



**UNHCR**  
The UN Refugee Agency



**2018**

**ANNUAL  
PUBLIC HEALTH  
GLOBAL REVIEW**

**Public Health, Reproductive Health & HIV,  
Nutrition & Food Security,  
Water, Sanitation & Hygiene.**

## Acronyms and Abbreviations

<b>ANC</b>	Antenatal Care
<b>ANM</b>	Anaemia
<b>BSC</b>	Balanced Score Card
<b>CPV</b>	Community Psychosocial Volunteer
<b>GAM</b>	Global Acute Malnutrition
<b>GAP</b>	Global Action Plan
<b>GCR</b>	Global Compact on Refugees
<b>GPHS</b>	Global Public Health Strategy
<b>HFUR</b>	Health Facility Utilisation Rate
<b>HIV</b>	Human Immunodeficiency Virus
<b>HSIRRP</b>	Health Sector Integrated Refugee Response Plan
<b>ILO</b>	International Labour Organization
<b>IRHIS</b>	Integrated Refugee Health Information System
<b>IYCF</b>	Infant and young child feeding
<b>LATS</b>	Persons per Latrine
<b>LPPPD</b>	Litres per Person per Day
<b>MAM</b>	Moderate Acute Malnutrition
<b>MC</b>	Measles Coverage
<b>MDA</b>	Multi donor account
<b>mhGAP</b>	mental health Gap Action Programme
<b>MHPSS</b>	Mental Health and Psychosocial Support
<b>MoH</b>	Ministry of Health
<b>NMCP</b>	National Malaria Control Programme
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PLHIV</b>	People Living with HIV
<b>PMTCT</b>	Prevention of Mother-to-child Transmission
<b>SAM</b>	Severe Acute Malnutrition
<b>SC</b>	Stabilization Centre
<b>SBA</b>	Skilled Birth Attendance
<b>SDG</b>	Sustainable development goal
<b>SGBV</b>	Sexual and Gender-Based Violence
<b>STUNT</b>	Stunting
<b>TB</b>	Tuberculosis
<b>U5MR</b>	Under 5 Mortality Rate
<b>USAID</b>	United States Agency for International Development
<b>WASH</b>	Water, Sanitation and Hygiene
<b>WASH MIS</b>	WASH monitoring information system
<b>WFP</b>	World Food Programme
<b>WHA</b>	World Health Assembly

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# PUBLIC HEALTH

2018 ANNUAL  
GLOBAL OVERVIEW



**51**  
COUNTRIES



**10.5m**  
POPULATION



**18**  
COUNTRIES USING HIS



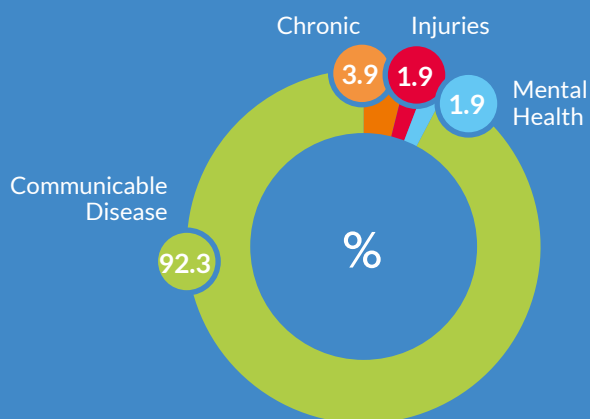
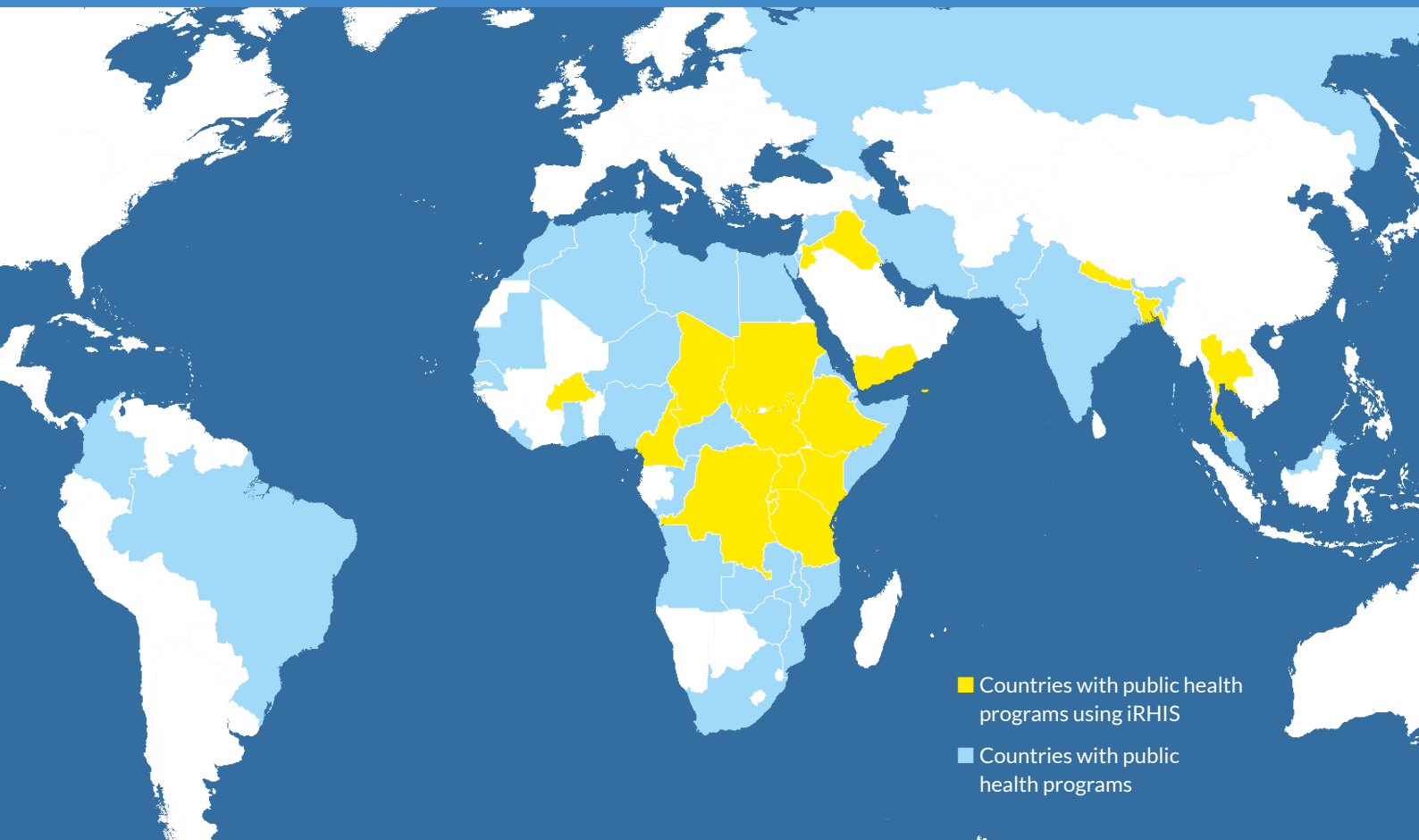
**170**  
SITES



