



2020 Annual Public Health Global Review

Acronyms and abbreviations

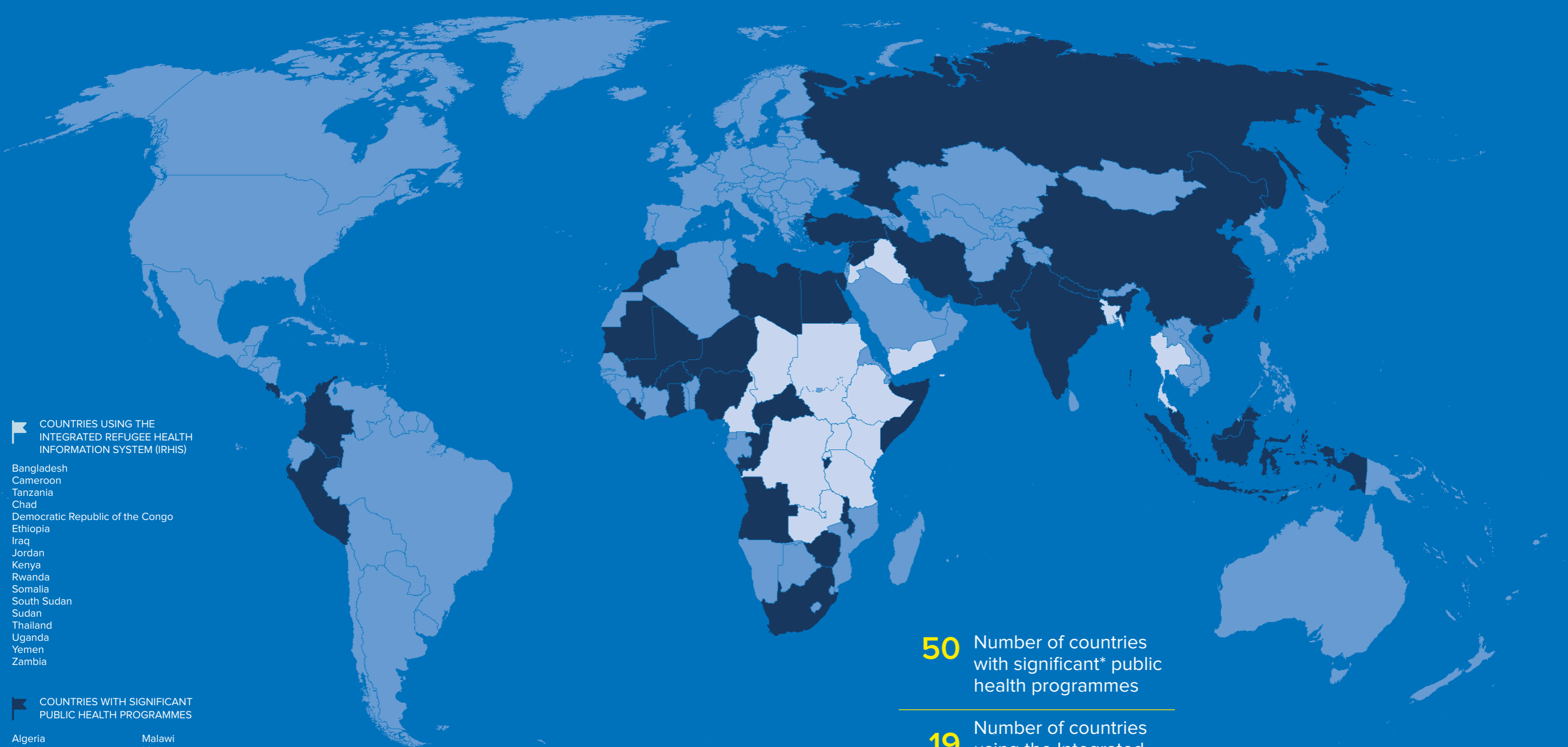
ANC	Antenatal Care
ANM	Anaemia
BSC	Balanced Score Card
CHW	Community Health Workers
GAM	Global Acute Malnutrition
GCR	Global Compact on Refugees
HFUR	Health Facility Utilisation Rate
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
IPT	Interpersonal Therapy
iRHIS	Integrated Refugee 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	Noncommunicable 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 Attendance
SDG	Sustainable Development Goal
TB	Tuberculosis
U5MR	Under 5 Mortality Rate
WHO	World Health Organization

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OVERVIEW



COUNTRIES USING THE INTEGRATED REFUGEE HEALTH INFORMATION SYSTEM (IRHIS)

- Bangladesh
- Cameroon
- Tanzania
- Chad
- Democratic Republic of the Congo
- Ethiopia
- Iraq
- Jordan
- Kenya
- Rwanda
- Somalia
- South Sudan
- Sudan
- Thailand
- Uganda
- Yemen
- Zambia

COUNTRIES WITH SIGNIFICANT PUBLIC HEALTH PROGRAMMES

- | | |
|----------------------|--------------------------|
| Algeria | Malawi |
| Angola | Malaysia |
| Syrian Arab Republic | Mali |
| Burkina Faso | Mauritania |
| Burundi | Central African Republic |
| China | Morocco |
| Congo | Turkey |
| Djibouti | Peru |
| Egypt | Nepal |
| Iran | Niger |
| Colombia | Nigeria |
| Ghana | Pakistan |
| India | Russian Federation# |
| Indonesia | Somalia |
| Lebanon | Zimbabwe |
| Liberia | South Africa |
| Libya | Costa Rica |

50 Number of countries with significant* public health programmes

19 Number of countries using the Integrated Refugee Health Information System

159 Number of sites/ facilities using iRHIS

* countries with health programmes AND expenditure > 50,000 USD in the year AND >5,000 refugees/or people in refugee-like situations or Low/ Middle Income Countries with > 150,000 refugees / asylum seekers



1. Public Health

UNHCR aims to ensure healthy lives and promote wellbeing of its persons of concern, enabling them to access safe, effective, equitable and affordable health care services. UNHCR supported access to comprehensive primary health care services as well as referral to secondary and tertiary care for refugees in 50 countries hosting 16.5 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.

