UNHCR and its partners continued to strive for a timely and robust public health response during refugee emergencies and ongoing operations. Strengthened weekly surveillance of health indicators during emergencies and monitoring of programs contributed to effective health interventions.

Globally, the average under-five mortality rate was maintained at 0.4 per 1000 under five populations per month. This is in spite of large influxes of refugees from Myanmar, South Sudan and the Democratic Republic of Congo, into the neighboring countries. It is recognized that there is underreporting of mortality to varying degrees and efforts are being made to improve this.

UNHCR and its partners successfully contributed to the management of multiple outbreaks including cholera (Kenya, Uganda, and Sudan), malaria (Uganda), measles (Angola, Bangladesh), diphtheria (Bangladesh), typhoid (Rwanda) and monkey pox (Republic of Congo).

The leading causes of under-five deaths were reported to be watery diarrhea (21.2%), lower respiratory tract infections (20%), neonatal deaths (17.7%), malaria (10.7%), and acute malnutrition (7.8%). In the 21 countries where UNHCR and its partners use the HIS, 8 million consultations were conducted at 361 health facilities, 90% of these were diagnosed with a communicable disease. Upper respiratory tract infections (23.4%), malaria (18.2%), lower respiratory tract infections (11.3%), skin conditions (5.7%) and watery diarrhea (4.9%) were the top five causes of morbidity in 2017. Together with Ministries of Health – UNHCR continues to promote and support an integrated approach that reinforces the right to health and builds upon national health service delivery mechanisms. This principle was reflected in the development of the draft global compact on refugees and in the development of a resolution on a framework of priorities and guiding principles on the health of refugees and migrants which was endorsed at the World Health Assembly (WHA) in May 2017. Progress on integration of refugees into national health systems was made in Ghana, where the enrolment process into the national health insurance scheme was concluded, and refugee health facilities were handed over to the Ghanaian Health Services. Similarly, Iran has entered the fourth project cycle of health financing for Afghan refugees, who are now allowed to enroll in the national health insurance system. The Department of Health of Pakistan included refugee children living in settlements into their immunization targets after UNHCR’s investment in enhancing the cold chain capacity as an important step towards full integration in immunization service delivery for 2018. Community-based health insurance schemes under national regulations are under way in 8 other countries. UNHCR is working in partnership with ILO’s Social Protection staff to explore opportunities for integration and support country operations to develop integration strategies.

UNHCR also participated in the development of a new GAVI policy launched in 2017 that offers greater flexibility and tailored support in vaccine provision to countries hosting refugees, further enhancing integration and sustainability.

The UNHCR non-communicable disease (NCD) project has entered its second phase with an aim to scale up the management of chronic diseases at primary care level through targeted capacity building of partners, linkages to national programmes and improvements in health service provisions. Based on lessons learnt from the first phase (2013-2016) the project was expanded to include an updated evidence-based NCD toolkit with training-of-trainers manuals and clinical tools. The methodology was expanded to include continuous learning approaches. The training was successfully conducted in Algeria and Rwanda in 2017 and will continue to expand in 6-8 operations in 2018/19.

Mental Health and Psychosocial Support

In 2017, the number of mental health consultations increased in absolute numbers to 177,287, almost doubling from figures of 2014. This can mainly be attributed to the introduction of the WHO/UNHCR mhGAP Humanitarian Intervention Guide to promote integration of mental health in primary health care. Since 2015, in partnership with the War Trauma Foundation UNHCR has organized trainings for mhGAP capacity building in various countries including Algeria, Bangladesh, Cameroon, Chad, Republic of Congo, Democratic Republic of Congo, Ethiopia, Kenya, Tanzania and Uganda.

The majority of mental health consultations were related to epilepsy/seizures (46%) and for severe mental disorders such as psychosis and bipolar disorder (20%). The percentage of people seen for common mental disorders such as depression, anxiety, PTSD and other psychological complaints remains low (27%) compared to the expected prevalence of these conditions. This underscores the need for continued capacity building on scalable psychological interventions (these consist of structured manualized therapies of 4 – 8 sessions to be delivered by non-specialists) in primary health care settings, which will be the focus in the coming year.

The number of consultations related to alcohol and substance use is low (3%) which is indicative of the lack of options for identification and therapy of such disorders in general health care settings.
In order to provide adequate protection and assistance to women and girls and men and boys, UNHCR commits to support all components of reproductive health, prioritizing the most impactful and feasible interventions at the onset of an emergency while moving rapidly to more comprehensive services to cover the needs and rights of women and girls and men and boys.