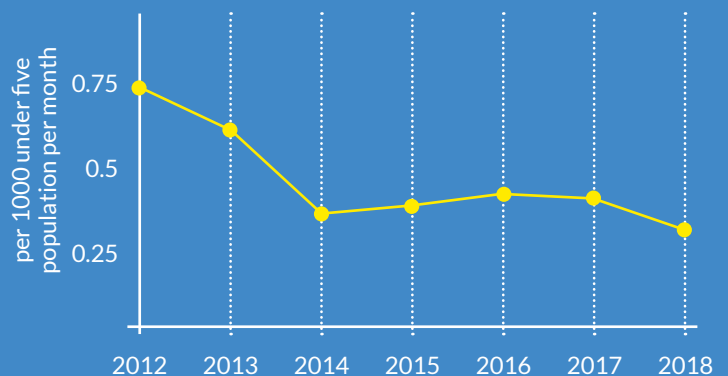
**2** COUNTRIES WITH SITES NOT  
MEETING U5MR STANDARD



**16** COUNTRIES WITH ALL SITES  
MEETING U5MR STANDARD



## UNDER-FIVE MORTALITY





# 4,575,052

POPULATION UNDER SURVEILLANCE



# 7,575,193

CONSULTATIONS

	U5MR	HFUR	MC
Bangladesh	0.34	2.1	94%
Burkina Faso	0.75	2.3	100%
Burundi	0.55	2.95	46%
Cameroon	2.65	3.45	100%
Chad	0.4	1.02	85.7%
Congo DR	0.38	1.32	65%
Ethiopia	0.14	1	91.8%
Iraq	0.0	0	N/A
Jordan	0.32	7.72	N/A
Kenya	0.45	2.04	99%
Nepal	0	0.58	97%
Rwanda	0.23	2.3	99.3%
South Sudan	0.17	1.12	88.7%
Sudan	0.34	2.72	87.8%
Tanzania	0.58	2.32	97.1%
Thailand	0.2	2.07	96%
Uganda	0.21	1.45	72%
Yemen	0.11	0.78	31%

## STANDARDS

# U5MR

< 1.5 deaths/1000 U5 population/month

# HFUR

1 - 4 new visits/year

# MC

> 95%

UNHCR aims to ensure that all refugees are able to fulfil their rights to access essential public health services. Its public health programmes are guided by the Global Strategy for Public Health (GSPH) 2014-2018 whose vision is to ensure that all refugees are able to enjoy their rights to access four broad sub-sectors of public health services: a) primary and secondary health care, b) HIV prevention, protection, care and treatment, and reproductive health services, c) food security and nutrition, and d) water, sanitation and hygiene (WASH) services.

UNHCR and its partners provide significant public health services in 51 countries reaching about 10.5 million refugees. Where health service provision is integrated into national health systems, data and information is obtained through the national health information systems and surveys (health access and utilization surveys done by UNHCR for refugees in non camp/urban settings, or national demographic and health surveys). UNHCR has an Integrated Refugee Health Information System (IRHIS), which is used to monitor refugee health status where services are provided specifically for refugees.