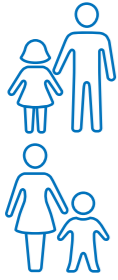


UNHCR works with nearly 150 NGOs and other partners in collaboration with and support to national health systems.

At the end of 2020, UNHCR had 153 public health, reproductive health, MHPSS (Mental Health and Psychosocial Support) and nutrition personnel globally with 88% percent working at country level.

The integrated Refugee Health Information System (iRHIS) is used by UNHCR and partners in 19 countries and 159 refugee hosting sites. Health information for refugees in other countries was collected through national health systems which mostly do not allow for disaggregated data. Enhancements were made to the system and modules integrated to facilitate COVID-19 case reporting amongst PoC.

A significant focus of 2020 was preparedness and response to the global COVID-19 pandemic. UNHCR worked with national authorities to include refugees and other persons of concern in national response plans; facilitate access to information on prevention as well as access to testing and clinical care. In many refugee hosting countries this included support to national health systems, increasing testing capacity through procurement of tests and support to laboratories, establishment of isolation facilities in government or camp health facilities, training of staff, procurement of essential medicines and supplies, including personal protective equipment (PPE) and oxygen concentrators and engagement with and communicating with communities. Community health workers played a critical role in many settings by providing vital information to communities as well as assisting in detection of cases, referrals, follow-up and tracing of contacts.

KEY INDICATORS

	INDICATOR	2020	2019	STANDARD
	Total consultations in countries using iRHIS	7,562,609	7,167,197	
	Total Population of Concern in Countries using iRHIS	4,669,953	4,741,914	
	Health Facility Utilisation Rate	1,6 consultation per person per year	1,5	UNHCR/SPHERE standard 1-4
	Crude mortality rate	0,11 deaths per 1,000 per month	0,12	<0.75 deaths per 1,000 per month
	U5 Mortality Rate	0,19 deaths per 1,000 population under 5 per month	0,3	<1.5 deaths per 1,000 per month
	Skilled birth attendance rate	92%	90.7%	Target >90%

ENGAGING AND COMMUNICATING WITH COMMUNITIES

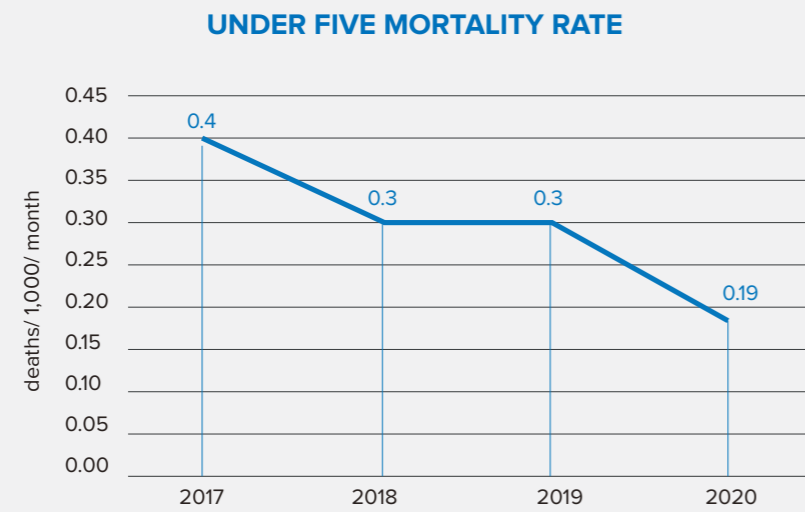
Refugees often do not have adequate access to health services due to lack of information, language, policy, or financial barriers. A community health workforce, comprised primarily of refugees, bridges gaps by providing no- to low-cost, culturally, and linguistically appropriate health information. Community health workers (CHW) serve as a gateway, via referrals, to primary or secondary healthcare.

Nearly one million Rohingya refugees from Myanmar live in Bangladesh's Cox's Bazar where 1,400 CHW provide assistance. Well before the first case of COVID-19 was detected in May 2020, CHW attended training and began disseminating prevention messages. Yet throughout 2020, fears and misperceptions about COVID-19 testing and treatment stopped many refugees with respiratory symptoms from seeking help. UNHCR and partners then developed new CHW information, education, and communication (IEC) materials on testing, quarantine, and isolation facilities. After training, CHW practiced active community-based surveillance to identify people with respiratory symptoms and provide targeted counselling to them and their families. CHW conducted weekly home visits to up to 83 percent of refugee households while the remaining households received biweekly visits. In addition, refugees who had recovered from COVID-19 shared their treatment experiences with local radio stations and community leaders. As a result of these community-based initiatives, the number of COVID-19 tests conducted in the camps increased from less than ten per day to more than 200. Testing and treatment have now become widely accepted.