In 2017, 83% of country operations using the UNHCR Reproductive Health Information System achieved at least 90% of deliveries occurring in health facilities (an increase from 67% of operations in 2014). However, only 22% of those operations reached more than 90% coverage of at least four antenatal visits but only 44% reached 90% coverage of three postnatal visits within 6 weeks of delivery (global average of 83%). Efforts will continue to be made to strengthen coverage and quality of antenatal and postnatal care and key associated interventions.

In 2017 a practical guide on adolescent sexual and reproductive health in refugee situations was piloted in two countries in 2017, Tanzania and Rwanda. The aim is to guide UNHCR and partner staff to develop programmes ensuring adolescent’s rights to access sexual and reproductive health information and services. Additionally, an assessment was conducted on the situation of refugee women and men involved in sex work in refugee camps in Malawi and Mozambique to provide practical guidance for improving the response to, and prevention of, the health and protection needs of sex workers in humanitarian settings.

UNHCR conducted a review of HIV prevention policy and practices in 10 country operations to provide evidence-informed recommendations on HIV prevention practices. The assessment and recommendations focused on HIV counselling and testing, Prevention of Mother to Child Transmission, behaviour change programmes, laboratory support and voluntary medical circumcision. Gaps identified in these areas will be addressed in 2018.

UNHCR has over 10,000 eligible refugees on ARTs in its supported operations. Approximately 85% of the women who attended antenatal care were tested for HIV, as part of efforts to eliminate mother to child transmission. Additionally, with funding received from UNAIDS, 16 UNHCR country operations were supported to address gaps in HIV and reproductive health programming, which contributed to:

- 192 refugees continued or started on ART in Malaysia;
- More than 9,000 people accessed HIV counselling and testing services in Pakistan, and more than 133,000 syringes and 80,000 condoms were distributed to persons who inject drugs (refugees and nationals);
- in Zambia UNHCR 247 people living with HIV were supported through supplemental feeding, livelihood and income generating projects, about 15,000 received HIV testing and counselling (HCT) and received their results, about 50,000 were reached with HIV prevention programs, and more than 2,000 males were circumcised through outreach community programs;
- In Tanzania more than 100,000 male and female condoms were distributed in the different refugee communities including transit centres and more than 1,500 refugees were supported to access ART services;
- In Rwanda more than 1.3 million condoms were distributed through condom boxes, camp clinics and community mobilisers combined with education programmes on HIV prevention; more than 17,000 refugees were supported to access HCT services.
Global acute malnutrition (GAM) is one of the main nutrition indicators tracked for the purposes of determining needs and for monitoring health status. In 2017, 61 of 98 surveyed sites (62.2%) met the GAM standards of < 10%, whilst 21/98 (21.4%) were above the emergency threshold of ≥ 15%. Out of these 21 sites 12 are ongoing emergency situations.

Comparing the 2017 results to previous years, improvements in GAM were remarked in 8/88 (9.1%) sites. Deterioration in GAM was noted in 7/88 (8.0%) sites, including in Bangladesh following the massive Rohingya influx, in Chad in the 4 northern-most camps in the East, and in Ethiopia amongst the Gambella and Assosa camps.

In order to have a more comprehensive understanding of the longer term nutrition status of refugee children, and a three-dimensional vision of nutritional status, UNHCR also considers stunting and anaemia to be of critical importance. One in three sites 32/98 (32.7%) registered stunting prevalence amongst children 6 – 59 months of age above the critical level of ≥ 40%. The proportion of sites meeting stunting standards has remained stable between the end of 2016 and the end of 2017. The majority of sites, for which we have previous data for comparative purposes, show however that the prevalence of stunting is persistently high with no significant change (66/88 sites 75.0%). Improvement in stunting was noted in 17/88 sites (19.3%) in Bangladesh, Burkina Faso, Chad, Djibouti, Eritrea, Ethiopia, Kenya, Uganda and Zambia.

Anaemia in children 6 – 59 months old is used as a measure of iron deficiency and general micronutrient status. Only 3/97 (3.1%) met the standard of <20%, whilst 45/97 (46.4%) were under the critical level of < 40%. This means that over half of the sites 52/97 sites (53.6%) exhibited anaemia levels over the critical ≥ 40% threshold. The majority of sites, for which we have previous data for comparative purposes, show that the prevalence of anaemia is stable but persistently high (55/86 sites 64.0%). However it is concerning that in 16/86 sites (18.6%) anaemia is significantly higher than in previous surveys.