UNHCR used IRHIS to collect and analyze health information in 18 countries, with a population of 4,575,052 under surveillance. In 149 out of 170 (87.6%) refugee settlements under-five mortality was within acceptable standards (< 1.5 under-five deaths per 1,000 under-five population). Globally, the weighted average under-five mortality rate was maintained at 0.3 per 1000 under-five per month, an improvement from 2017 (0.4 per 1000 under-five population per month). 40% of all deaths reported were children under the age of five years. The leading causes of under-five deaths were neonatal conditions (24.7%), malaria (15.9%), lower respiratory tract infections (14.8%), acute malnutrition (7.2%) and watery diarrhea (2.1%). Globally, the weighted average crude mortality rate for the same period was 0.13 deaths per 1,000 population per month, which is within the acceptable standards (< 0.75 deaths per 1,000 population per month).





Despite continued influxes of refugees from Myanmar, South Sudan and the Democratic Republic of Congo into neighbouring countries, mortality rates were maintained below the emergency threshold in most settlements. In coordination with partners, UNHCR's public health teams responded to various outbreaks in refugee settings including diphtheria and suspected measles in Bangladesh, cholera and viral hemorrhagic fever in Kenya and Uganda, and scurvy in Kenya.

UNHCR and its partners reported 7,575,193 consultations at the health facilities, 92.3 % of them being diagnosed with communicable diseases, 3.9% were non-communicable diseases, 1.9% were mental health conditions and 1.9% injuries cases. The top five causes of morbidity were upper respiratory tract infections (24.7%), malaria (22.1%), lower respiratory tract infections (11.4%), skin diseases (6.7%) and watery diarrhea (5.7%). Childhood diseases had a similar profile, except that acute malnutrition (4%) continued to be an additional major cause of morbidity among this age group.

## Mental Health

In 2018, integration of mental health into primary care continued to be a priority. The total number of consultations in the refugee health facilities increased to 154,210 which constitutes 1.9% of the total number of consultations. There were major differences between various settings. For example, the share of epilepsy and seizures among the total mental health consultations ranges from a high of 62% in South Sudan to a low of 17% in Yemen. Conversely, problems of a more psychological character (severe emotional disorder / other psychological complaints) ranged from 13% in South Sudan to 57% in Yemen. These differences reflect various factors including different epidemiological patterns, help-seeking behaviour and capacity of health care staff to identify and manage mental, neurological and substance use conditions.

In the last four years, the mhGAP Humanitarian Intervention Guide was introduced in ten refugee operations through trainings organized and funded by the Public Health Section mainly through its partner, War Trauma Foundation. This year,

trainings in the use of the WHO/UNHCR training tool for mental health integration (the mhGAP Humanitarian Intervention Guide) were organized in Sudan, Bangladesh and Ethiopia for a total of 102 health staff of partners for periods of 5 to 8 days. Additionally, during 2018, a total of 211 refugee health staff in various country operations were trained with additional mhGAP trainings by partners such as the Dohuk Directorate of Health (Iraq), the International Medical Corps (Ethiopia, Iraq and Jordan), International Rescue Committee (Kenya), TPO Uganda (Uganda), Relief International/ Health Rights (Uganda), and Un Ponte Per (Iraq).

The data in the Health Information System reflect the data collected during consultations in health facilities. However, mental health and psychosocial support (MHPSS) is also provided outside health facilities. For example, in Bangladesh, the UNHCR mental health team and partners also recruited and trained Community Psychosocial Volunteers (CPVs) through health partners to promote community-based activities and has been providing training to psychologists and counsellors to use evidence-based brief psychotherapeutic interventions.

## MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN BANGLADESH

**2,569**

REFUGEES RECEIVED INDIVIDUAL PSYCHOSOCIAL SUPPORT SERVICES

**542**

CLINICAL MENTAL HEALTH CONSULTATIONS PROVIDED

**1,572**

REFUGEES AND LOCAL STAFF PARTICIPATED IN CAPACITY BUILDING ACTIVITIES ORGANISED BY UNHCR

**34,351**

REFUGEES PARTICIPATED IN PSYCHOSOCIAL GROUP ACTIVITIES

## Inclusion

UNHCR has assessed the extent of inclusion of refugees into national health systems in 37 countries. Significant progress has been made with TB, malaria and HIV – 93% of the 37 refugee-hosting countries surveyed reported that refugees could access antiretroviral medicines, 100% reported that first- and second-line TB drugs were available at no cost to refugees, just as for nationals, and 100% refugees access to essential immunizations at the same level as nationals.

Some countries have made notable efforts to expand the opportunities to include refugees into health insurance schemes and other pillars of social protection. This is a major step towards enhancing resilience of refugees and overall universal and equitable access to health care. This will contribute to the development of multi-year multi-sectoral inclusion and solutions strategies. For example, in Rwanda, UNHCR is working with the government to deliver on their commitment from the 2016 Leaders' Summit to integrate refugees into the national health insurance scheme. The governments of Cameroon and Chad are now including refugees into their efforts on advancing on their commitments to achieving universal health coverage under sustainable development goal (SDG) 3. Other countries, including Burkina Faso, Senegal, Kenya and Sudan are well under way in including out-of-camp refugees into national and/or community-based health insurance schemes.

UNHCR is expanding its partnerships, for example with the International Labour Organization (ILO), to accelerate the inclusion of refugees, including those not living in camps, in national health systems and health financing mechanisms. In line with SDG 3, which aims to ensure healthy lives for all, UNHCR will explore ways to engage with governments to develop multi-year integration plans that support refugees in sustainable ways.