Globally the COVID-19 pandemic had an impact on access to and utilisation of health services. At the onset of the pandemic with the first cases detected in respective countries, there was generally a reduction in outpatient consultations associated with fear of getting infected at facilities, the impact of lockdowns and reduction in movements, and as the health workforce was diverted to provide COVID-19 care.

Adaptations were made to ensure continuity of safe access to essential services, particularly safe deliveries, as well as adaptations to ensure continuity for those with chronic care needs such as TB and HIV, including dispensing 2-3 months of medicines supply and remote follow-up for stable patients.

As lockdowns and restrictions were lifted, access and utilisation of health services increased. Overall, the health facility utilisation rate remained within acceptable ranges over 2020 compared to 2019, despite periodic decreases in utilisation.



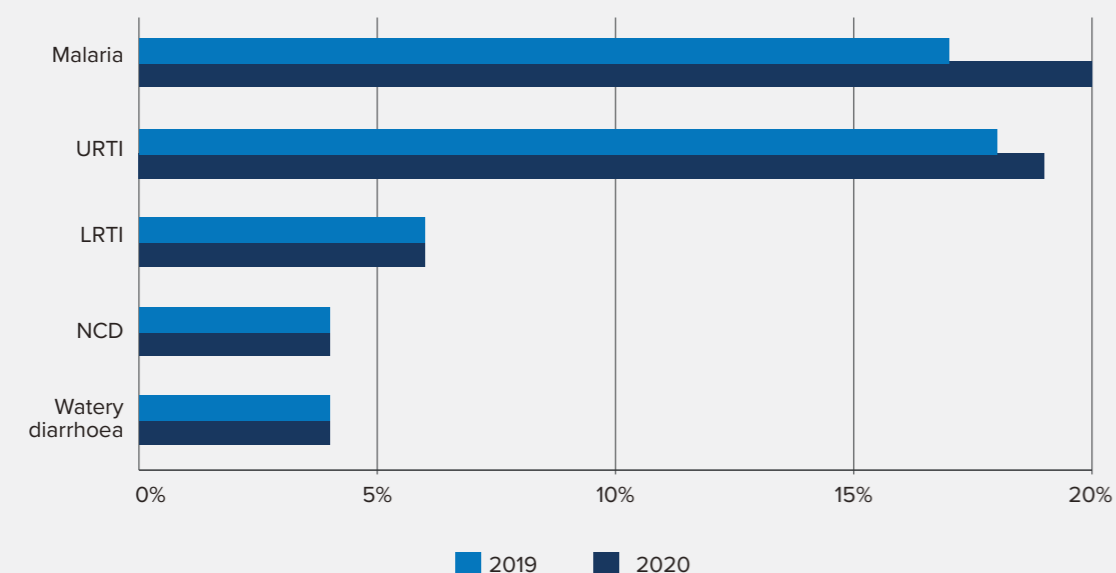
Morbidity and Mortality

The average crude mortality rate was 0.11 deaths per 1,000 total population per month, similar to that reported in 2019 (0.13 deaths/1,000 population).

The under-5 mortality rate was an average of 0.19 deaths per 1000 under five population per month, across 159 sites in 19 countries compared to a rate of 0.3 in 2019. The trend shows a progressive reduction over time.

The most common causes of morbidity were malaria (20%), upper respiratory tract infections (19%), and lower respiratory tract infections (6%), similar to 2019. NCD and mental health consultations accounted for 4% (333,011) and 2% (142,971) of outpatient consultations respectively.

TOP 5 CAUSES OF MORBIDITY 2019 AND 2020



COVID-19 Morbidity and Mortality

There were 41,401 cases of COVID-19 amongst persons of concern reported to UNHCR in 2020 and 401 deaths, a case fatality rate of 0.97%. Although this is similar to case fatality rates reported elsewhere it is recognized that there is significant under-detection and under-reporting of both cases and deaths.

COVID-19 CASES AMONGST PERSONS OF CONCERN	DEATHS DUE TO COVID-19	CASE FATALITY RATE
41,404	401	0,97%

With the announcement of several promising COVID-19 vaccines in the latter part of 2020, focused advocacy efforts were made at country, regional and global levels to ensure refugees and other persons of concern were included in national plans for roll-out. UNHCR participated in an Interagency Working Group to develop the principles and design of the Covax Humanitarian Buffer—an allocation of doses within the Covax facility as a last resort mechanism for humanitarian affected populations who may have been excluded from national vaccine rollout.



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Mental Health

The COVID-19 pandemic increased the [levels of psychological distress among refugees](#), while delivery of and access to services was much more complicated. During periods of movement restrictions and lockdowns, activities that were less essential had to be scaled down or suspended while new interventions and innovative ways of service delivery had to be developed. UNHCR co-chaired the inter-agency working group that produced [IASC-endorsed guidelines for continuation and adaptation of MHPSS services during the pandemic](#). For example, messages about coping with distress were distributed through [community volunteers](#) and social media. Many first responders were trained in Psychological First Aid and other [basic psychosocial skills](#). In some countries such as Greece, Lebanon and Uganda, psychological support to refugees was provided through helplines. Telephone and internet were increasingly used as modalities to provide [psychotherapy for refugees](#) with mental health issues such as depression, anxiety, post traumatic stress, and bereavement. Within MHPSS

programming a priority was to ensure continuous care for persons with moderate to severe mental health conditions. They should continue to have access to clinical and other services, through primary health care facilities with trained and supervised health workers, or through dedicated mental health programmes. Some services could be delivered through remote support, but in many cases, direct person-to-person support could continue in safe ways by more extensive use of community-based workers and by adapting facility-based care to prevent infections. Data from the iRHIS demonstrate that while the absolute number of consultations decreased, the percentage of primary care consultations dedicated to mental health remained stable at around 2%.

