	97,3%	78,9%	23.863		1.121	1.279	9%		
Kenya	**66.027**	45,3%	9.015	8.238	91,4%	74,7%	4.664	71.733	428	7.372	32%	197	100%
Rwanda	**8.159**	89,0%	3.054	3.054	100,0%	83,5%	78.504	1.199.812	1.337	4.128		25	92%
Burundi	**678**	10,9%	220	211	95,9%	4,1%	186	120.670	157	418	183%	2	50%
Iraq	**0**												
Yemen	**1.342**	81,3%	192	191	99,5%	58,9%	270		6	320	64%	16	100%
Burkina	**1.202**	43,5%	372	84	93,3%	16,2%	66				0%		
Chad	**51.289**	77,6%	13.949	13.789	94,3%	100,9%	73.172	177.337	1.432	23044	76%	34	12
Republic of Congo	**91**	43,6%	39	35	89,7%		62					5	0
South Sudan	**5.820**	69,0%	1.245	1.153	92,6%	47,9%	4.583	19.035	597	394	21%	3	100%
Total	**462694**	94,7%	108545	98480,1	90,7%	57,8%	369137	6109509	14526	99742	48%	2010	

Neonatal deaths continue to represent a significant proportion of deaths among children under the age of five in UNHCR operations and maternal mortality continues to raise concerns in most of the settings where UNHCR supports services. Although the large majority of women come to **deliver in a health facility** and progress has been made to ensure births are **attended by a skilled health worker,** there are still significant challenges regarding the quality of care including adherence to principles of respectful maternity care. **Maternal deaths are reported and audited** in refugee operations, however, despite efforts a number of births, maternal and newborn deaths go unreported. A detailed analysis of audits and support to operations not reporting deaths or reporting unrealistically low rates is underway to strengthen the maternal and newborn services, timely and complete maternal death audits and neonatal mortality and stillbirth reporting **because every death counts.**

In line with the SDGs and their specific focus on the reduction of maternal and newborn mortality, as well as access to modern contraceptive methods, UNHCR, with support from the Bill and Melinda Gates Foundation, implemented **high impact maternal and neonatal health interventions** such as active management of 3rd stage of labour, skin-to-skin thermal control, early and exclusive breastfeeding, umbilical cord care and reinforced

Newborn baby Marian lies beside her mother, 29-year-old Congolese refugee Tosha, after being delivered by a Tanzanian midwife at Nyarugusu's main clinic. Tosha came to the camp in 1989. This is her fifth child. UNHCR/Georgina Goodwin

post-partum home visits particularly for low birth weight and premature newborns. See case study on Chad, Cameroon and Niger for more information.

Data on **deliveries of young women under the age of 18 years** has not been reported from all country operations, but data from countries such as Uganda indicates teenage pregnancy to be an important challenge amongst both refugee and national populations. Data from health facilities in 13 settlements in Uganda captured 28,700 livebirths in 2019; 4.7% of these were delivered to girls age below 18 years. In the same period 16,704 births were reported for the national population with 7.2% to girls below age 18 years. The percentage of deliveries of refugee girls below the age of 18 years in two out of these 13 refugee settlements were as high as 10 and 17%. UNHCR has published a **practical guide to launching adolescent sexual and reproductive health in refugee situations**[1] in order to strengthen reproductive health outcomes for this vulnerable age group.

During 2019, UNHCR provided support to ensure the continuation of **HIV services** for refugees and other displaced populations in humanitarian settings in approximately 48 operations. Across its operations, in 2019 UNHCR supported HIV counselling and testing, to nearly 350,814 people of concern to UNHCR, with 14,526 persons on antiretroviral treatment.

Despite sustained advocacy six countries (12% of operations) still report mandatory HIV testing for refugees and a smaller proportion place movement and other restrictions on refugees who test positive. On a positive note, 44 operations (~90%) reported that HIV-positive refugees receive antiretroviral drugs through the national health system with 88% of those reporting that this is under the same conditions as nationals. UNHCR will continue to advocate against mandatory testing and subsequent restrictive measures being applied to HIV positive refugees as they do not serve public heath objectives.