**70.6 %**

OF COUNTRIES INCLUDED REFUGEES IN NATIONAL HEALTH POLICY

**100 %**

OF COUNTRIES INCLUDED REFUGEES IN NATIONAL VACCINATION PROGRAMMES

**90 %**

OF COUNTRIES INCLUDED REFUGEES IN NATIONAL MALARIA PROGRAMMES

**23 %**

OF COUNTRIES INCLUDED REFUGEES IN NATIONAL INSURANCE SCHEMES

In the United **Republic of Tanzania**, the Ministry of Health (MoH) integrated refugees into their National Malaria Control Programme (NMCP). As a result, refugees living in the camps will now receive anti-malaria drugs and diagnostic kits from the NMCP rather than through separate procurement by UNHCR or partners working in the camps. Working partnership with the MoH continues to be expanded.

In **Jordan**, progress on improving the availability of disaggregated data has been made with refugees included for the first time as a separate sample in the national 2018 Demographic and Health Survey, allowing analysis of key indicators to be presented by host community and refugee status. There has also been greater engagement of development actors with the United States Agency for International Development (USAID), spearheading the establishment of a multi donor account (MDA) to allow donors to provide funding support directly to the Ministry of Health which resulted in improved policies towards Syrian refugees accessing national services. It also paved the way for the new donors to contribute to the health sector in Jordan through their contributions to the MDA.

In **Zambia**, UNHCR continued to link refugees into national health services, and their health status will now be monitored using the national health information surveillance systems .

In **Nepal**, advocacy efforts resulted in the inclusion of refugees in Beldangi into the national health insurance scheme at par with nationals. 4,874 refugees were enrolled into the insurance programme. This allowed the refugees to access the same health facilities as the nationals and ultimately led to the closure of the parallel health services that had been established in the camp and support to the local health facilities.

UNHCR **Kenya** operation is orienting its programmes to align to UNDAF as well as National Development Plan (NDP). To steer development and achieve its vision 2030, the Kenya government has identified Universal Health Coverage (UHC) as one of its pillars. UHC focuses on improving infrastructure, human resource capacity and health financing. For sustainable financing, the government wants everyone to register with the National Health Insurance Fund (NHIF) which is a government-subsidized health insurance scheme. UNHCR has advocated the inclusion of refugees to NHIF and as at the end of 2018, 8771 families (approx. 23,000 individuals) in the urban centres had been enrolled under a UNHCR funded scheme implemented by NCCK; while advocacy and sensitization are ongoing to have those refugees with resources or access to various livelihood activities, to be able to enrol themselves. The NHIF pilot project is in its fourth successful year and was evaluated in Oct 2018 and found to be a success.





South Sudan. South Sudanese surgeon named as UNHCR's 2018 Nansen Refugee Award winner. © UNHCR/Will Swanson

## Global Compact on Refugees

The affirmation of the Global Compact on Refugees (GCR) in December 2018 marks a new stage in the global and collective effort to deliver more inclusive and sustainable responses to refugee situations. It sets out the blueprint for ensuring that refugee responses are better able to meet the needs of refugees and their host communities. Often, the (large-scale) arrival of refugees stretches already limited local resources. The new approach set out in the GCR offers an opportunity to provide sustainable, lasting solutions and will contribute to improving access to relevant health services for refugees and their host communities. Health features in the GCR, where several elements are included, for example on contribution of resources and expertise to expand and enhance the quality of national health systems to facilitate access by refugees and host communities. Gender and age provisions have also been taken into account.

In May 2017, the World Health Assembly (WHA) endorsed resolution WHA70.15 on "Promoting the health of refugees and migrants". The Resolution urges Member States to strengthen international cooperation on the health of refugees and migrants in line with the New York Declaration for Refugees and Migrants. UNHCR closely and actively engaged in the process. The resolution, proposed the development of a draft Global Action Plan (GAP) to promote the health of refugees and migrants to be considered for adoption by the Seventy-second WHA in 2019.

In Uganda, UNHCR signed a Memorandum of Understanding with the Ministry of Health (MoH) on the provision of integrated health care services for refugees and host populations in the country. To address the needs and ensure access to quality health services in refugee-hosting districts for both hosting communities and refugees, the Uganda Health Sector Integrated Refugee Response Plan (HSIRRP, 2019-2024) was developed under the leadership of the MoH. The Plan sets out how to realise a vision where the over 1.1 million refugees as well as the over 7 million hosting community across the refugee-hosting districts have access to quality health services. It entails a paradigm shift from a mainly humanitarian focus to developing integrated services for the long term for both refugees and host communities. The Plan advocates for predictable and sustainable financing and reinforces an interdependent approach over a five-year period that addresses both an immediate humanitarian crisis response, as well as medium- and long-term investments towards consolidation and development.

