UNHCR
The UN Refugee Agency

2021 ANNUAL PUBLIC HEALTH GLOBAL REVIEW

Public Health, Sexual and Reproductive Health, Mental Health and Nutrition

Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AGD	Age, Gender, and Diversity
ANC	Antenatal Care
ANM	Anaemia
BSC	Balanced Score Card
BFS	Baby-Friendly Spaces
CCSS	Costa Rican Social Protection Fund
CHWs	Community Health Workers
CMAM	Community Management of Acute Malnutrition
CMR	Clinical Management of Rape
ECD	Early Child Development
FAO	Food and Agriculture Organization
GAM	Global Acute Malnutrition
GBV	Gender Based Violence
GCR	Global Compact on Refugees
HFUR	Health Facility Utilisation Rate
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IRS	Indoor Residual Spraying
IPT	Interpersonal Therapy
IPV	Intimate Partner Violence
iRHIS	Integrated Refugee Health Information System
ITN	Insecticide Treated Net
IYCF	Infant and Young Child Feeding
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
MAM	Moderate Acute Malnutrition
MAMI	Management of Small and Nutritionally at-Risk Infants under Six Months
MC	Measles Coverage
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
NCDs	Noncommunicable Diseases
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
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
SBA	Skilled Birth Attendance
SC	Stabilization Centre
SDGs	Sustainable Development Goals
SENS	Standardized Expanded Nutrition Surveys
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
TB	Tuberculosis
ToT	Training of the Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
U5MR	Under 5 Mortality Rate
WFP	World Food Programme
WHO	World Health Organization
WASH	Water Sanitation and Hygiene

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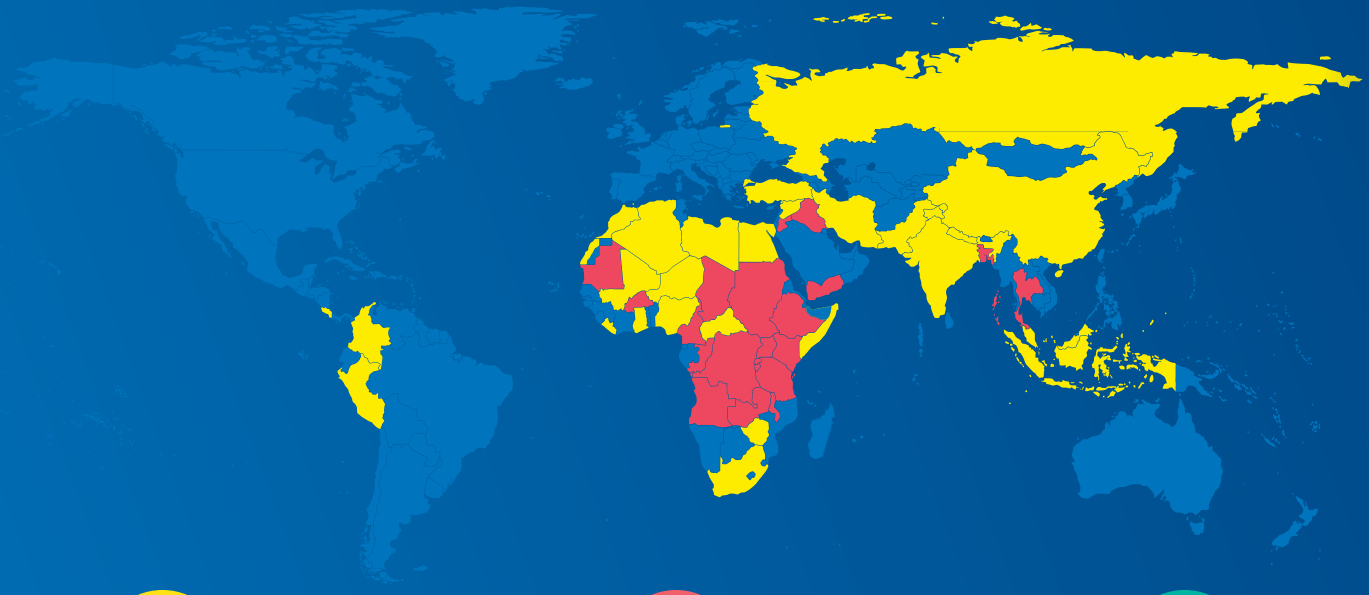
Introduction

Refugees – and all people of concern to UNHCR – have the right to live healthy lives. UNHCR's approach to public health is inclusive of all ages, genders, and diversities.

In 2021, UNHCR, in close collaboration with governments and partners, took further strides to help refugees and the communities that host them achieve health-related Sustainable Development Goals (SDGs). To improve access to health services and address the social determinants of health, UNHCR advocated for inclusion of refugees and other persons of concern in national health systems and plans, worked with partners in the direct provision of health services in several contexts, monitored health status and access to health services, and built local capacity through technical guidance, trainings, infrastructure improvements, as well as provision of medicines, equipment and supplies when needed.

The Annual Public Health Global Review 2021 presents the successes and challenges during a year with record numbers of forcibly displaced people, significant concurrent conflict and climate induced emergencies, and stark COVID-19 vaccine access inequity between high-income and low-income countries. The Global Review also serves as the first-year baseline report on UNHCR's 2021 – 2025 Global Public Health Strategy.

COUNTRIES WITH PUBLIC HEALTH PROGRAMMING AND COUNTRIES USING IRHIS:



50

Number of **countries with public health programming***

22

Countries **using the integrated Refugee Health Information System (iRHIS)****

155

Number of **sites/facilities using iRHIS**

198 partners including MoH

119 NGO partners

62% national NGOs

192 UNHCR Public Health and MHPSS personnel

92% working at country-level

**Countries with public health programmes – Algeria, Angola, Bangladesh, Burkina Faso, Burundi, Cameroon, CAR, Chad, China, Colombia, Congo Rep., Costa Rica, Djibouti, DRC, Egypt, Ethiopia, Ghana, Greece, India, Indonesia, Iran, Iraq, Jordan, Kenya, Lebanon, Liberia, Libya, Malawi, Malaysia, Mali, Mauritania, Morocco, Nepal, Niger, Nigeria, Pakistan, Peru, Russia, Rwanda, Somalia, South Africa, South Sudan, Sudan, Syria, Tanzania, Thailand, Uganda, Yemen, Zambia and Zimbabwe.*

*** iRHIS countries – Angola, Bangladesh, Burkina Faso, Burundi, Cameroon, Chad, Congo Rep., DRC, Ethiopia, Iraq, Jordan, Kenya, Malawi, Mauritania, Rwanda, South Sudan, Sudan, Tanzania, Thailand, Uganda, Yemen, Zambia. Countries also using DHIS 2- Kenya, Malawi, Zambia, Uganda and Bangladesh.*

1. Access to Essential Health and Nutrition Services throughout the Displacement Cycle

At all stages of the displacement cycle – fleeing from active conflict, crossing borders, stabilization, protracted stays as refugees and eventual return home when possible – refugees require access to essential health and nutrition services. However, many challenges may be faced including disruption in continuity of care for those with chronic conditions, user fees, long distances to health facilities and sub-optimal health care quality.