CAPACITY BUILDING TO HELP REFUGEES WITH DEPRESSION

Interpersonal psychotherapy (IPT) is an evidence-based therapy that can help people with depression and post-traumatic stress disorder (PTSD). WHO and UNHCR recommend its use as part of their [mhGAP Humanitarian Intervention Guide for Clinical Management of Mental Neurological and Substance Use Conditions in Humanitarian Emergencies](#). However, refugees often reside in areas where there are no skilled psychotherapists, and even if they are there, refugees face challenges related to access, language and culture. In order to increase the local capacity to provide scalable psychological interventions in resource-constrained settings, UNHCR embarked on a multi-year partnership with the [Global Mental Health Lab \(GMH Lab\)](#) at Teachers College, Columbia University New York to introduce IPT in Bangladesh (Rohingya refugees), Tanzania (Congolese and Burundian refugees) and Peru (displaced Venezuelans). In 2020, the experts from New York worked intensively with 50 mental health providers in the three countries through online trainings and weekly supervision in small groups. Preliminary results suggest that patients with depression are improving and function better in their social environment. The mental health providers see the intervention as relevant and useful in their contexts and found the interpersonal focus of the therapy well-suited to the cultural and social strengths of refugees and appropriate to the mental health challenges that refugees face.

Non-Communicable Diseases (NCDs)

Non-communicable diseases are recognized as an increasing cause of morbidity and mortality in humanitarian settings. Capacity strengthening focused on integration of NCD care into primary health care and adaptations to COVID-19. UNHCR continued to convene the informal interagency working group on NCDs in emergencies and along with IRC published operational guidance on [Integrating Non-communicable Disease Care in Humanitarian Settings](#) in collaboration with the group.

In light of COVID-19 restrictions support was provided to countries on continuity of NCD services including through webinars, provision of guidance on NCDs and COVID-19 and continuity of services and through the community of practice. Adaptations were made to ensure continuity of care for persons living with NCDs including dispensing medicines for 2-3 months for stable patients and remote follow-up where possible.

ENSURING CONTINUITY OF ESSENTIAL HEALTH SERVICES, NCD CARE IN JORDAN

People living with noncommunicable diseases (NCDs) face chronic health issues and often require life-long care. They are also at increased risk of becoming severely ill with COVID-19. Yet, the COVID-19 pandemic disrupted essential health services worldwide. Disruptions in NCD treatment can often have devastating health consequences, including severe disability and premature deaths.

Jordan is host to the second-largest share of refugees per capita. As the country went into lockdown in March 2020 due to COVID-19, health providers rapidly put in place measures to ensure continuity of treatment for 425 refugees living in urban areas and 6,502 refugees living in camps. Refugees in urban areas whose health was already stable and managed via treatment received telephonic guidance and a three-month supply of individually packaged medicines. UNHCR arranged special government approval for a transportation company to make household deliveries of medicines. After lockdown, patients were contacted for a physician review and adjustment of medication if needed. A challenge and lesson learnt was the lack of glucometers and testing strips for diabetic patients to improve self-monitoring at home.

Working with national health systems

Social health protection and universal health coverage (UHC) improve health status and contribute to the Sustainable Development Goals (SDGs), in particular targets under SDGs 1, 3 and 8 to reduce mortality and morbidity at all ages, reduce poverty, hunger and malnutrition and improve livelihoods. Since 2014, the ILO and UNHCR have been collaborating on the extension of social health protection to refugees. [Experiences, learnings and practical tools](#) were published in 2020 and collaboration continued on assessing the prospects for inclusion of refugees in national social health protection schemes in a number of countries in the Middle East and East and Horn of Africa as part of the [Partnership for improving prospects for forcibly displaced persons and host communities \(PROSPECTS\)](#)

SUPPORT TO NATIONAL SYSTEMS DURING COVID-19

In line with the GCR to ease the burden on host communities UNHCR supported national systems in a number of countries including Lebanon, Jordan, Bangladesh, Egypt and Uganda. In Lebanon UNHCR supported the establishment of 100 COVID-19 Intensive Care Unit (ICU) beds and 319 regular COVID-19 beds in 12 hospitals across Lebanon in support of the national response. In Bangladesh UNHCR established an ICU in the district hospital through refurbishment of an empty ward, installation of piped oxygen, hiring human resources and providing equipment, medications and supplies; UNHCR also established and equipped two Severe Acute Respiratory ICTs.

Depending on the context and the location of refugees there may be a need for expanded modalities to finance access to health care. UNHCR continued to support **cash assistance** to facilitate health service access in selected countries including Jordan, Egypt, Iraq, Mexico and other countries in Latin America. [The Role of Cash Assistance in Financing Access to Health Care in Refugee Settings and other Persons of Concern to UNHCR](#) was published in 2020 providing an overview of health financing mechanisms and the specific role cash assistance can play in financing access to health services in refugee settings and for other PoC to UNHCR.

In line with the Global Compact on Refugees UNHCR continued to work with ministries of health to promote **greater inclusion** of refugees and other POCs into national health policies, plans, funding proposals and services. UNHCR is tracking this in 48 countries globally with the [Public Health Inclusion Dashboard](#). The importance of this was demonstrated with the COVID-19 response with the majority of refugee hosting countries adopting inclusive approaches.