UNHCR supports services for the **clinical management of rape** and other forms of sexual violence in humanitarian settings. This includes the provision of urgent medical care, including emergency contraception and post-exposure prophylaxis for HIV, mental health and psychosocial support (MHPSS), referral for legal and protection services as well as for specialised and reparative surgical care. A total of 2,010 rape survivors were reported to health services from 14 country operations in 2019 though a number of these incidents did not occur in the country of asylum. While most operations report systematic availability and use of post-exposure prophylaxis for HIV, data is not available for all operations.

While the number of cases seems high, the number of reported cases between countries varies greatly. Data from DRC, Yemen and Uganda reflects reporting rates greater than 100 rape cases per 100.000 population over the reporting year, but a number of these cases occurred prior or during flight. Differences may also reflect active screening being applied in some locations. However, in a number of countries reporting rates are unrealistically low and reflects persistent challenges with survivors not seeking medical care or other services in time or not feeling comfortable enough to report. This highlights the further need for accessible, safe, confidential and quality services, staff and community awareness, strengthened collaboration between protection and public health actors and continuous investment in capacity. UNHCR public health and protection staff will continue to work jointly at country level to improve service quality and overcome barriers to care-seeking.

Together with WHO and UNFPA, UNHCR has updated the guidance on the **clinical management of rape and intimate partner violence**[2]. The three agencies collaborate further in capacity building and sensitization regarding improved community awareness, a proactive approach to the identification of rape survivors and comprehensive and timely clinical care of survivors as well as linking with all relevant services, particularly protection.

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[1] Adolescent sexual and reproductive health in refugee situations: A practical guide to launching interventions for public health programmes https://www.unhcr.org/5d52bcbd4

[2] Clinical management of rape and intimate partner violence survivors Developing protocols for use in humanitarian settings. WHO 2020. https://apps.who.int/iris/bitstream/handle/10665/331535/9789240001411-eng.pdf?ua=1

CASE STUDIES

Chad, Cameroon and Niger: Saving maternal and newborn lives

Background: Recognizing the need to strengthen maternal and newborn health services, UNHCR with support of the Bill and Melinda Gates Foundation implemented the Saving Maternal and Newborn Lives in Refugee Settings project in Chad, Niger and Cameroon in 2018-2019. In 2018 national neonatal mortality rates were 34, 25 and 27 per 1000 live births in Chad, Niger and Cameroon, respectively. The project aimed to improve maternal and newborn health care provision through strengthening essential maternal and neonatal interventions, as well as reinforcing quality family planning services, contraceptive awareness, promotion and uptake in refugee settings. Providing quality health services in refugee camp settings faces numerous constraints. Camps are often located in remote, border regions, and many have security restrictions. Shortages, and a high turnover, of key health staff are often seen, and limited financial resources may result in lack of regular training for staff as well as ruptures in essential medications and supplies.

Capacity building approach: The project covered 29 health facilities (21 health centres in refugee sites and 8 referral district hospitals). In the period October 2018 to December 2019 these health facilities catered for a total of 16,326 births and recorded 267 neonatal deaths. A baseline assessment highlighted 2 important shortcomings: (1) deficiencies or complete lack of essential supplies and (2) the majority of maternity staff (64% in Cameroon, 67% in Chad and 55% in Niger) had never received training in neonatal resuscitation. These baseline findings signalled the need for context- specific clinical tools and guidance; procurement of essential supplies and medical equipment; infrastructure improvements; technical support and monitoring; and to increase awareness of neonatal health amongst management level staff. Importantly, the project targeted capacity building of all relevant staff involved in maternal and newborn care including doctors, midwives, nurses and nurse aids.