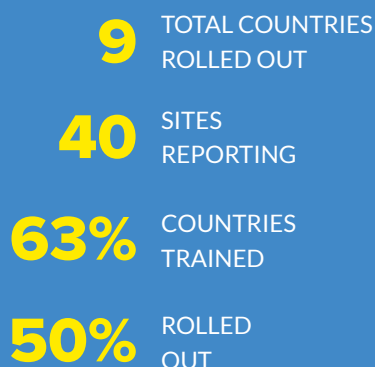


IRHIS Training in Tanzania. © UNHCR/Vincent Kahi

## Integrated Refugee Health Information System

UNHCR field tested and rolled out its updated Integrated Refugee Health Information System (IRHIS) to 9 countries, and global reporting through the new system will start in 2019. The new system, which replaces the previous system TWINE, includes improved tools for mortality surveillance, both at community and health facility levels and allows UNHCR to monitor the health status of populations, disease patterns, detect outbreaks and strengthen timely evidence-based decision-making. It integrates a range of information management tools including WASH and nutrition that can be used across a range of operational settings. Utilizing the latest advancement in technology, the new system uses tablets to collect data at the point of care and periodically synchronizing it to a central database that allows for quick and timely availability of information at all levels. Custom made dashboards that are available online on the data collection tablets will allow the field users to access real time information about their clients, and be able to

respond to any alerts or signals generated by the system. The system will not only move UNHCR and its partners to be paper less, but will also provide an opportunity to utilize artificial intelligence, machine learning, interoperability and integration that will result in better analysis, accuracy, timeliness, comprehensiveness and utilization of public health information that will lead to improved quality of services and health status of refugees. Full roll out is planned in 2019.







Meeting Bangladesh. UNHCR WASH meeting with beneficiaries. © UNHCR/David Azia

## Balanced Score Cards- Assessing Quality of Care

UNHCR completed the review, development and subsequently the launch of a new electronic health facility quality assessment tool known as the Balanced Score Card (BSC) to standardize quality monitoring, identify quality gaps and provide additional information beyond the indicators reported in IRHIS. The new version of the BSC utilizes up-to-date technology that makes the results of assessments immediately available to the operations. Decisions are subsequently made in a timely manner, and resources can be targeted where they are needed most. In 2018, assessments were conducted in Ethiopia, Kenya, Rwanda and Uganda, covering 20 sites in total. The tool provides additional information to complement the statistics collected in IRHIS. This is expected to lead to improved quality of health services.