Pharmacy Management Capacity building

Access to affordable, quality-assured essential medicines reduces the financial burden of health care, reduces pain and suffering, shortens illness duration, and

averts preventable disabilities and deaths. Access to essential medicines is also necessary to achieve UHC and the SDGs. Medicines are potentially high-cost items that are easily diverted or misused or can fail to meet quality standards without appropriate systems in place. To strengthen medicines management in UNHCR and partner facilities, UNHCR has been providing in-country and remote technical support, partnering with QUAMED, a specialist NGO working on quality assurance system assessments, to do local pharmaceutical market assessments, developing pharmacy management monitoring tools and undertaking capacity building. Tools developed included standard operating procedures on medicine management at UNHCR, and monitoring checklists for pharmacies in health facilities and central medical stores.

Medicines and Medical Supplies Management for COVID-19 response

In response to COVID-19, a list of essential medicines and medical supplies for the prevention, diagnosis and case management was updated. The operating environment was challenging during the first phase of the pandemic due to supply chain and transport limitations. Quality assurance was provided for products procured including for any local procurement in case international procurement was not possible. Some limited stockpiles of PPE were kept for mobilization in case of urgent country needs. In addition, forecasting and ordering was done for regular medical services to avoid stock outs and ensure continuity of services.

TANZANIA: STRENGTHENING PHARMACY MANAGEMENT

Medicines are essential for treating acute and chronic health conditions. In humanitarian settings, however, accessing lifesaving medication is often very challenging. Refugees are particularly vulnerable to interrupted or lack of medication due to multiple displacements or limited access to health services.

In northwest Tanzania, all the three refugee camps (Nyarugusu, Mtendeli, and Nduta) face severe pressure as overcrowding continues to hamper humanitarian efforts. Yet, in 2020, UNHCR and health partners provided 593,847 health consultations.

In 2020, pharmacy staff in Tanzania's Nyarugusu and Mtendeli camps and Ngaraganza Medical warehouse implemented new UNHCR-designed standard procedures and monitoring tools that reduced shortages, eliminated expired medicines, and optimized consumption reporting. In addition, UNHCR led the "Drug and Therapeutic Taskforce," composed of UN agencies and health implementing partners. Taskforce members meet quarterly to review reports, identify gaps, and propose preventative or corrective action. These initiatives led to greater collaboration, improved standardized management, and increased availability and access to uninterrupted essential medicines and medical supplies.¹



Pharmacy management training for Nyarugusu Camp pharmacy staff
@ UNHCR/Ahmed Abdurahman HAJIKEDIR

¹ Uddin, A., & Sumi, H. (2019). The story of a Rohingya refugee: becoming a community psychosocial volunteer. *Intervention, 17*(2), 296.



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2. SEXUAL AND REPRODUCTIVE HEALTH & HIV

Access to integrated comprehensive sexual and reproductive health (SRH) services remains a priority for UNHCR to enhance the wellbeing of women, men, girls and boys. In 2020, access to health services was impacted globally by COVID-19. SRH service provision, as a critical service area, continued uninterrupted throughout the year while adjustments were made to facilitate safe service provision. Nevertheless, several country operations saw a temporary decline in the uptake of preventive services such as antenatal care. Intensive community engagement by refugee volunteers and health staff contributed to building confidence in health services, leading to an overall increase in the uptake of SRH services when compared to 2019.

2020
19 countries

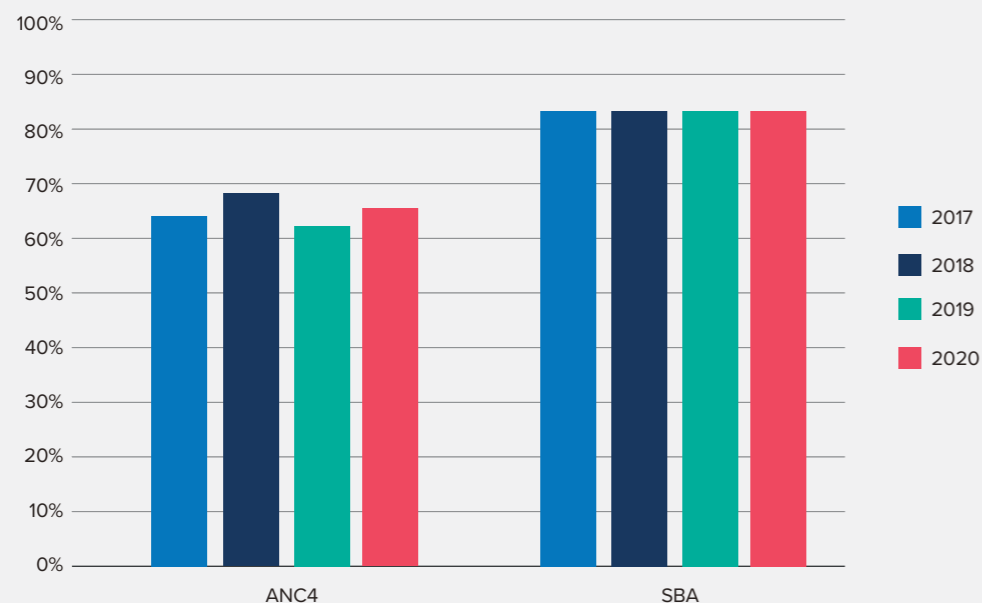
112,130
Number of live births

92%
Percentage of deliveries assisted by SBA

In 2020, 112,119 **live births** were reported from 159 refugee settlements in 19 countries, a similar level to 2019 (108,545 live births). The overall skilled birth attendance remained at similar levels (92.0% in 2020). Disparities remain between countries, with only 12 countries (63% of countries) achieving the minimum standard of more than 90% skilled birth attendance.