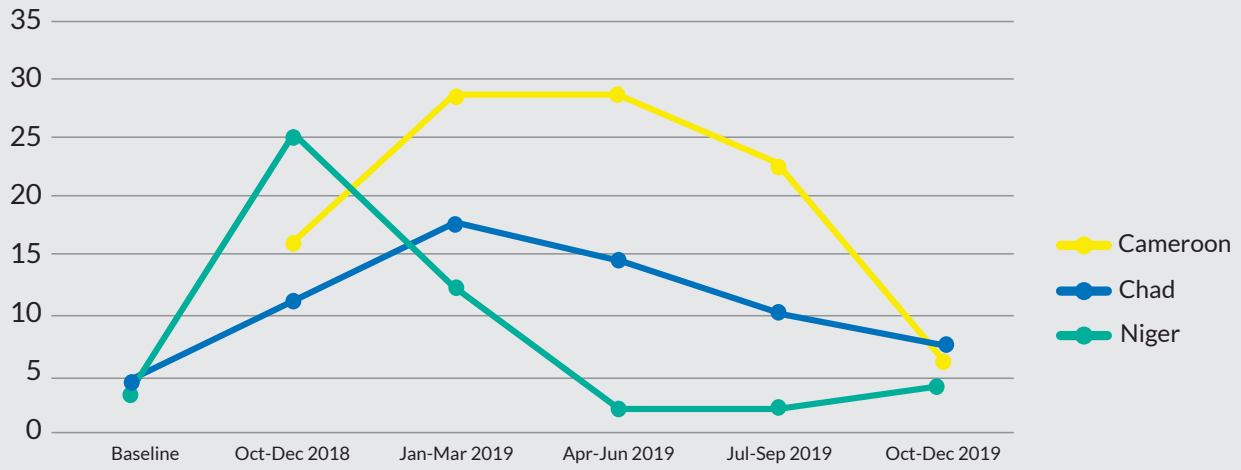
A Low-Dose-High-Frequency (LDHF), competency-building approach that promotes maximum retention of clinical knowledge, skills, and attitudes, which has been evaluated in other settings, was used. The initial step involved seven master Training of Trainer sessions (three in Year 1 and four in year 2). Each session ran for 10-12 days in each country and trained 45 health workers to be master trainers. In continuation, master trainers implemented LDHF training in the respective health facilities under their responsibility.

Results: Monitoring of maternal and newborn morbidity and mortality was improved through awareness raising and capacity building for health staff and community health workers. Further efforts will be needed to ensure the full capture of all maternal and newborn deaths.

Low-dose-high frequency training was implemented in 29 health facilities. Overall, 118 sessions were conducted on Helping Babies Breathe (HBB) and complemented with sessions on Essential Care for Every Baby and Essential Care for Small Babies. Over the course of 15 months, 16,326 mother-baby dyads received care at the 29 health facilities. In terms of impact on newborn survival, low neonatal mortality rates at baseline (likely due to underreporting) made it difficult to assess change in this indicator, although trends seem positive (see below graph). Health facilities increased and sustained the availability of essential supplies, medications and clinical guidelines.

FIGURE 2

NEONATAL MORTALITY RATE TRENDS CAMEROON, CHAD, NIGER



*Data from 5 District hospitals in Chad is excluded as incomplete

Conclusions: The project and training approach provided key lessons regarding training implementation; monitoring and communication; and creating an enabling environment.

The comprehensive approach to improving maternal and newborn health care in refugee settings and reducing morbidity and mortality through evidence based high impact strategies is a feasible approach adapted to the challenges of humanitarian and low-resource settings and should become the new standard for UNHCR support to maternal and newborn care.

Tanzania: Integrating HIV prevention into reproductive health, care, support and treatment programmes

Background: Nyarugusu camp hosts over 145,260 refugees with equal proportions of male and female population from the Democratic Republic of Congo (DRC) and Burundi. HIV services are available to refugees including PMTCT. In the period between January 2017 to June 2019, 3,407 men and 3,536 women consented to HIV counselling and testing (C&T) and respectively 1.5% (male) and 2.2% (female) tested positive for HIV. As of June 2019, there are 724 PLHIV, 28% are males and 72% are female. With 90-90-90 goals in sight, it appeared important to improve the effectiveness of HIV C&T services. The project made a consolidated effort to increase HIV C&T as part of ANC consultation and involving male partners to improve their testing uptake.