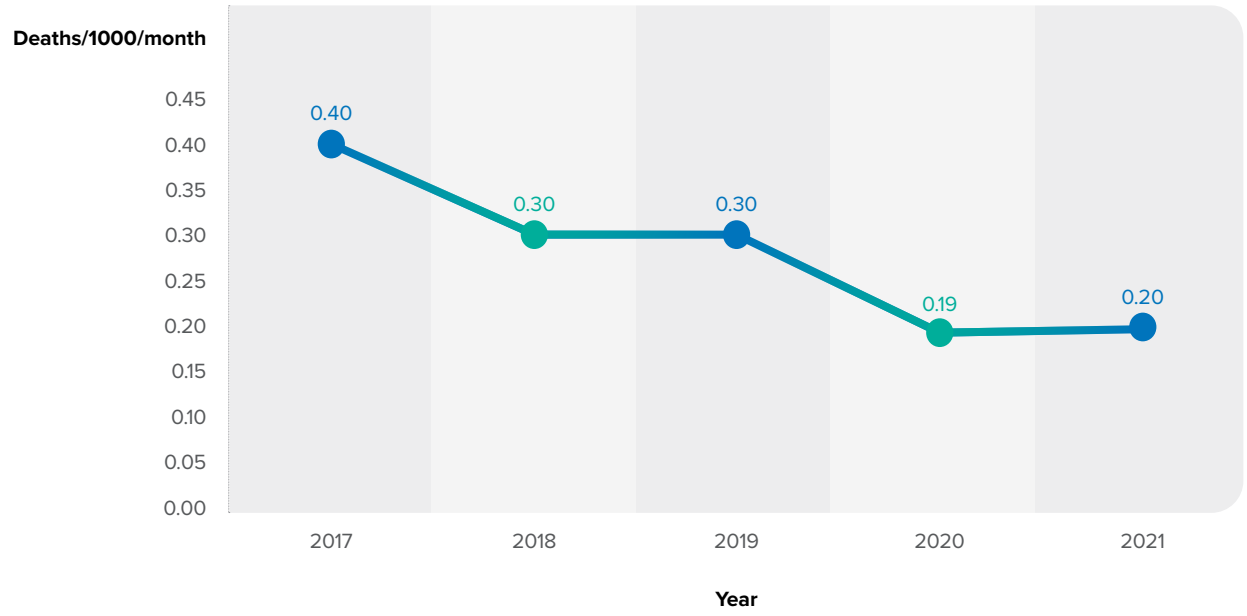
In 2021, the second year defined by the COVID-19 pandemic restrictions, continuity of access to health and nutrition services, as well as impact on health outcomes, remained a high priority. UNHCR and partners monitored refugee access to services through multiple means, including through surveys and the **Integrated Refugee Health Information System** (iRHIS) that collates and analyses a comprehensive set of health and nutrition data visualizing trends over time. iRHIS data covers 155 sites in 22 countries covering over 5 million refugees.

KEY INDICATORS

Indicator	2021	2020	Standard
1. Total Consultations in Countries using iRHIS	7,620,115	7,562,609	
2. Total Population in Countries using iRHIS	5,096,755	4,669,953	
3. Health Facility Utilisation Rate	1.5 consultation per person per year	1.6 consultation per person per year	1-4 consultation per person per year
4. Crude Mortality Rate	0.10 deaths/ 1,000 per month	0.11 deaths/ 1,000 per month	< 0.75/1,000/month
5. Under 5 Mortality Rate	0.20 per 1,000 population under 5 per month	0.19 per 1,000 population under 5 per month	UNHCR threshold < 1.5/1,000/month
6. Skilled Birth Attendance Rate	93% (121,976 live births)	92%	>90%

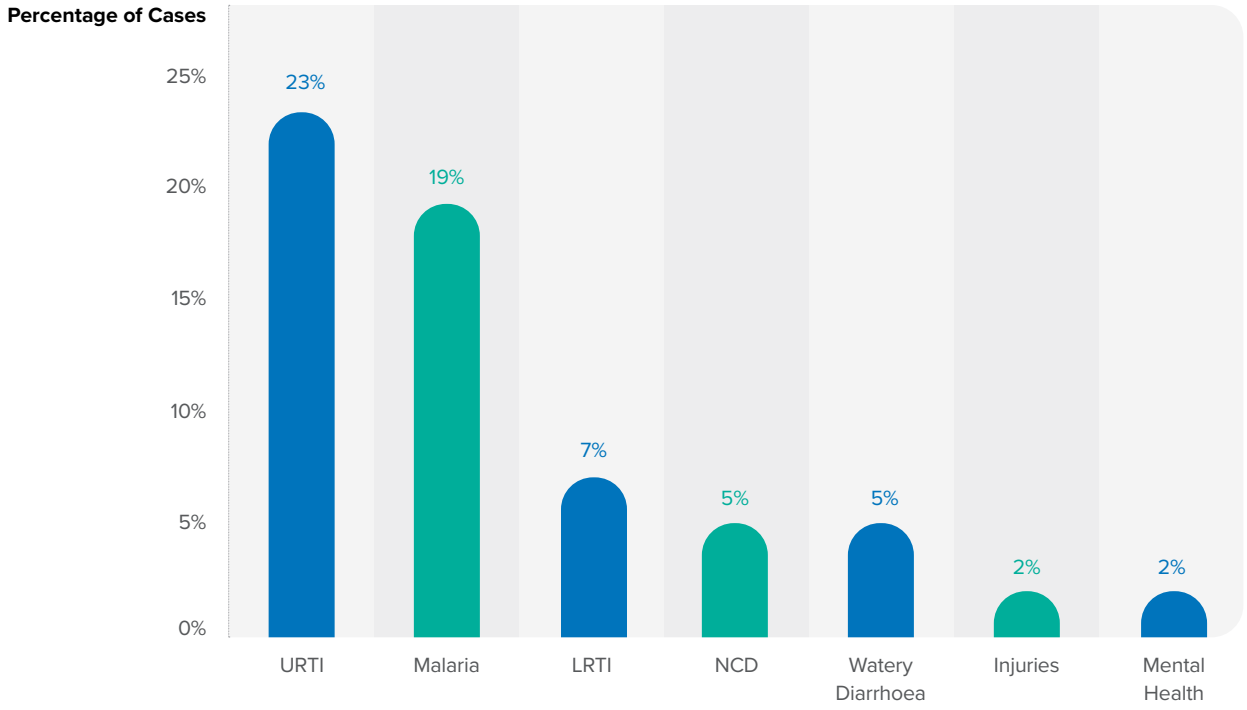
The under-five mortality rate, an important indicator of child health and the social, economic and environmental conditions in which children and their families live, remained stable globally and below emergency thresholds. There are concerns about the impact of COVID-19 and service continuity disruptions on childhood immunization. UNHCR worked with partners and communities on maintaining access to and uptake of routine vaccinations and this will continue to be a focus in 2022.