The overall uptake of antenatal care (ANC) services increased by 6 percent in comparison to 2019, a total of 489,452 consultations were provided in comparison to 462,694 consultations in 2019. Similarly, the percentage of women who accessed at least four ANC visits increased from 69.6% in 2019 to 73.1% in 2020, with three countries reaching a coverage of more than 90%. Nearly three quarters of women (72.4%) attended the recommended three PNC visits within 6 weeks compared to 64.1% in 2019.

SKILLED BIRTH ATTENDANCE, ANC 4 COVERAGE 2017- 2020



Neonatal deaths 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. **Maternal deaths are reported and reviewed** in refugee operations and the overall mortality reporting system has been strengthened at facility and community level. Nonetheless, as in many countries it is recognised that neonatal and maternal deaths are underreported in refugee settings. A detailed analysis of 83 maternal death reviews in refugee camps in East and Horn of Africa revealed gaps in systematic, standardised reporting. In response UNHCR updated the [Maternal Death Review](#) Guidance. Capacity strengthening will continue in order to improve timeliness and quality of maternal death reviews and ultimately improve services. A three-year project supported by the Bill and Melinda Gates Foundation which focuses on low-cost high-impact activities to reduce maternal and neonatal deaths is being implemented in Cameroon, Chad and Niger and learnings are shared with operations globally.

Community engagement efforts were further strengthened in 2020 to contribute to trust building in health systems during COVID-19 and to enhance uptake of skilled birth attendance, antenatal and postnatal care. Community Health Workers (CHWs) engaged with women and men as well as community leaders to improve awareness, strengthen linkages between the community and health facilities and enhance health service utilisation. In several countries former traditional birth attendants are engaged as agents of change and counsel and accompany women to health facilities for social support during labour.

During 2020, UNHCR continued protection related activities relating to HIV globally and supported specific HIV-related activities in more than 50 countries, including the focus on continuity of HIV services during the COVID-19 pandemic. This included activities to protect refugees from exposure to COVID-19 (the provision of multi-month refills of ART for people living with HIV); and

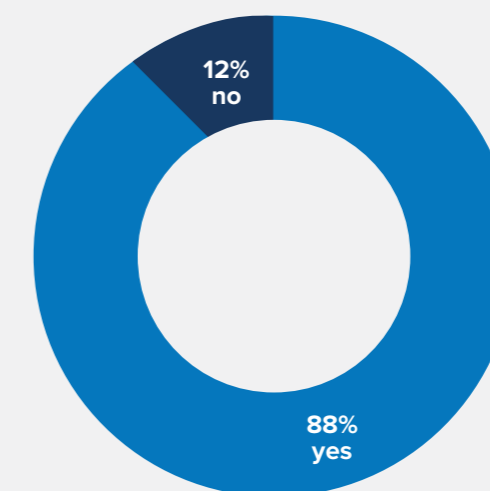
adapting delivery mechanisms for essential HIV services through community networks to prevent treatment disruption and ensure continued access to condoms and lubricants.

In 2020 UNHCR supported HIV counselling and testing to more than 500,000 people. In addition over 150,000 pregnant women were tested for HIV and at least 14,526 persons were on antiretroviral treatment. HIV testing and care services supported by UNHCR are accessible to refugees and host communities alike. For example in Uganda, more than 224,300 people were provided with HIV counselling and testing, of which 37% were host community members. Operations focused on increasing the capacity of community health workers to address key priorities including training in outreach for TB/HIV, improving services for adolescents and young people, improving services for key populations including sex workers, and improving retention in care. Key partners in both HIV and TB related activities included UNAIDS, the Global Fund for HIV, TB and Malaria and the Intergovernmental Authority on Development.

UNHCR supports services for the **clinical management of rape** and other forms of sexual violence. This includes the provision of post-exposure prophylaxis, emergency contraception and prophylaxis for sexually transmitted infections for survivors; psychosocial support and mental health services; and referral for legal and protection services as well as for specialised care.

WHO, UNFPA and UNHCR released [updated guidance](#) on the **clinical management of rape and intimate partner violence in 2019**. In 2020, the three agencies continued collaboration in developing and rolling out capacity building and sensitization on community awareness, a proactive approach to the identification of rape survivors; comprehensive and timely clinical care of survivors and linkages with relevant services, particularly protection.

RAPE SURVIVORS WHO SOUGHT CARE WITHIN 72H PROVIDED WITH PEP



UGANDA: MULTISECTORAL COLLABORATION TO ENHANCE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR ADOLESCENTS

Forced displacement can exacerbate issues already faced by adolescents. Displaced adolescents may have lost access to family, social supports, education, and health services. They need to be empowered to exercise their human rights to make informed decisions and give informed consent regarding sexual health, sexual relationships, and health services.

In 2020, UNHCR and Save the Children issued a [guidance tool](#) to address adolescent sexual and reproductive health (ASRH) needs in refugee situations. To operationalize the tool, the two organizations piloted a two-phased capacity building project in Bidibidi settlement, Uganda, where ASRH needs are high (girls under 18 years old represent 11.8 percent of deliveries compared to other camps in Uganda where they represent 3.3 percent).