Intervention: Combined interventions were organized and included (1) invitation of males through their pregnant partner to attend the next Ante Natal Care (ANC) visit, (2) targeted sessions with male partners of pregnant women through routine household visits by community health workers (CHW) where discussion on importance of partner testing was prioritized, (3) engagement of the community leaders in developing strategies to enhance community support for partner testing and (4) provision of competency-based trainings to facility-based health care providers on couples counselling as well as CHWs on delivery of appropriate messaging at the community level were done.

Results: This combination of interventions significantly increased HIV partner testing amongst refugee populations (mostly Burundians) in Nyarugusu. Over the past 3 years, the percentage of pregnant women accepting testing in ANC has increased from 73% to 95% and all those who tested positive were put on ARV treatment. The proportion of men accompanying their pregnant partner for HIV testing has improved from an annual average of 35% in 2017, 75% in 2018 and 83% in the first six months of 2019. In this period, a total of 10,592 male partners were tested, of whom 41 (0.4%) tested positive and (93%) were put on treatment.

Conclusion: This strategy has proven to be feasible, acceptable and effective in increasing partner HIV testing, referral and follow-up in this context. Effective couple counselling and mobilization of the CHWs on delivery of the RH and HIV messages at the household level was also one of the most impactful interventions that increased the number of male partners testing in the camps. Further efforts will be necessary to expand the reach of HCT and increase knowledge of HIV status amongst all refugees in Nyarugusu camp, access to ART for those in need and viral suppression to maintain their health and reduce the potential transmission of HIV infection to a minimum.

Uganda: Prevention of Mother to Child Transmission (PMTCT) in a post-emergency refugee context, Northern Uganda

Background: Programs for the prevention of mother to child transmission of HIV (PMTCT) have had remarkable success in reducing vertical HIV transmission worldwide. In Uganda national coverage is reported to have increased from 27% in 2009 to >95% in 2015, reducing transmission from 29% to 3%.

Given limited information on PMTCT in humanitarian settings UNHCR supported the interim assessment of routine PMTCT data collected from Jan 2017 to Apr 2019 in northern Uganda (Imvepi) and where refugees (59,799) are included in the national health services.

Results: In total, 56 refugee mother-baby pairs were included is the analysis. During this period one positive case was identified by PCR at 4-6 weeks. Analysis showed an improvement in the time of inclusion of HIV+ women in the programme, from 32% during breastfeeding in 2017, to 8% in 2019. Early initiation on Nevirapine improved from 67% in 2017 to 92% in 2019, and loss-to-follow-up at the second PCR at 9-13 months decreased from 37% in 2017 to 7% in 2018. All women exclusively breastfed their infant during the first 6 months. Interventions that contributed to this were the establishment of clinics in the settlement and active outreaches; pregnancy mapping enabled early identification of the HIV+ women and encouraged facility-based deliveries. The network of village health teams contributed to lower numbers of loss-to-follow-up, since missed appointments could be traced and linked back to care. Family support groups also greatly contributed to the efforts.

Conclusion: The program demonstrated that it is possible to provide effective PMTCT care as a component of comprehensive reproductive health services in a post-emergency context. Early inclusion of refugees into the national HIV programmes was an enabler as HIV testing kits, antiretroviral drugs, supervision and technical support were provided on par with the national population. Integrated health and nutrition services and community-based interventions, such as village health teams and pregnancy mapping, are conducive to early identification of HIV+ women and facilitate linkage to care.

NUTRITION

In line with the Global Compact for refugees UNHCR is tracking the extent of inclusion into national nutrition programmes. In 2019 66% of 49 countries responding to the survey indicated that pregnant refugee women and girls receive iron and folate through the national programme. Though progress has been made more work will be done to improve engagement with national nutrition programmes. UNHCR monitors the nutrition status of populations of concern through Standardised Expanded Nutrition Surveys (SENS). In 2019, UNHCR and partners conducted SENS and other nutrition surveys in 77 refugee sites across 13 countries, including 11 sites in emergency situations, 18 sites in post-emergency situation[4] and 48 in protracted situations. In line with the inclusion commitments in the Global Refugee Compact, UNHCR also undertook an additional 14 surveys in either host populations surrounding refugee sites or in sites with a mixed refugee and host population. The data reported here focuses on refugee sites.