UNDER FIVE MORTALITY RATE OVER TIME



For those refugees accessing services as recorded in iRHIS, the main causes of **morbidity** continued to be upper respiratory tract infection (23%), malaria (19%), lower respiratory tract infection (7%), non-communicable diseases (NCDs) (5%) and watery diarrhoea (5%) followed by injuries (2%) and mental health (2%).

LEADING CAUSES OF MORBIDITY IN 2021



Malaria: uneven access to prevention and control measures

In refugee settings, malaria persists as a leading cause of morbidity and mortality. Limited funding and insufficient opportunities for partnerships impacted UNHCR's capacity to reach refugees and host communities with antimalarial commodities and services.

In **Kenya** (Kakuma), UNHCR achieved a high-level of malaria prevention through indoor residual spraying (IRS) coverage of over 85% and general distribution of 89,000 insecticide treated nets (ITN) reaching a desired ratio of one-net-to-two-people.

Whereas in **Ethiopia** (Gambella) funding shortages meant IRS was not able to be conducted and ITN coverage fell below 70%. Malaria remained a considerable cause of morbidity (21% of outpatient consultations).

In **South Sudan** (Maban) through a partnership with Mentor Initiative malaria prevention and control was strengthened with IRS, larvicide, and provision of anti-malaria commodities.

In **Uganda,** malaria was the leading cause of morbidity and one of the leading causes of mortality in the refugee settlements (36% of outpatient consultations and 15% of deaths). ITN distribution continued in the refugee settlements following a mass hang-up campaign in 2020. All of the 987 community health workers were trained in integrated community case management which enables children under five years with malaria, pneumonia or diarrhoea to receive treatment within 24 hours of onset of symptoms.

Non-communicable diseases (NCDs) are a significant health burden accounting for 5% of all consultations globally. UNHCR continues to focus on improving access to and quality of care for people with NCDs. Technical capacity building was provided to governments and partners through two regional training-of-trainers (ToT) sessions with over 30 remote participants in the East and Horn of Africa and West and Central Africa. Procurement of medicines and supplies ensured availability of treatments for NCDs including access to insulin.

Refugee access to **mental health and psychosocial support services,** particularly those with complex and severe conditions, is critical. Two percent of the consultations as recorded in the iRHIS are related to mental health, a slight increase from 2020.[1] UNHCR aims to have a mental health specialist provider in primary health care programmes serving more than 25,000 refugees. In 2021, 49 (83%) of 59 camps with more than 25,000 inhabitants had a mental health professional, typically a psychiatric nurse or a clinical psychologist. UNHCR also routinely integrates mental health into its public health programmes through health worker capacity building to identify and manage mental health conditions. In 2021, UNHCR covered 69% of the training costs for 1,683 primary health care staff in 19 countries on the WHO/UNHCR mhGAP Humanitarian Intervention Guide. Over three-quarters (78%) of the trainings took place in camps or rural settlements.[2]

1. For longitudinal data see: Fine et al (2022). Ten years of tracking mental health in refugee primary health care settings: an updated analysis of data from UNHCR's Health Information System (2009-2018). BMC Med. 20(1):183.
2. More information on UNHCR's multisectoral activities on Mental Health and Psychosocial Support can be found in the report 'Strengthening Mental Health and Psychosocial Support in UNHCR - Achievements in 2021 and priorities for 2022 and beyond'.

Naima Ismail, a 29-year-old refugee from Somalia, works for an online support project which aims to provide a safe space for refugee women to seek support and help on matters concerning their mental health.

Training Nurses and Midwives on Mental Health for Refugees in Rwanda

In 2021, UNHCR funded a mental health training for nurses and midwives from all refugee settings in Rwanda. The training was facilitated by a Rwandan psychiatric nurse from UNHCR's health partner, Africa Humanitarian Action, who had earlier in 2021 participated in an intensive online training and mentoring programme to become an mhGAP facilitator. The co-facilitator in the training in Rwanda was a mental health professional from the University Teaching Hospital affiliated with Rwanda's national mental health programme, contributing to strengthened national capacity building by the government. The training evaluation through pre and post-test for knowledge, competencies and attitude showed major improvements.

Globally, UNHCR continued to support capacity strengthening of national health systems so that refugees could access **COVID-19 prevention and treatment.** UNHCR procured and delivered personal protective equipment and other critical items and services worth $69.1 million to 75 operations, including 532,000 rapid diagnostic tests and 1,340 oxygen concentrators. Intensive care equipment was provided to Bangladesh, Zambia, Lebanon and Uganda, including 164 ventilators. UNHCR also helped to establish quarantine and treatment centres in Cameroon, Bangladesh, Brazil, Kenya, Lebanon, Uganda, Costa Rica, Peru, Rwanda and Ethiopia.

125,011

Reported COVID-19 cases amongst people of concern in 2021[3]

2,306

Reported COVID-19 deaths (case fatality rate **1.84%**)

Many health conditions cannot be adequately managed at primary care level and require referral for higher level care. UNHCR continued to support **medical referrals** to secondary and tertiary care for those in need in line with country-specific standard operating procedures. A range of care providers who are predominantly public referral facilities are identified and mechanisms put in place for the transport of patients and support with costs where user fees are a barrier.

217,399 **Medical Referrals** in 2021

Number of countries UNHCR supporting **referral to secondary and tertiary care:** **37**

UNHCR is strengthening efforts to improve access to elective surgical procedures including through national partnerships. For example, African Humanitarian Action in collaboration with the Ophthalmological Association of South Sudan conducted an eye surgical campaign in Ajoung Thok, South Sudan; 2,600 refugees and host community members were reviewed during the campaign of whom 730 underwent eye surgeries (including 320 cataract surgeries). Cataracts are a major cause of preventable blindness globally.

3. The COVID-19 cases and deaths reported to UNHCR are an underrepresentation of the actual burden. Not all cases and deaths are reported to UNHCR at country level and disaggregated data from national systems is not always available.

Deborah and Kip from the Myanmar Ethnic Women Refugee Organization, conduct virtual support group sessions with Myanmar refugee women.

To advance towards the global SDGs, including health and well-being for all, UNHCR supported **sexual and reproductive health** as a component of primary and secondary care. In 2021, iRHIS-reporting operations reported 123,264 deliveries. Despite COVID-19 pandemic-related restrictions and interruptions to reproductive health services, the percentage of deliveries assisted by skilled birth attendants remained stable from 2019 to 2021 at 92.8% in 2021 (114,490 out of 123,264 deliveries).