Improving the prevention of under-nutrition and micronutrient deficiencies in addition to managing the existing cases of malnutrition as best as possible, is a priority for UNHCR. The new nutrition and food security road map, developed in late 2017 and currently undergoing external review aims at providing guidance as to effect positive change for improvement in nutrition status in refugee populations. Promoting and supporting adequate Infant and young child feeding (IYCF), remains a major effort in improving nutrition as does working in synergy with other sectors. In line with this, the Infant and Young Child Friendly Framework, which aims to bring multiple sectors together around the theme of improving young child and infant survival and improving growth and development, was rolled out further in East Africa and during the emergency in Bangladesh in 2017.

A key challenge to maintaining refugee nutritional status is the increased food insecurity faced by many refugee populations. Due to growing numbers in need and limited resources, WFP has not been able to provide the standard amount of food assistance to several countries including Chad, Cameroon, Djibouti, DRC, Ethiopia, Mauritania, Rwanda, South Sudan, Tanzania and Zambia. Additionally, UNHCR budget constraints have resulted in limited delivery of other basic assistance. With limited opportunities to work and lack of land in many contexts, refugees are forced to resort to negative coping strategies and risky behaviours to meet their basic needs. In addition to the concerning protection situation, potential deterioration of the nutrition situation is of particularly concern in Chad, Djibouti, and Ethiopia given the already high levels of GAM.

In conclusion, UNHCR remains extremely concerned about the continued high levels of anaemia and persistently high levels of stunting and GAM in many refugee operations alongside the continued cuts to food and other basic assistance. UNHCR is working on several fronts to address this including:

1. The distribution of specialized nutritious products in key operations coupled with relevant multisectoral programming (e.g. WASH, malaria prevention and treatment, deworming, improved IYCF and maternal and child health),
2. Promotion of the IYCF framework,
3. Monitoring of and advocacy for well-balanced food rations (adequate quantity and quality) where provided in-kind (including the provision of fortified blended foods),
4. Improving the methods of data collection and reporting to inform improved decision making and advocacy, the SENS will be revised in 2018.
In line with the 2014 – 2018 Global Public Health Strategy and working towards SDGs, UNHCR is ensuring that refugees have access to safe water of sufficient quality and quantity and to access hygienic sanitation services, both at home and at institutions including schools and health facilities.

Access to quality WASH services will reduce morbidity and mortality and enhance protection, dignity and quality of life. Participatory approaches with refugee communities are used to make sure their needs are met by our interventions. In addition UNHCR is committed to durable WASH solutions which are efficient in reducing long term operational costs and environmental impacts, without compromising quality.

The average litres per person per day globally was at 21 litres. Where possible, high yield boreholes coupled with solar energy have been used to provide water to refugees through chlorinated gravity fed distribution systems. An average latrine ratio of 22 persons per latrine was achieved globally, which is just below standard and represents an improvement from 2016.

In order to keep on improving WASH services delivery to refugees, UNHCR focuses on the development of key guidance documents to be used globally. In 2017, it published a pocket-sized WASH Manual that is being used in all operations by colleagues and partners. Hygiene Promotion Guidelines as well as recommendations on the use of cash based interventions for WASH programmes in refugee settings have been disseminated.

With the objective of reducing global WASH related costs, the development of guidelines on the use of solar power for groundwater extraction as well as direct technical support to a number of countries (including Sudan, Chad and Mauritania) have been prioritized, with a view to capitalizing on these experiences and lessons learnt to scale up these initiatives to other operations. A waste-to-value project has been conducted in Ethiopia and Kenya, piloting low-cost sanitation technologies in difficult ground environments, with an aim to develop Standard Operating Procedures that provide solutions for the reuse of the waste.
Public Health
2017 ANNUAL GLOBAL OVERVIEW

DISEASE PROFILE
Proportion of all consultations

8,033,571 Total number of consultations in 21 countries

Communicable diseases (8,006,222) 92.8%
Non-communicable diseases (332,492) 3.9%
Mental Health (141,221) 1.6%
Injuries (143,732) 1.7%

UNDER-FIVE MORTALITY
Deaths/1,000/month (lowest-highest rates)

[Graph showing deaths per thousand for different countries]

Country overview

Under-five mortality

Deaths/1,000/month (Standard <1.5)

Some sites exceeded the standard for under-five mortality.

Health utilisation rate

New visits/person/year (Standard 1-4)

MEASLES COVERAGE
Proportion received measles vaccination (Standard ≥95%)

NR: Not reliable NA: Not available

Cholera Epidemic in Adjumani Camp, Uganda

Large scale population movements, such as the one experienced in Uganda in 2017, and associated breakdowns in water, sanitation and hygiene combined with overcrowding increase the risk of cholera transmission.