UNHCR met the standard of less than 10 per cent global acute malnutrition (GAM) in 47 (61%) sites over 11 countries. This shows improvement compared to 2018[5] when the proportion of sites meeting the standards was at 45%. In 10 sites (13%), levels of GAM were above the emergency threshold of greater or equal to 15 per cent. These results represent a stable situation regarding the proportion of sites above the emergency threshold compared to 2018 which stood at 8 sites. The proportion of sites surveyed in 2019 and classified as an emergency situation was far lower in 2019 at 14 per cent compared to 2018 at 35 per cent. Sites where GAM is ≥ 15 per cent were recorded in 7 locations in Ethiopia, and in one site respectively in Nigeria, the Sudan and in South Sudan. Comparing the 2019[6] results to previous years, improvements in GAM were reported in 12 sites located in Algeria, Djibouti, Ethiopia (Gambella), Rwanda, the Sudan and Tanzania. Deterioration in GAM however was noted in 6 sites in 2019 compared to only 1 in 2019, the statistical deterioration compared to previous years was observed in refugee sites in Algeria, Democratic Republic of Congo, Ethiopia and South Sudan, these sites would all be classified as protracted situations.

GAM is one of the main nutrition indicators tracked for the purposes of determining needs and for monitoring health status. UNHCR's approach also includes the consideration of stunting and anaemia indicators in addition

4 Where the acute emergency situation has passed but the refugee situation is less five years (after which it will be classified as protracted)

5 Surveyed sites do not necessarily match from one year to another.

6 This data compares the same locations for previous years.

to GAM in order to have a more comprehensive understanding of the nutrition status of a population. In 2019 the SENS methodology was reviewed and updated to include changes in global guidance and to ensure coherence with methodologies of our major partners in Nutrition and Food Security. An associated data visualisation tool has been released, which provides real-time access and analytical possibilities. This tool will enhance the UNHCRs objective of widely sharing good quality data externally and in so doing promote multi-sectoral actions in the prevention and treatment of malnutrition. Data from other sources are being pulled into the visualisation tool to enhance its usefulness.

While improvements have been seen, the outcomes from the nutrition surveys conducted in refugee situations highlight the extremely precarious nutrition situation of the populations. All forms of childhood malnutrition are of concern, with very high stunting – indicative of longer-term nutritional deficits - in almost 50% of sites, very high anaemia in almost 70% of sites and GAM exceeding the 10% thresholds in 39% of the sites monitored.

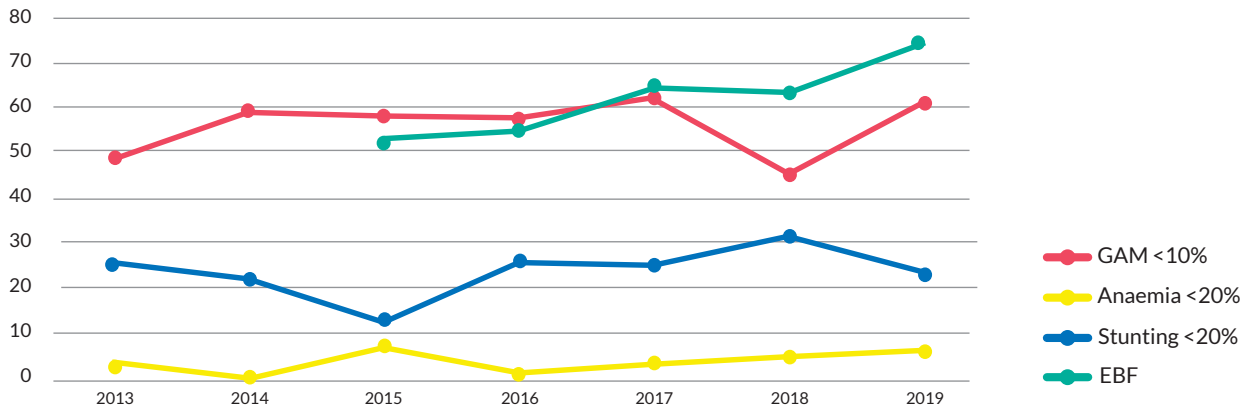
In addition to treatment, UNHCR has been focusing on prevention of malnutrition in collaboration with a number of other sectors. Poor Infant and Young Child feeding (IYCF) is a major driver of malnutrition and although the level of exclusive breastfeeding amongst UNHCR operations is clearly improving (see graph above), complementary feeding indicators remain poor. The IYCF-Framework has been rolled out in new sites in 2 countries in 2019 (Tanzania, Uganda) and trainings were conducted in Burkina Faso, Rwanda and Uganda, in addition to the 5 countries where the IYCF framework has already been rolled out (Bangladesh, Jordan, Ethiopia, Kenya, South Sudan), with further roll-out and translations planned for 2020. The IYCF framework promotes the engagement of many sectors around addressing the needs of infants and young children under 2 years old as well as pregnant and lactating mothers.