To expand access to quality services, including maternal and neonatal health, UNHCR partnered with UNFPA on a training of trainers in comprehensive sexual and reproductive health services. Twenty-three personnel from 19 countries from both agencies were trained. Recognizing the critical role of contraception and family planning in women's (and children's) health and well-being, 37 operations monitor and support programming to improve service provision and 27 operations reported that contraception was routinely made available (without interruption) to refugees within their operations.

Saving Maternal and Newborn Lives in Chad, Cameroon and Niger

Saving maternal and newborn lives is at the heart of UNHCR's public health programming. An increasing proportion of under-five mortality is due to neonatal deaths. In 2021 an end-of-project evaluation was conducted of a three-year Bill and Melinda Gates Foundation- funded project to reduce neonatal and maternal mortality and morbidity among 772,000 refugees in Cameroon, Chad and Niger. The project focussed on low-cost, high-impact interventions. The evaluation demonstrated that among 33,530 births, neonatal mortality rate was reduced by 25% and weighted case fatality rate for newborns with complications and very low birth weight newborns decreased from 11.8% to 6.3% and 31.5% to 12.3% respectively, from 2019 to 2021. Overall, the project improved the access to and quality of maternal and newborn care and family planning in underserved refugee hosting areas of the three countries. The project reach extended beyond refugee populations, improving host populations' access to quality services. UNHCR is disseminating the learnings from this project to other refugee settings.

Overcoming COVID-19-related Barriers to Maternal and Newborn Health Services in Jordan

In Jordan, financial and movement restrictions continued to hinder access to the essential services of maternal and newborn care. UNHCR introduced remote consultations and home delivery of essential medicines while reinforcing cash assistance and communication with communities to facilitate access to health services.

At **community level**, in-person households visits by community health volunteers were replaced by remote telephone consultations for Sexual and Reproductive Health (SRH) awareness raising and referrals as well as antenatal and postnatal follow-up. At **primary care level**, obstetricians deployed a telemedicine approach for remote consultation, counselling and delivery preparation for high-risk pregnant women. Through the United Parcel Services and in collaboration with the Jordanian Ministry of Health, UNHCR organized the distribution of essential reproductive health medications to places of residence.

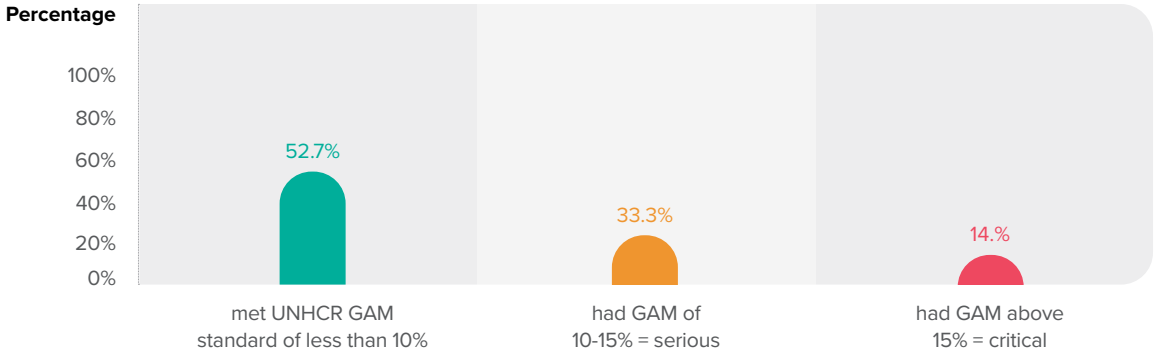
To ensure continued access to **life-saving services**, support was provided for deliveries including caesarean sections where indicated, and cash to facilitate access to health services continued without interruption during the lockdowns. UNHCR used existing communications channels, including Facebook, information sharing groups, community support committees, and health partners' communication channels to promote awareness and information on how to access health services.

Upon arrival from the DRC, children at Nyakabande transit centre are checked and screened for acute malnutrition.

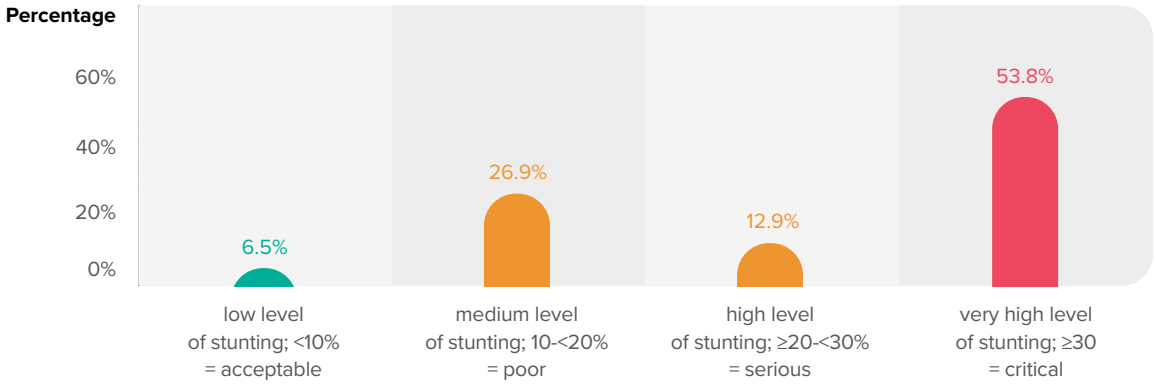
Refugee **nutrition** status is a growing concern due to the combined impact of reduced humanitarian funding and multiple shocks including food insecurity, impact of COVID-19 pandemic restrictions and limited legal access to employment/livelihood opportunities. In 2021, UNHCR resumed monitoring of the nutrition situation through the Standardized Expanded Nutrition Surveys (SENS), which had been paused due to COVID-19 restrictions in 2020. The 2021 SENS assessed malnutrition levels in 93 sites across 13[4] countries. In a context with combined multiple shocks including growing food insecurity, impact of Covid-19 pandemic restrictions and limited livelihood opportunities, 33% of these sites had a serious global acute malnutrition prevalence, and 14% were above the critical emergency threshold of 15% prevalence. Stunting amongst children aged 6-59 months remained concerning: 54% sites had stunting prevalence above the critical 30% level. Only 4% of sites met the standard for anaemia and general micronutrient status, while 34% and 62% had serious and critical levels of anaemia respectively.

4. Bangladesh, Cameroon, Chad, Ethiopia, Kenya, Niger, Nigeria, Rwanda, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe.