Phase One of the pilot launched in 2020. It focused on training 36 health providers from 21 facilities and three youth representatives on knowledge, skills, and tools for ASRH responsive services in refugee settings. Participants developed action plans for mainstreaming ASRH, ASRH mentoring in health facilities, and creating ASRH committees. After the training, participants received ongoing mentorship to promote ASRH. Phase Two of the pilot is slated for 2021. It will scale up the project across refugee camps in Uganda through multistakeholder train-the-trainer workshops focused on designing multisectoral ASRH action plans.



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PARTNERING WITH LOCAL COMMUNITY SERVICE PROVIDERS TO BRING HIV SERVICES TO PEOPLE WHO SELL OR EXCHANGE SEX AND OTHER VULNERABLE POPULATIONS

Forcibly displaced people who sell or exchange sex or live with HIV face significant barriers to accessing health services. Their needs are often neglected, and they experience heightened risk of exploitation.

In Ecuador, over 2.2 million displaced Venezuelans have already passed through the country, and another 418,000 remain. Many arrived on foot, living for days and even weeks in precarious conditions. Up to 20 per cent of arrivals, including at-risk women, children, and persons with disabilities, had urgent protection needs and other vulnerabilities. While working with this population, UNHCR identified refugees who engaged in selling sex and developed community-based programming to assist them.

In 2020, UNHCR collaborated closely with local partners to strengthen community-based services for people who sell or exchange sex, young people and those living with HIV. Throughout four provinces, UNHCR and UNFPA supported MoVIHlizate, a community-based organization that brings together displaced and host youth living with HIV to raise awareness and promote advocacy. In Machala, UNHCR and the Latin American Platform of Sex Workers (Plaperts) established a safe space for persons selling sex where they can join community activities to foster community networks and attend information sessions on sexually transmitted infections (STIs) and HIV. UNHCR also partnered with Fundación Aldhea to conduct film workshops where people who sell sex and LGBTIQ+ persons produced their own documentary, Siempre Bella (Forever Beautiful), while developing skills and creating community networks.

As a result of these partnerships, some 2,400 people who sell or exchange sex, young people and people living with HIV received HIV services. Through community brigades, more than 1,900 people accessed HIV and STI testing and education and hygiene items, including condoms, lubricants and masks. In addition, eight community providers were trained to work with this population to promote HIV prevention, raise awareness, and improve economic literacy, facilitated access to local HIV testing for nearly 500 people.



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3. NUTRITION

Community Management of Acute Malnutrition (CMAM) in 2020

2020

32 countries

79,971

children 6-59 months with Severe Acute Malnutrition (SAM) admitted into treatment programmes

182,151

with Moderate Acute Malnutrition (MAM) admitted into treatment programmes ^[5].

Promotion and advocacy for adequate nutrition throughout the life cycle and eliminating all forms of malnutrition remained integral to UNHCR's nutrition programming. Most refugee operations were confronted with persistent multiple burdens of malnutrition as highlighted by the most recent nutrition surveys from 2019^[1] in 77 refugee sites across 13 countries. Of the 77 sites (61%) met the GAM standards of <10%, (26%) had a GAM prevalence 10-15% indicating a serious situation and the rest (13%) were above the emergency threshold of ≥15% indicating a critical situation. Stunting amongst children aged 6-59 months remained of concern. Only (12%) of the sites had an acceptable level of (<10%), and 12% a medium level of stunting, 27% of the sites recorded high levels and the rest (49%) had stunting prevalence above the critical level of ≥30%. Anaemia in children 6-59 months old – a measure of iron deficiency and general micronutrient status – only met the standard of <20% in (6%) of the sites, 25% of the sites had medium level anaemia levels and the rest (68%) had critical level of ≥40%.

GAM*	STUNTING*
77 sites GAM children 6-59 months	77 sites Stunting children 6-59 months
61% met GAM standard of less than 10%	12% were <10% = acceptable
26% had GAM of 10-15% = serious	12% medium level of stunting
13% were above 15% = critical	27% high levels of stunting
	49% critical levels of stunting

*2019 data

ANAEMIA*
77 sites Children 6-59 months
6% met standard
25% medium levels of anaemia
68% critical levels

The onset of the COVID-19 pandemic in 2020 resulted in mobility restrictions in most operations. As a result, in collaboration with other key partners including WFP and UNICEF, the delivery of nutrition programs was reviewed to ensure both continuity of care and appropriate COVID-19 mitigation measures.

Infection prevention and control and improved hygiene practices were integrated in nutrition service delivery, including Community Management of Acute Malnutrition (CMAM), Infant and Young Child Feeding (IYCF) support and promotion and blanket supplementary feeding.^[2] In addition, adaptations were made in the delivery of nutrition services to reduce gatherings at clinics and frequency of face-to-face consultations.