**4** COUNTRIES  
HAVE DONE BSC

**71-89%**



SCORE RANGE

# REPRODUCTIVE HEALTH

2018 ANNUAL  
GLOBAL OVERVIEW



**17**  
COUNTRIES



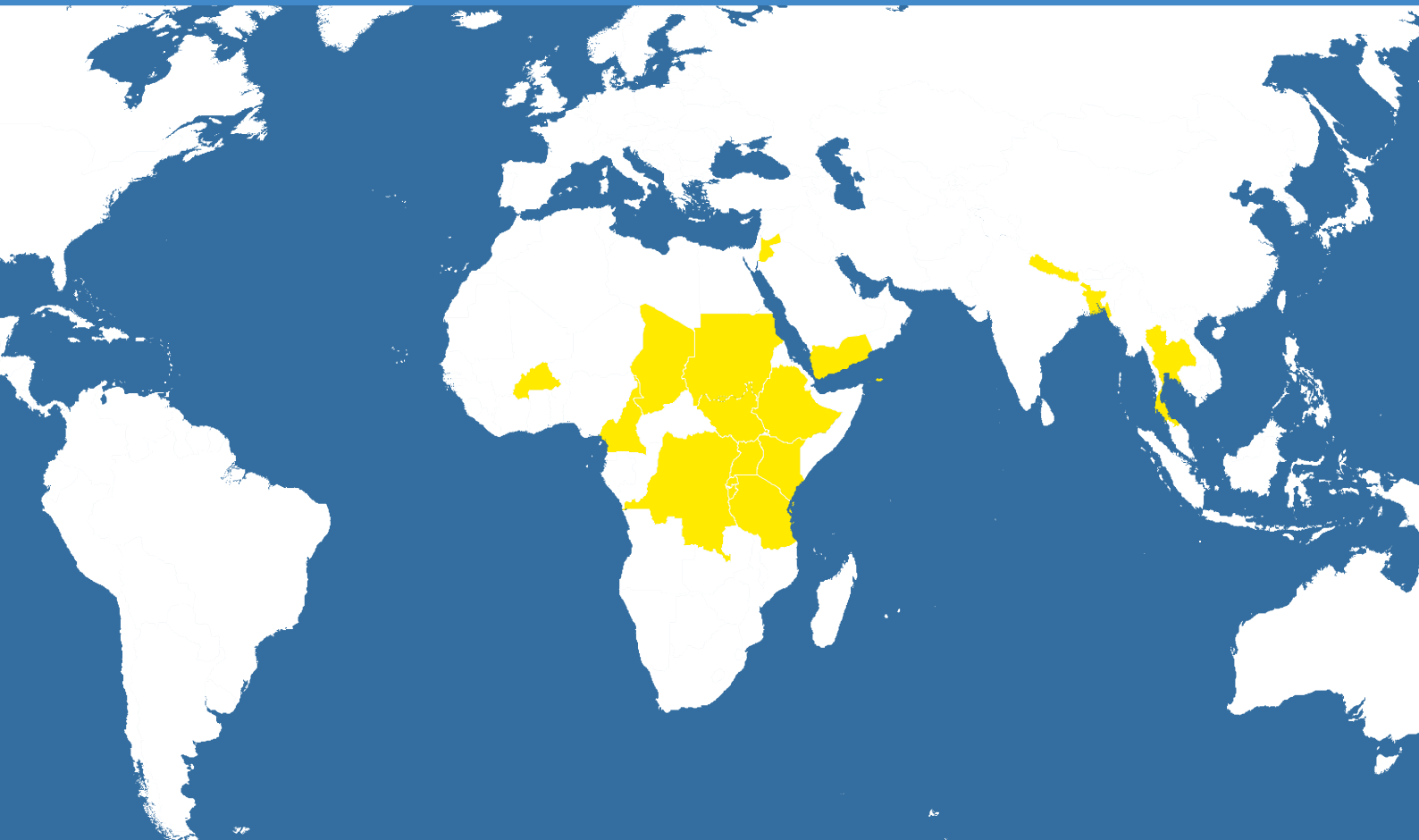
**151**  
SITES



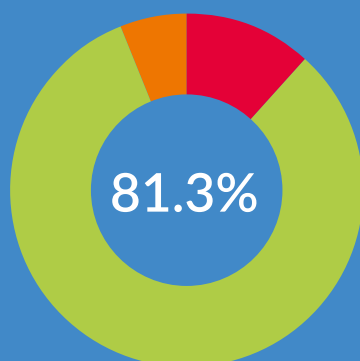
**109,492**  
DELIVERIES ATTENDED BY  
SKILLED HEALTH WORKERS

**109,492**

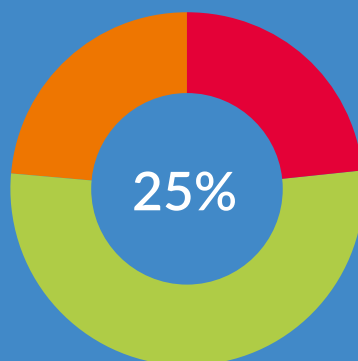
WOMEN ATTENDED AT LEAST  
4 ANC VISITS DURING PREGNANCY



SKILLED BIRTH  
ATTENDANCE



ANC COVERAGE



■ Not meeting standards  
■ Meeting standards  
■ Borderline

	SBA	PEP	PMTCT
Bangladesh	95%	50%	N/A
Burkina Faso	98%	N/A	100%
Burundi	97%	22%	94%
Cameroon	92%	100%	69%
Chad	97%	52%	97%
Congo DR	99%	92%	86%
Ethiopia	97%	52%	91%
Jordan	99%	100%	N/A
Kenya	91%	96%	100%
Nepal	100%	33%	100%
Rwanda	99%	70%	100%
South Sudan	87%	94%	85%
Sudan	89%	N/A	26%
Tanzania	89%	88%	100%
Thailand	92%	33%	99%
Uganda	94%	81%	95%
Yemen	95%	N/A	49%

## STANDARDS

SBA 100%

PEP 100%

PMTCT 100%

In line with UNHCR's Global Public Health Strategy efforts continued throughout 2018 to promote and facilitate access to comprehensive reproductive health services including maternal and newborn health and family planning.

In 2018, 81.3% of country operations under surveillance achieved the standard of at least 90% of deliveries occurring in health facilities (an increase from 75% of operations in 2015). With regards to complete antenatal care (ANC), 25% of operations reached more than 90% coverage of four or more antenatal visits (a slight improvement from 2017 which was 22.2%) and only 31.3% reached >90% coverage of three postnatal visits within six weeks of delivery (cf. 26% in 2015). Much sensitization has to be done to empower pregnant women and their partners to attend ANC and PNC. Strengthening links between the community and the health facility can increase utilisation of services, including ANC, and impact maternal and neonatal mortality as well as stillbirths.

Although progress has been made on skilled attendance at delivery, there are still significant problems in quality of care including respectful maternity care. Maternal deaths are reported and audited in refugee operations. In 2018, 100 percent of maternal deaths were audited within 48 hours. Of audited maternal deaths which occurred in six countries in East Africa 94% of deaths occurred in health facilities with 59% occurring in the post partum period. Haemorrhage (often associated with uterine rupture) was the leading cause of maternal death (44%), followed by embolism (19%), and sepsis or infections (18%). Third delay factors were significant contributors to maternal mortality highlighting the need to strengthen comprehensive emergency obstetric care services including referral.

Globally, 24.7 percent of under-five deaths were neonatal deaths. UNHCR continued efforts to improve quality and coverage of essential neonatal care especially in countries with the highest mortality rates. In 2018, UNHCR started to implement the "Saving Maternal and Newborn Lives" project with funding from the Bill and Melinda Gates Foundation in Cameroon, Niger, and Chad. By expanding coverage of key low-cost, high-impact maternal and newborn interventions, the project is improving the quality of care provided to refugees through a multi-pronged approach that includes: additional medications and





Cameroon. Saving babies' lives with Kangaroo care. © UNHCR/Xavier Bourgois

supplies; infrastructure improvements for health facilities (such as the installation of solar panels for maternity departments and rickshaw ambulances for women in labour); improving thermal care including through kangaroo mother care, and capacity building of health workers including community health workers in home visit for the newborn.

UNHCR is also working with partners to improve contraceptive services in refugee sites. Although the uptake of contraception is improving, there are still significant gaps in provider attitudes, method-mix, stock outs and disempowerment of women affecting health seeking behaviour.