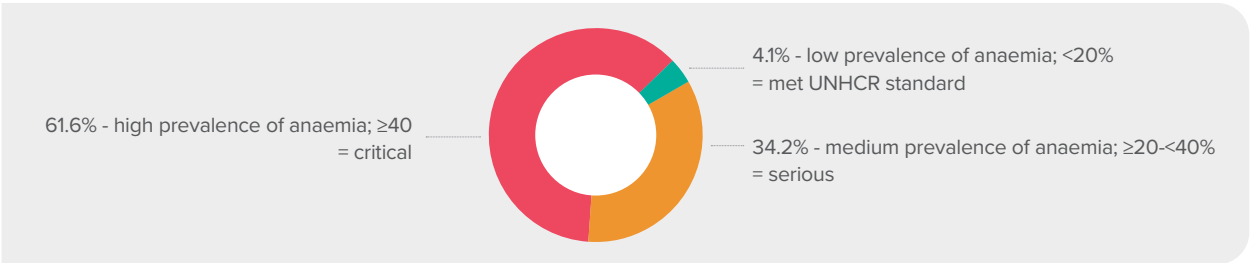
GLOBAL ACUTE MALNUTRITION (GAM) IN CHILDREN 6-59 MONTHS IN 93 SITES



STUNTING IN CHILDREN 6-59 MONTHS IN 93 SITES



ANAEMIA IN CHILDREN 6-59 MONTHS IN 73 SITES



To address the various forms of malnutrition and improve food security and nutrition, UNHCR supported both treatment and prevention of undernutrition. This included treatment of wasted children through community management of acute malnutrition (CMAM). Malnourished children aged under five years were screened at both community and facility level and referred for treatment. UNHCR trained 6,017 community outreach workers to facilitate screening and referrals. 71,695 children aged 6-59 months were managed for severe acute malnutrition (SAM) and 164,509 for moderate acute malnutrition (MAM) across 30 countries.

6,017
community outreach workers
trained in identification and referral of acutely malnourished children

71,695
children aged 6-59 months treated for **SAM**

164,509
children aged 6-59 months treated for **MAM**

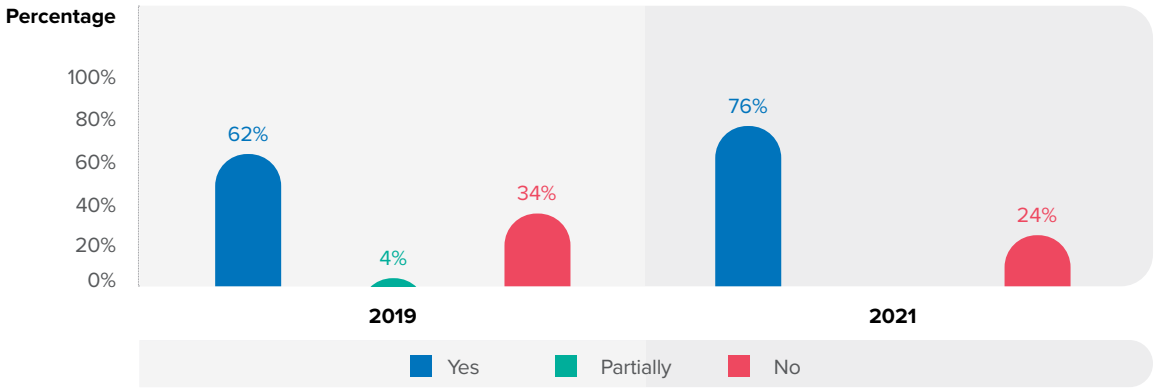
2. Working with National Health Systems

UNHCR's Global Public Health Strategy is grounded in the principle that, wherever possible, refugees should be included and integrated into functioning national health systems and services enabling equitable access to health care. UNHCR recognizes that many refugee-hosting countries are low- and middle-income and need support to ensure their capacities are strengthened to meet the needs of refugees as well as host communities.

Medical staff at a health centre in Loya Wala, north of Kandahar, which serves more than 30,000 people including returned refugees and displaced people.

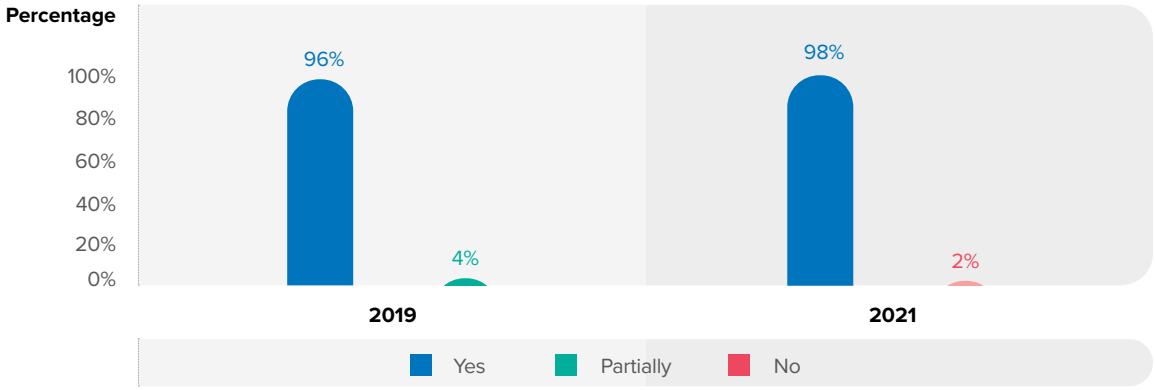
In 2021, the results of UNHCR's biannual inclusion survey of 48 countries were encouraging: there is promising progress in overall inclusion in national policies. Access to services was generally on par with nationals for primary health care, but to a lesser extent for secondary care where additional support for refugees from UNHCR was often required; 58% of countries reported having a national health insurance scheme or system with 39% of these including refugees in 2021.

ARE REFUGEES INCLUDED IN THE NATIONAL HEALTH PLAN/POLICY?



DO REFUGEES HAVE ACCESS TO NATIONAL PRIMARY HEALTH FACILITIES?

DO REFUGEES HAVE ACCESS TO NATIONAL SECONDARY HEATLH FACILITIES?



Throughout 2021, UNHCR explored prospects for the inclusion of refugees in national **social health protection** schemes. In Egypt and Ethiopia, UNHCR conducted feasibility studies in collaboration with the ILO and the government. In Rwanda, 12,080 refugees living in urban centres are included in the national community-based health insurance scheme assisted by UNHCR's advocacy efforts. In Burundi, more than 600 households or 3,500 individuals were enrolled in the mutual health insurance scheme through the support of a donor.

Inclusion in Social Health Insurance in Costa Rica

Costa Rica hosts 10,242 recognized refugees and 152,616 registered asylum seekers primarily from Nicaragua. UNHCR promotes access to health services for the most vulnerable refugees and asylum seekers, including through inclusion in the national health system and insurance scheme.