To ensure continuity of the treatment of acute malnutrition under the CMAM program the following measures were adopted:

- ▶ The frequency of house-to-house community health workers screening increased (9 countries 51 operations)^[3] to maintain community screening and case finding.
- ▶ Additional community avenues for malnutrition screening included the use of Mother to Mother Support Groups and the training and adoption of a family-MUAC approach (8 countries (44 operations)^[4].
- ▶ MUAC tapes were disinfected after every use.
- ▶ At the facility level modified/simplified treatment protocols were used including reduced frequency of follow-up appointments and the number of children visiting the nutrition clinics at one time
 - Outpatient Therapeutic feeding (from once a week to every two weeks) and
 - Targeted supplementary feeding from biweekly to monthly.
- ▶ Treatment protocols were modified with most operations adopting the use of MUAC-only admission and discharge criteria while some used a combined severe and moderate acute malnutrition protocol with Ready to Use Therapeutic Food (RUTF) being used for both.
- ▶ Some operations used community health workers to deliver treatment of uncomplicated acute malnutrition using low literacy tools to facilitate their work.

Blanket supplementary feeding programmes (BSFP) helped bridge the nutrition gap experienced by children, women, or other populations with additional nutritional needs including persons living with HIV and/or TB. BSFP remained essential to confront the increased risk of food insecurity and reduced access to acute malnutrition services caused by the COVID-19 pandemic. Eight out of the 13 surveyed countries^[6] implemented BSFP covering different populations, for example, persons living with TB and/or HIV ranging from children aged 6-23 months to 6-59 months, pregnant and lactating women, and older people.

To allow continuation of BSFP service in the COVID-19 context:

- ▶ increased supplies were prepositioned,
- ▶ more distribution days were scheduled,
- ▶ two months of rations were provided instead of one.

Distributions were thus less crowded and less frequent.

Optimal IYCF promotes child survival, growth and development. IYCF continued to be strengthened in 2020. COVID-19 adapted IYCF information, education and communication was put in place. UNHCR, including in southern Chad, western Rwanda and South Sudan, explored innovative ways to deliver services to communities (remote IYCF counseling via radio or telephone and utilizing practical communication platforms (such as broadcasted text messages). Support and counselling was provided to mothers with suspected or confirmed COVID-19 on the recommended feeding practices and infection prevention (respiratory hygiene practices during breastfeeding, importance of exclusive breastfeeding, and mental health support). The implementation of the IYCF multisectoral framework for action in the COVID-19 context was followed up and documentation of the delivery experiences done in Ethiopia, Uganda and Bangladesh (three of the six countries where the framework has been rolled out). The Framework aims to optimise conditions for IYCF-sensitive interventions in refugee settings. Lessons from the review in the three countries resulted in an IYCF program COVID-19 adaptations brief.

SOUTH SUDAN: ADAPTING SERVICE PROVISION

The number of food insecure and malnourished people in humanitarian settings continues to rise, exacerbated by COVID-19 restrictions and climate change. Refugees, especially refugee children, are at increased risk of suffering dire consequences. Yet, proper breastfeeding and complementary feeding practices amongst children can prevent all forms of malnutrition.

In South Sudan, UNHCR integrated COVID-19 risk management into IYCF communications, emphasizing the importance of continued breastfeeding and appropriate complementary feeding practices. Nutrition Workers and Community Outreach Workers attended virtual trainings on adapting programming and communication strategies in the COVID-19 context. To decrease exposure, UNHCR pivoted its programming from group events to physically distanced household visits and radio message broadcasting. When in-person group sessions were necessary, only 10 participants were present, and they kept physically distant.

At the facility-level, some 10,310 pregnant women and 25,398 lactating women received individual counselling. There were also approximately 1,000 group sessions attended by 107,964 PoC (88,529 females and 19,435 males). The trend of increased male participation continues as a result of successful awareness-raising during household visits by community outreach workers and other community contact points. At the community-level, a monthly average of 8,900 households learned about IYCF. For the year, some 8,131 children aged 0-to-23 months in these households were screened for breastfeeding or feeding difficulties and 551 received referrals for individual counseling.

BANGLADESH: MAINTAINING NUTRITION SURVEYS

Nutrition data on forcibly displaced people can be limited. Insufficient data can impact the ability to develop and target programming. Conducting nutrition surveys in refugee settings is essential to improve health and nutrition outcomes.

In 2020, many health and nutrition surveys were postponed due to the COVID-19 pandemic. It was during the last two months of the year that UNHCR was able to conduct a modified survey on core nutrition indicators in Kutupalong Mega Camps, Nayapara, and Kutupalong Registered Camps in Bangladesh.

Survey results for all camps indicated acute malnutrition and stunting at similar levels to 2019 while mortality rates remained below the emergency threshold. The results suggest that nutrition program adaptations during the COVID-19 pandemic averted further deterioration. For 2020, there was a notable improvement in diarrhoea prevalence, likely a consequence of improved hygiene and COVID-19 mitigation measures. The situation, however, continues to be alarming. Global Acute Malnutrition (GAM) prevalence ranged between 10 to 15 percent. Although below the critical 15 percent threshold, the rates remain high, indicating a serious situation requiring continued attention. Stunting prevalence was very high ($\geq 30\%$) in both Kutupalong Mega Camps and Kutupalong Registered camps and high ($20\text{--}30\%$) in Nayapara Registered camps.

End notes

[1] 2019 SENS

[2] UNHCR Operations' Adaptations of Nutrition and Food Security Programmes in the COVID-19 context report

[3] Chad, DRC, Kenya, Niger, Nigeria, Rwanda, South Sudan, Uganda, Zambia

[4] Algeria, Bangladesh, Chad, Ethiopia, Kenya, Rwanda, South Sudan, Uganda

[5] HIS report (19 countries); GHRP report (additional 13 countries)

[6] Bangladesh, Chad, Ethiopia, Kenya, Niger, Rwanda, South Sudan, Uganda



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