Adolescent pregnancy and its consequences represent a major public health issue with enormous social implications, in many countries of the world. UNHCR and partners continued to try to increase access and utilisation of services in this age group including through specific outreach in eastern Chad,

Burundi and Algeria. From 2014 to 2017, there has been a reduction in the proportion of deliveries among under 18s from 6.4% in 2014 to 4.3% in 2018.

A survey on the UNAIDS 90 90 90 targets was conducted in 22 UNHCR refugee sites in 14 country operations from May to December 2018, assessing HIV testing and treatment cascades. Findings showed that 37% of the sites achieved 90% of estimated People living with HIV (PLHIV) knowing their status; while 77% of operations achieved 90% PLHIV who know their status being linked to care and on HIV treatment; and only 24% of site operations achieved 90% of PLHIV on ART being virally suppressed. In 2019, UNHCR will reinforce HIV counselling and testing, scaling up testing approaches that help increase uptake among people who do not typically use healthcare services and amongst those at highest risk of infection and more investment in support to those on treatment.

During 2018, UNHCR provided support to ensure the continuation of HIV services for refugees and other displaced populations affected by humanitarian emergencies in approximately 50 UNHCR operations. Across its operations, in 2018 UNHCR provided HIV counselling and testing, including testing pregnant women, to nearly 500,000 people of concern to UNHCR. In camp-based settings under surveillance there were 13,422 refugees on ART – over a four-fold increase since 2014.

UNHCR supports services for the clinical management of rape and other forms of sexual violence in humanitarian emergencies. 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. Across UNHCR's operations, in 2018 Sexual and Gender-Based Violence (SGBV) services (including referral for clinical services, mental health and psychosocial support, community-based protection) were provided to over 27,000 refugees and other displaced populations. In Burundi, Bangladesh, Thailand and Nepal less than 50% of survivors of sexual violence received PEP within 72 hours. Late presentation of sexual violence survivors is one of the major factors affecting provision of health services.

Capacity building of health workers is an important component of the project supported by the Gates Foundation, Saving Newborn Lives in Refugee Settings. The implementation of an innovative low-dose high frequency training method, has resulted in the certification of 32 “Master Trainers” ready to give regular, short training sessions to their peers in key maternal and newborn care topics. Procurement of training materials for each health facility, including newborn mannequins for neonatal resuscitation training, and birth simulators, allow health workers to regularly practice their new skills without being absent from their posts. Health workers have already reported increased confidence in dealing with sick newborns and obstetrical emergencies, resulting in decreased number of referrals.