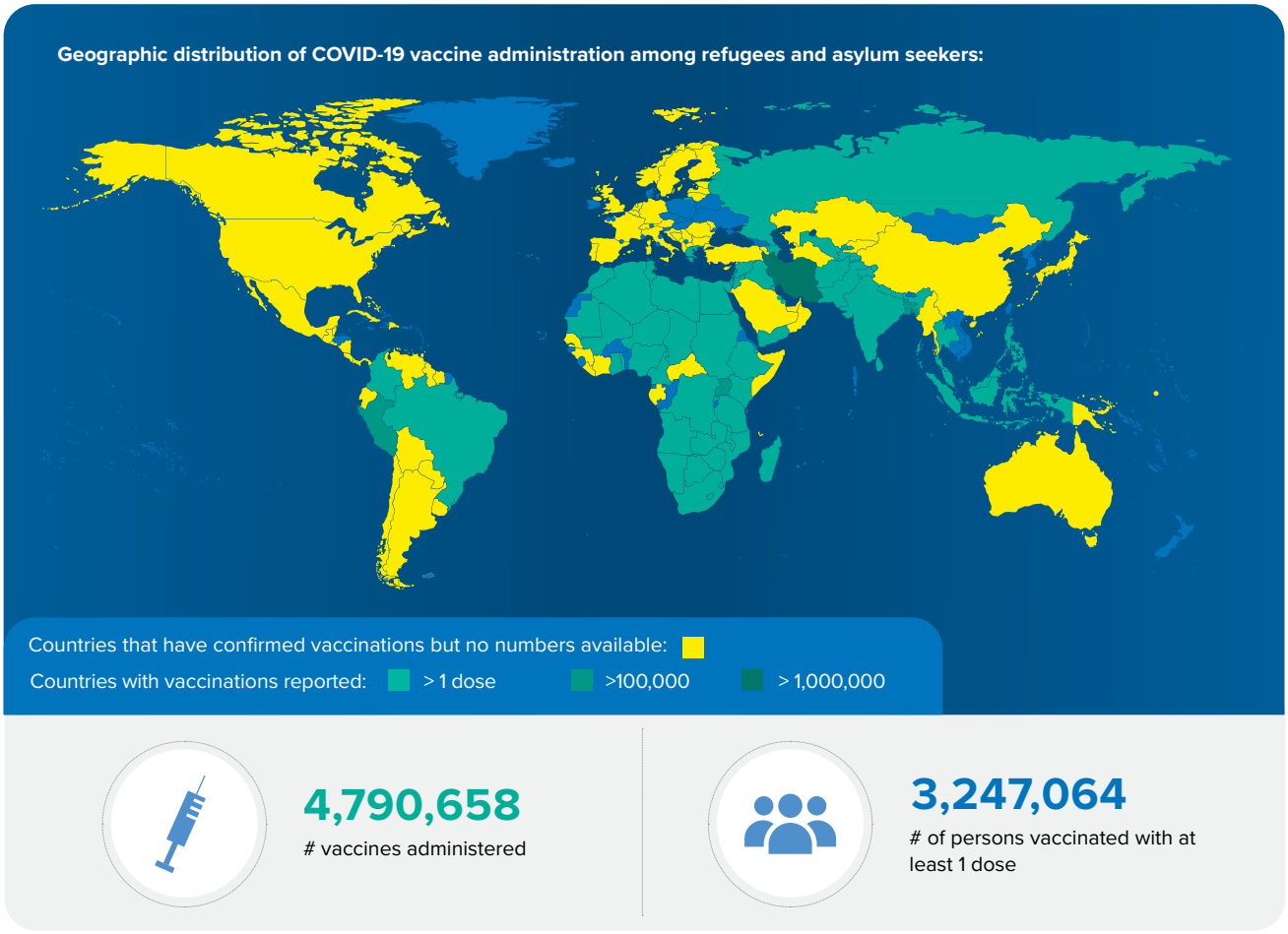
The Costa Rican Social Security Fund (CCSS) is a public social health insurance system where the employee, employer, and State contribute so that those insured are able to access health services. Due to high unemployment, exacerbated by the COVID-19 pandemic, many refugees and asylum seekers are unable to pay the premiums putting them at risk of being unable to access health services and high out-of-pocket expenses.

UNHCR embarked on intensive dialogue with the government and negotiated the inclusion of up to 10,000 of the most vulnerable refugees and asylum seekers in 2021. UNHCR currently covers the insurance premium by paying the CCSS directly.

Partnerships to tackle child wasting

Following the launch of the **Global action plan on child wasting** in 2020, UNHCR worked alongside UNICEF, WFP, WHO, FAO and others to develop multi-system, costed country roadmaps to tackle child wasting. UNHCR's advocacy ensured refugees were included in roadmaps for 12 of the 14 eligible countries: Bangladesh, Burkina Faso, Burundi, the Democratic Republic of the Congo, Ethiopia, Kenya, Malawi, Mali, Nigeria, South Sudan, Sudan and Yemen. UNHCR also became a signatory to **Catalysing action and accountability on the prevention, early detection, and treatment of Child Wasting - A call to action**, a joint effort highlighting six priority areas of action developed jointly with almost 50 governments and organizations.

COVID-19 VACCINATION AMONG REFUGEES AND ASYLUM SEEKERS



Worldwide inequity marked the **COVID-19 vaccine** rollout in 2021. UNHCR was at the forefront advocating for refugee inclusion into national plans. By the end of the year, 162 countries had included persons of concern and 4.79 million vaccine doses were administered to 3.25 million refugees in 66 countries. An additional 72 countries confirmed they had started vaccinating refugees, asylum-seekers, stateless persons and internally displaced people. In several countries, UNHCR worked with governments and partners to provide last-mile support to facilitate vaccine rollout in remote camps and refugee hosting areas. As a member of the COVAX Humanitarian Buffer Working Group UNHCR contributed to policy development and advocacy for improved vaccine access for humanitarian populations.

3. Equitable Provision of Health Care Services

Health services should be available, accessible, and adapted to meet the needs of all persons, with particular attention to vulnerable groups, including persons with disabilities, LGBTIQ+ persons, adolescents, older persons and persons who are deprived of their liberties, as well as considering gender-related factors in accordance with UNHCR's Age, Gender and Diversity (AGD) policy. Throughout 2021, UNHCR, governments and partners designed and monitored health services to promote and support equitable outcomes.

Louai suffered a stroke in 2014 which left him completely dependent on his wife's care. UNHCR and its partner CTR advocated for his inclusion in national assistance programs which allows him to receive free healthcare, transport and assistive devices in Tunisia.

As a cosponsor of UNAIDS and contributing to the global goal of ending AIDS by 2030 in line with the Global AIDS Strategy (2021 – 2026), UNHCR continued to promote equity and inclusion into national HIV programmes. UNHCR worked with partners at national, regional and global levels to strengthen services for adolescents, improve health and protection services for people who sell sex and strengthen TB programming and linkages with HIV care.

Sex and age disaggregated data highlights differences in access to HIV services. Amongst adults 53% of those on antiretroviral treatment for HIV are female while for children and adolescents under 18, 73% are male. Greater effort is needed to understand and eliminate barriers faced by adolescent females in receiving the treatment they need and deserve.