The index case was a 16 year old boy seen at Elegu Medical Screening Centre, who was immediately isolated; laboratory samples tested positive for Vibrio Cholera 01 Inaba. In total, 98 cases were identified and treated in the camp. No deaths were reported among the cases. This was attributed to the timely identification and proper case management, multi-sectoral prevention activities including chemoprophylaxis for contacts; decongestion of reception centres; improvement in water quality and quantity; additional latrines construction and proper usage; provision of adequate hand-washing facilities including soap; decontamination of infected shelters, latrines/surfaces; social mobilization - health education on prevention and control measures and distribution of ORS and training community on appropriate usage.
In December 2017, a two-year project supported by the Bill and Melinda Gates Foundation "Saving Newborn Lives in Refugee Situations" was completed. This aimed to improve neonatal and maternal health care services focusing mainly on key low cost, high impact newborn interventions in refugee camps in South Sudan (Sudanese refugees), Kenya (Somali refugees) and Jordan (Syrian). Refresher trainings were provided to qualified health care providers including midwives, nurses and doctors on comprehensive maternal and newborn care, and community health workers (CHWs) were trained to follow up newborns and mothers on days 1, 3 and 7 post-delivery. The final evaluation showed important improvements in the technical capacity of health providers, with positive learnings from supervisory visits: better follow-up care for mothers and new-born by the CHWs addressing harmful community practices and improved care for small and sick new-borns including increased acceptance and practice of kangaroo mother care, a low cost but high impact intervention.
**Deteriorating Nutrition Outcomes and Increased Protection Concerns in Eastern Chad**

In the four northernmost refugee camps of Eastern Chad Oum Cassoni, Am Nabak, Intedir and Touloum, all three main nutrition indicators of GAM, stunting and anaemia were classified as either deteriorating or remaining persistently high. The context is one of decreasing food assistance in these camps since 2013 and a severe lack of livelihood opportunities as alternatives for the refugees to maintain adequate food security. UNHCR initiated a programme to supplement the youngest children with a low quantity lipid based nutrient supplement (LQ-LNS) in mid-2013 in response to high levels of GAM, stunting and anaemia and despite the cuts in food assistance and other budget reductions have managed to maintain a fairly healthy pipeline of this product over the years. The prevalence of GAM, stunting and anaemia had subsequently decreased, until 2015 when GAM in all camps showed an increase. Stunting levels increased after 2016 surveys in 3 out of 4 camps. Anaemia was persistently high (between 30-40%) with some unclear trends towards decrease/stabilization.

Concerns over these deteriorating nutrition indicators prompted a series of studies evaluating the LQ-LNS programme. The results of these studies (forthcoming) highlight that refugees have resorted to extreme coping mechanisms faced with the decreasing food and non-food assistance over the past years. Many of the negative coping practices revealed during the studies directly have resulted in refugees with heightened protection concerns including incidents of sexual exploitation for women and children and increases in domestic violence, and organized emigration to third countries for economic reasons.

In addition to the programme evaluation UNHCR together with ACF conducted a nutritional causal analysis in some of the camps in Chad to better understand the determinants leading to the deteriorating or persistent nutrition indicators. In the case of Am Nabak for example, the triangulation of the findings showed that sale of food assistance, poor access to drinking water, and poor sanitary conditions, as well as the heavy women’s workload for women and poor infant feeding practices were amongst the major causes of malnutrition in this context.
WASH PROFILE
Proportion of sites meeting the standard

Country overview

WATER ACCESS (Litres/person/day) (Standard ≥ 20)
SANITATION ACCESS (Persons/latrine) (Standard ≤ 20)
Countries with sites not meeting standards (Water Access < 10; Sanitation Access > 50)
Countries with sites borderline (Water Access 10-19; Sanitation Access 21-50)

Rapid Method for Assessing WASH Services in Emergencies

UNHCR is scaling up its capacity to respond to emergencies in the most efficient manner. A Rapid Method for Assessing WASH Services in emergencies was rolled out during the year. This rapid assessment provides quality data to guide decisions that allow field practitioners to adapt and target their activities at short notice to provide persons of concern with life-saving support. Mapping of infrastructure linked with groundwater monitoring through emergency hydrogeological studies and geophysical studies have also proved to be highly beneficial in both Uganda and Bangladesh, allowing for boreholes to be drilled in locations with greater probability of higher yields. This saves precious time and resources and permits the delivery of up-to-standards quantities of water to refugees in the early phases of the influxes, reducing the need for water trucking and related issues.