Over the year 2019 almost 33,000 children 6-59 months with Severe Acute Malnutrition (SAM) were admitted into treatment programmes with 61,000

FIGURE 3

TRENDS OF NUTRITION INDICATORS MEETING TARGETS 2013-2019

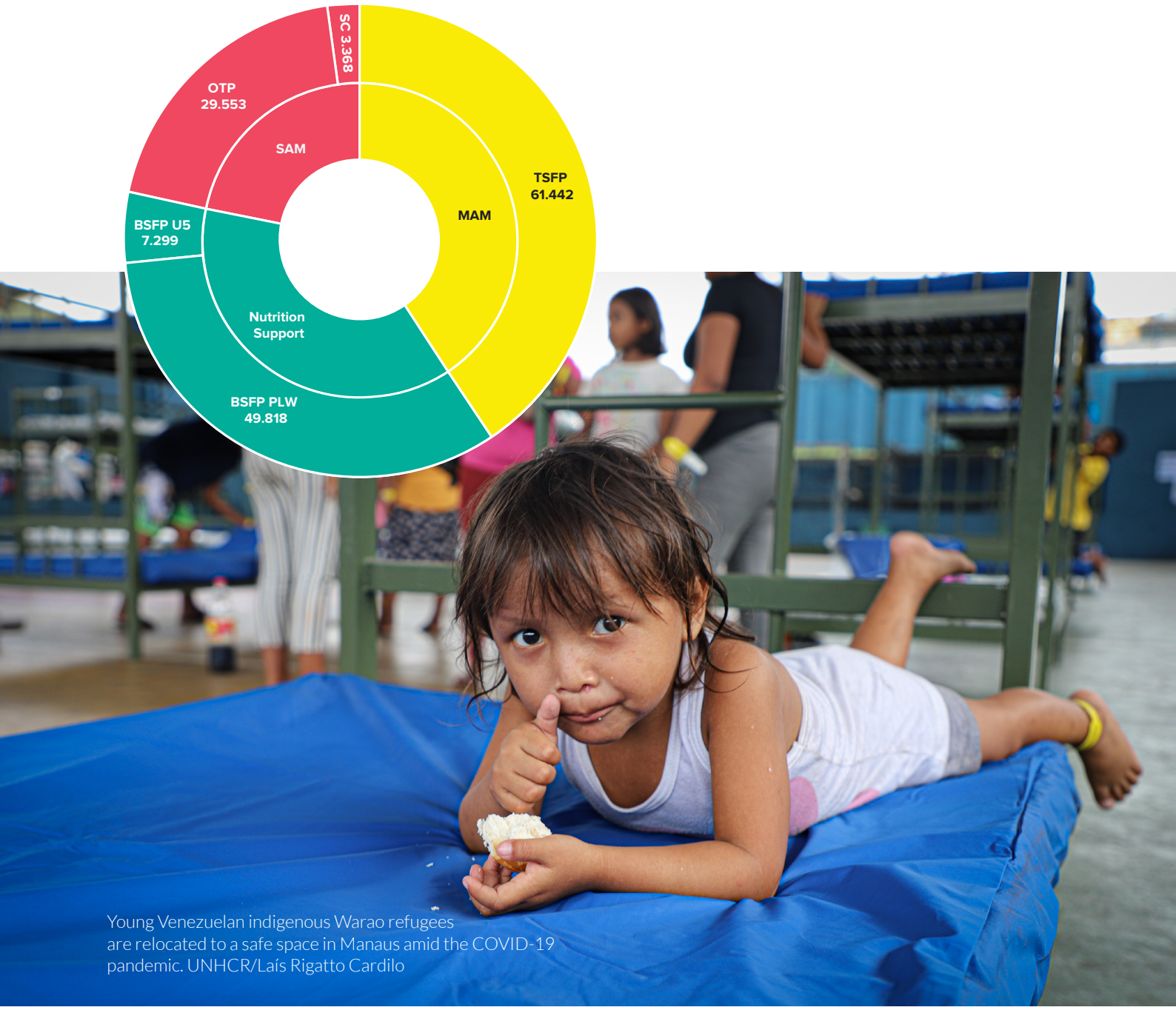
Nutrition indicators meeting targets in % of surveyed refugee sites:
GAM (<10%), Stunting (<20%), Anaemia (<20%) and
Exclusive Breastfeeding (EBF) (≤70%)