271,815 people received HIV **testing and counselling**

57% tested aged under 18 were females

70% tested aged 18 and over were females

93% found to be positive were newly initiated on lifesaving antiretroviral treatment

21,145 **refugees on ART**

>18 of age **53%** are female while <18 only **26%** are female

During 2021, 271,815 persons received HIV testing and counselling in UNHCR-supported operations. There were gender differences in access to testing. Of those aged 18 or over 70% tested are female while under 18 years 57% are female. In some countries the differences are even more marked. For example, in Kenya three times as many women 18 years and over accessed HIV testing compared to men in 2021. Testing is the first step to linkages with treatment and care and there are nearly twice as many women accessing treatment in Kenya than men. The higher proportion of women accessing testing is a reflection of the routine offer of HIV testing in many ANC settings but also highlights that more needs to be done to reach males including through workplace testing, varied clinic hours and promotion of self-testing.

Young people and adolescents are a particularly at-risk population with special needs that are often neglected. In 2021, UNHCR reinforced its adolescent sexual and reproductive health (ASRH) programming in refugee settings **in sub-Saharan Africa and beyond.** Thirty UNHCR country operations monitored and supported programs to improve **service delivery for adolescents and youth** in refugee settings; 20 operations reported the availability of **information, education and communication materials for adolescent refugees;** 16 operations reported that **health providers received training on adolescent- friendly approaches** to service delivery; and 15 operations identified and trained **community promoters to facilitate ASRH programme implementation.**

Reaching Adolescents in Uganda

In **Uganda** over seventy local and district staff across 11 refugee settlements were trained as trainers (ToT) in adolescent sexual and reproductive health and rights (ASRHR). Following the ToT and multi-sectoral workshops, action plans were developed to increase the capacity of key stakeholders to integrate ASRHR in refugee settings and engage meaningfully with youth and adolescent refugees. Training materials utilized for this project were shared on a global platform IAWG, available for other ASRHR actors working in humanitarian settings.

Assisting persons with specific needs in Tanzania

UNHCR strives to ensure that persons with disabilities have access to essential services, adequate accessible living conditions and have opportunities to develop and apply their skills and capacities. In **Tanzania** a collaboration with HelpAge International established rehabilitation centres in the camps assisting 3,490 persons with disabilities with physiotherapy, assistive devices, psychosocial support, non-food items, as well as cash assistance to the most vulnerable. Axillary and elbow crutches, wheelchairs, walking sticks, commode chairs, walking frames, hearing aids, and corrective glasses were among assistive devices provided, while 2,518 persons received multipurpose cash assistance. With the aim of building community capacity 318 refugee caregivers were trained on how to care for persons with disabilities, including home-based physiotherapy and mobility support.

Peru: Regulation of Stay for Venezuelan Refugees and Migrants in Peru living with, or at risk of HIV

Peru hosts 1.3 million Venezuelans, around 61% of whom are in an irregular migratory situation. Those living with HIV face significant difficulties accessing treatment. In 2021, UNHCR and its partner, PROSA, provided legal guidance to some 1,700 Venezuelan refugees, asylum-seekers and migrants living with HIV and/or part of the LGBTIQ+ community to regularize their migratory status, obtain a foreigner's ID and access the national health system. UNHCR also successfully advocated for an amendment to the Ministry of Health policies on comprehensive assistance for foreign citizens living with HIV in Peru that resulted in simplified procedures, including the number of required tests, prior to starting antiretroviral treatment.

4. Multisectoral Collaboration

The immediate causal factors of any disease are complemented by actions to modify the social, economic and environmental (including climate change) determinants of health. UNHCR champions intersectoral actions with protection, shelter and settlement, food security, education, livelihoods, WASH and energy to improve health outcomes and reduce health inequities.

A South Sudanese refugee monitors her crop in the 180-hectare sorghum farm at Kalobeyei Integrated Settlement.

A reliable **energy** supply for health facilities is essential to maintain cold chain, to power equipment and provide good lighting. UNHCR is committed to mitigate the environmental impacts from non-renewable energy sources. 358 health facilities were surveyed in 2021 and 41% need an improved energy source including 15% that are reliant on a diesel generator. Of concern, 13% lacked an energy source altogether affecting quality of care and health provider working conditions. **WASH** in health facilities is essential to provide quality patient care and as a core component of infection prevention and control. Of 233 health facilities surveyed, only 51% had an improved water supply and only 55% a toilet available for use. Improvements are underway in both WASH and energy in health facilities, but increased funding and broader partnerships are required to accelerate progress.

Country highlights: improvements to energy supply and WASH in health facilities

In **Kenya**, a renewable energy system scale-up has started with the potential to provide 7 health facilities with improved access to electricity.

In **Bangladesh**, a solar mini grid has been installed to power a health facility, streetlights and latrines.

In **Uganda**, local and national authorities were supported with the solarization of 3 health centres and in Rwamwanja, water supply was transitioned to the national utility service, and water connections were made to institutions including health facilities.

In **Pakistan**, solarization of 40 facilities including schools, health centres, and water pumping systems to improve the quality of education and health services is ongoing.

In **Malawi**, a health clinic servicing refugees and the host community has been equipped with a solar system to supply lighting and continuous power to the cold chain thus supporting the conservation of vaccines and medicines.

In **Nigeria**, UNHCR supported installation of solar panels in 3 PHC centres to ensure continuous electricity availability and enable functioning of equipment and provision of after-hours emergency services.

In **Mozambique**, water supply to Maratane Health Centre was improved with installation of a submersible electric pump.

In **Mauritania**, as part of COVID-19 preventive and control measures, access to water for drinking and handwashing has been increased in health centres and refugee reception areas.

In 2020 and 2021, UNHCR and partners implemented multi-sectoral action to prevent and respond to **gender-based violence (GBV)** providing medical and psychosocial services, protection and legal services. Awareness-raising and capacity building were conducted at community level with partners and local authorities on GBV prevention and response in a culturally sensitive and appropriate manner.

Throughout 2021, 89,742 survivors received psychosocial counselling, 4,066 received legal assistance and 3,845 medical assistance. In countries where data is available 58% received post exposure prophylaxis for HIV, a marker for early access to appropriate care. There is a need to continue to establish and promote safe entry points for disclosure and support as well as referrals to comprehensive services. In Ecuador, UNHCR donated 492 paediatric post-exposure prophylaxis kits to the Ministry of Health allowing the expansion of GBV care to 134 health care units, enabling the presence of age-appropriate GBV services in 24 provinces.

At the intersection of health, human rights and protection, UNHCR, WHO and UNFPA developed and rolled out a master training on the updated guidance for Clinical Management of Rape and Intimate Partner Violence Survivors in humanitarian settings, which includes strengthened responses to children, male survivors, intimate partner violence and MHPSS. During 2021, 470 health providers in 18 operations were trained. The operational guidance on responding to the health and protection needs of people who sell or exchange sex in humanitarian settings was finalized and the rollout started jointly with UNFPA.

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Neema, 35, is leading a women-led initiative in Masisi that is supported by UNHCR and helps mobilize social action especially for women who are affected by violence or abuse.

Multisectoral action instrumental in improving infant and young child feeding practices

Prevention of malnutrition through infant and young child feeding actions (IYCF) protects and promotes recommended breastfeeding practices from birth as well as age-appropriate feeding practices in the first two years of life. The IYCF multisectoral framework promotes action across multiple sectors, skilled support at the health facility and community and peer support. In 2021, the multisectoral IYCF approach was in place in 33% of 42 operations, skilled support at the health facility in 85% and community support in 50%. Training on the framework reached 312 health and nutrition staff while at the community level 3,245 mother-to-mother support groups provided peer support. In 2021, UNHCR developed an accompanying handout and training package to increase uptake at country level. Results from the 2021 nutrition surveys showed 51% of the 87 surveyed refugee locations met the recommended UNHCR exclusive breastfeeding rate target (≥75%) indicating uptake of positive practices. Exclusive breastfeeding and adequate appropriate complementary feeding are key interventions for improving child survival, potentially reducing deaths among children under five by about 20%.

As part of a community-led project in Kutupalong,Rohingya refugee youth meet to discuss and plan awareness raising activities to help prevent the spread of COVID-19.

5. Actively engage communities in activities to promote and sustain their health

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

Altogether 8,793 community health workers (CHWs) are supporting health activities in 32 operations, evenly divided between male and female (4,389 female and 4,396 males), with more than 90% working in camp settings. In 17 of 29 operations (59%) these are linked to the formal health system. CHWs collect health information as part of their tasks, providing important insights on health seeking behaviour and potential gaps in service delivery. A systematic community-based information system is in place in 13 of 29 operations (45%). Greater efforts are needed to link CHWs with the health facilities, improve community-based data collection and expand community health programmes in urban areas.

Twenty seven of 29 operations reported that the public health programme had a mechanism to elicit community participation. Capacity building of the community health workforce focused on a wide range of topics in 2021, covering public health including SRH, nutrition and MHPSS amongst other topics.

Country highlights: Community Health Workers

Ethiopia: Enhancing community-based health promotion activities

In Melkadida, community-based activities for communicable and non-communicable disease prevention, health, nutrition and reproductive health promotion were conducted through a network of 878 CHWs (327 F, 521 M), youth and women's groups and community leaders. This included prevention activities such as awareness raising, distribution of IEC materials, environmental cleaning, and sanitation/hygiene campaigns. Measles vaccination coverage improved to 91% in 2021, an increase of 24% compared to 2020. This increase is attributed to the resumption of community-based activities and outreach.

Tanzania: Promoting male involvement in contraception and family planning

Male champions (community leaders) were identified to provide reproductive health information, education, and communication in communities, including relating to family planning/contraception. This contributed to an increase in the contraceptive prevalence in camps in Tanzania from 32.5% to 36.2% (from 2020 – 2021).

Bangladesh: Increasing the proportion of deliveries in health facilities

In Cox's Bazar refugee camps, the Community Health Working Group (CHWG) is working with over 1,400 community health workers (CHWs) of different health partners. The CHWs engage with communities on disease prevention and provide information on health services. A maternal health support system is in place to follow up pregnant women including high-risk pregnancies, counselling on danger signs in pregnancy and referral to health facilities.

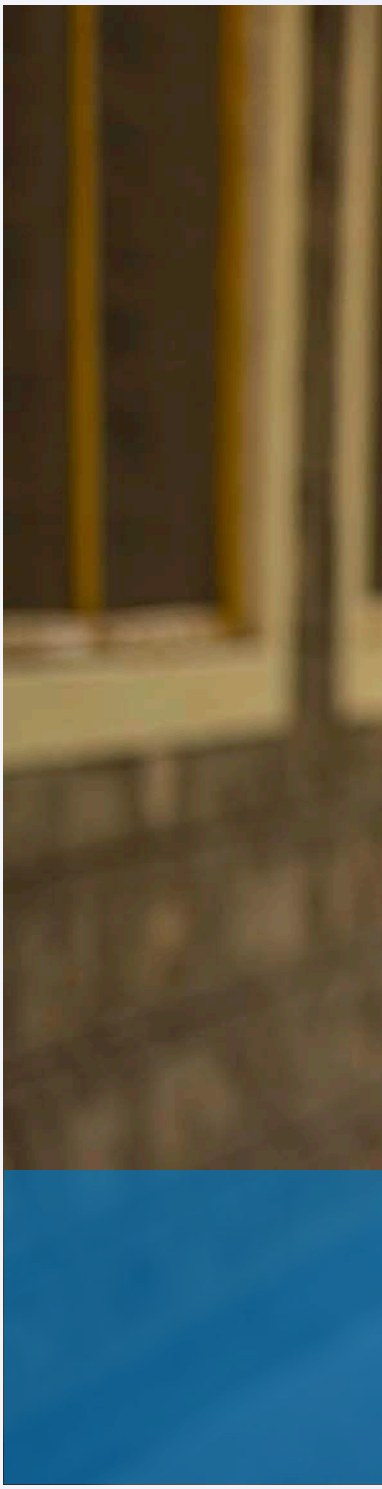
CHWs track the expected date of delivery and pay more frequent visits to pregnant women and their families in the last month of their pregnancy to encourage birth preparedness and facility-based deliveries. Former traditional birth attendants support referral and accompany pregnant women to facilities while community leaders are engaged in advocacy. Subsequently, the percentage of facility delivery increased from 12% in 2018 to 70% in 2021.

Nutrition: community engagement to promote healthy child/caregiver interactions

Promotion of healthy child/caregiver interactions was strengthened by supported mother-child pairs at the facility level. In Ethiopia, 4,954 mother-child pairs were reached in the management of small and nutritionally at-risk infants under six months. This utilises the MAMI Care Pathway Package which systematically includes MPHSS support during care. Preventive interventions seek to promote and support optimal infant and young child nutrition through baby-friendly spaces (BFS), which provide individual and group counselling, early child development (ECD) play activities and mother-baby bonding sessions. At the community level mother-to-mother support groups were maintained. In Gambella and Melkadida, 14,313 caretaker/mother-child pairs received individual or group counselling; 32 BFS were operational where approximately 9,900 children under two years and their parents attended ECD play activities monthly; 1840 mother-to-mother support groups and 85 father- to-father support groups were functional. As a result improved mother-child interactions, enhanced maternal wellbeing, and improved children's nutritional status and growth outcomes were observed.

Knowledge Products Developed

1. Global Public Health Strategy 2021- 2025
2. UNHCR and UNFPA Responding to the health and protection needs of people selling or exchanging sex in humanitarian settings
3. WHO, UNFPA and UNHCR Clinical management of rape and intimate partner violence (IPV) survivors in humanitarian settings: E-learning
4. WHO and UNHCR mhGAP Humanitarian Intervention Guide (mhGAP-HIG) training of health-care providers: Training manual
5. UNHCR. Strengthening Mental Health and Psychosocial Support in 2021
6. Infant and Young Child Feeding in Refugee Situations: A Multi-Sectoral Framework for Action Roll-Out Guide



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