being admitted for Moderate Acute Malnutrition (MAM). Prevention activities involving delivery of specialized supplementary food products were provided for nearly 50,000 pregnant and Lactating Women (PLW) and a little over 7,000 children between 6 months and 5 years of age[7].

FIGURE 4

ADMISSIONS IN NUTRITION PROGRAMMES 2019 IN 16 COUNTRIES



Young Venezuelan indigenous Warao refugees are relocated to a safe space in Manaus amid the COVID-19 pandemic. UNHCR/Laís Rigatto Cardilo

7 Admissions for Acute Malnutrition (SAM and MAM) are likely to be a little underestimated due to changes in reporting methods during the year. Data is extracted from the UNHCR iRHIS system where not all sites with Nutrition programmes report.

Case Studies

RWANDA

Based on the most recent SENS in May 2019, the prevalence of GAM in the 5 Congolese refugee camps in Rwanda fell an average of 2.8%, to within the acceptable WHO standards (<5%) for the third year in a row. The prevalence of stunting was 22%, between 20% and 30% (serious level according to WHO criteria). The prevalence of childhood anaemia was 27%, between the 20% serious and 40% critical threshold in the 5 Congolese camps. This impressive progression in Rwanda is certainly due to continued investment in nutrition at the country level and an excellent collaboration between partners. Examples of actions that have been prioritised and maintained within the operation are: the community-based acute malnutrition programme (from January to December 2019 there were 460 new admissions), supplementary feeding for pregnant and lactating women, PLHIV and TB patients and children 6-24 months in all the camps; the Nutrition, Education Communication (NEC) project has also continuously benefited communities. Sensitization/ education sessions, cooking demonstrations, provision of supplementary feeding (Supercereal for porridge), and promotion of family kitchen gardens were done to reduce anaemia in children aged 6-59 months, women of reproductive age, stunting in children, as well as acute malnutrition.

ALGERIA

The anaemia levels amongst refugee children have far ranging consequences on long-term growth and development. Unfortunately, primarily due to resource constraints, the gains in certain countries made in past years are now on the decline. Levels of both total and severe anaemia in the Saharawi camps in Algeria, for example, showed great progress between 2008, when the anaemia project was rolled out, to 2012 but in 2013 a major part of the resources for the continuation of the project were cut and the levels of anaemia have increased steadily since then. This highlights the necessity to sustain investment in improving nutrition in refugee situations.

UNHCR
The UN Refugee Agency