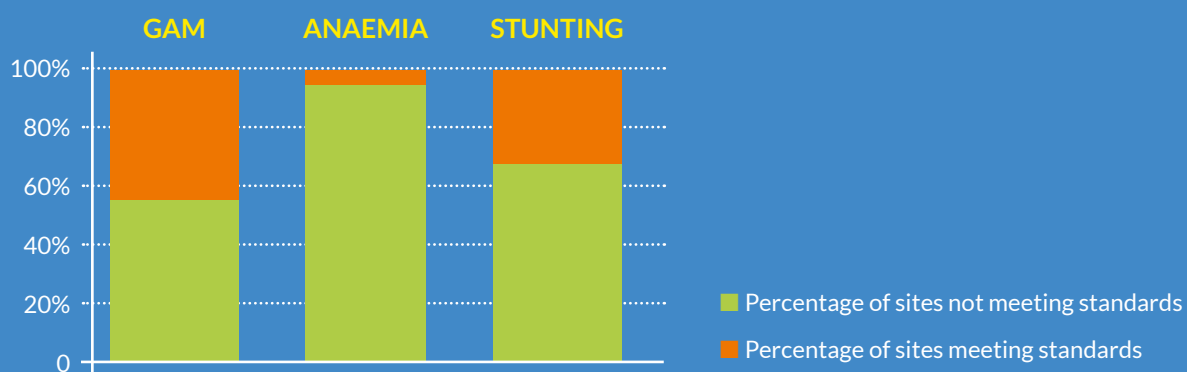
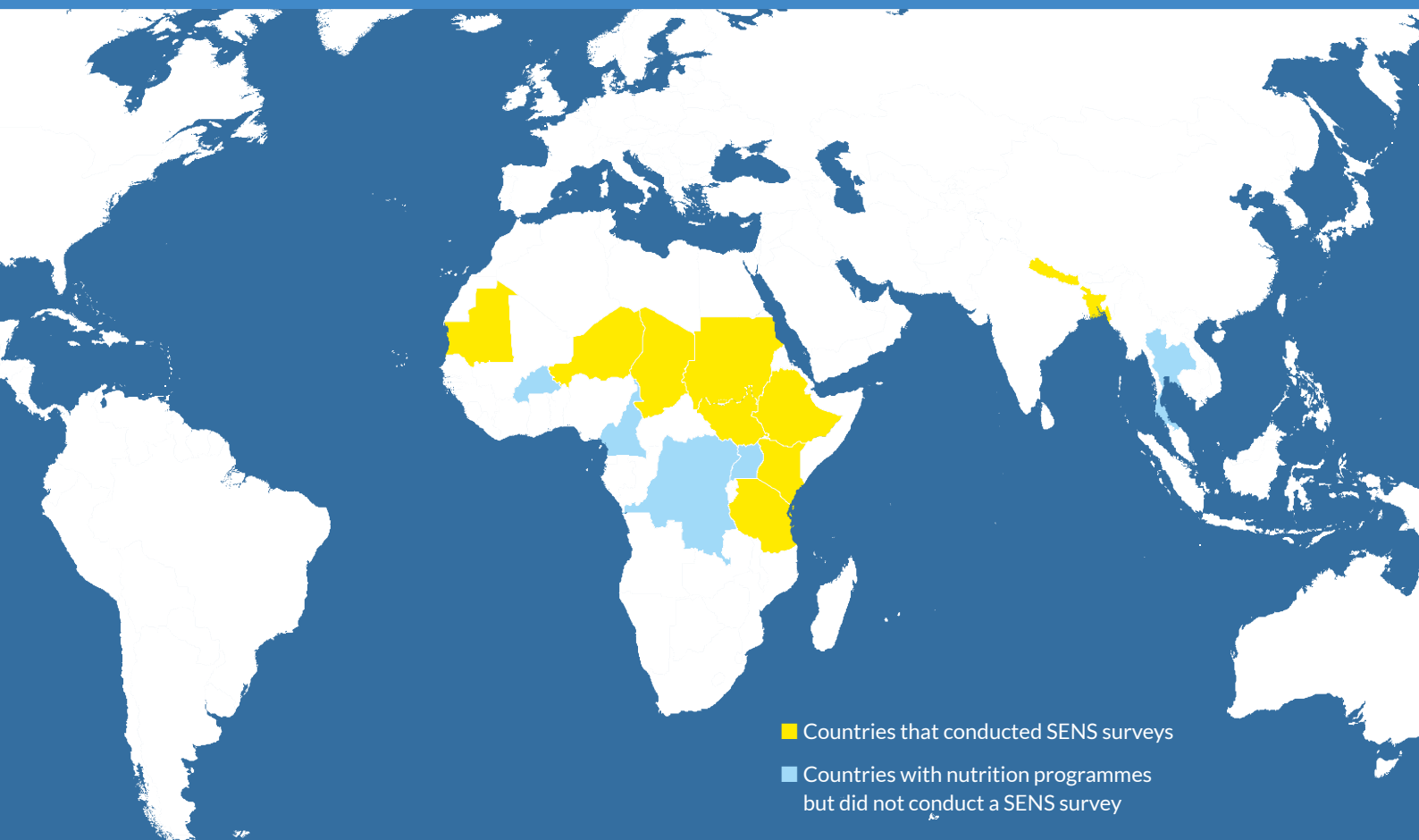
Thanks to the contribution of the Bill and Melinda Gates Foundation funding, the District Hospital of Garoua-Boulai in East Cameroon is developing a new kangaroo mother care unit to manage large numbers of low-birth weight babies they receive from the refugee sites and the local host population. Globally, preterm birth is a leading cause of newborn death, and it is similarly the case in refugee populations. In order to improve the quality of care provided to these fragile newborns and increase survival, health workers in the Gates project sites in Cameroon, Niger, and Chad have received training in clinical management of prematurity, including the use of kangaroo mother care – a life-saving method of thermal management and breastfeeding promotion that keeps the premature newborn skin-to-skin with his mother continuously until he or she reaches a more healthy weight. Local fabrication of over 2300 kangaroo wraps is underway, with local production providing the advantage of reducing costs, providing livelihood opportunities, and increasing sustainability for future use. For example, in Cameroon, local production of the kangaroo wraps was completed for only \$4 USD each, almost half the cost of ordering internationally.

# NUTRITION

2018 ANNUAL  
GLOBAL OVERVIEW

 **15** COUNTRIES WHICH **147** SITES  
HAD NUTRITION PROGRAMS

 **11** COUNTRIES WHICH **74** SITES  
COMPLETED A SENS SURVEY





**5,943**

SC ADMISSIONS

**89,729**

MAM CASES

**33,901**

SAM CASES

	GAM	ANM	STUNT
Bangladesh	11.0–13.6%	29.4–39.8%	26.9–40.4%
Chad	6.5–7.2%	37.6–52.5%	37.8–42.0%
Ethiopia	6.4–19.4%	16.4–60.3%	4.0–51.0%
Kenya	5.6–12.7%	46.7–60.7%	18.0–27.3%
Mauritania	10.5%	40.0%	33.4%
Nepal	1.6%	35.7%	33.9%
Niger	12.0–15.8%		37.5–50.2%
Rwanda	1.5–4.4%	28.3–44.6%	14.3–29.8%
Sudan	9.1–19.4%	23.0–56.8%	4.6–58.8%
South Sudan	5.3–6.3%	45.9–46.8%	21.1–28.8%
Tanzania	1.6–2.9%	35.3–56.0%	36.4–56.7%

## STANDARDS

**GAM** <10%**ANM** <20%**STUNT** <20%

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 and harmonisation with new guidance and tools (Sphere, SDGs, new WHO/UNICEF thresholds etc.) aims at providing guidance on how 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 and through 2018. Increasing collaboration with UN agencies and other partners in including refugees into treatment and prevention programmes has been a major drive for country operations through 2018, although there is still a great deal of ground to be covered in harmonising different valets of the continuum of care, there has been progress in this area.

Global acute malnutrition (GAM) is one of the main nutrition indicators tracked for the purposes of determining needs and for monitoring health status. In 2018, 33/74 sites (44.6%) met the GAM standards of < 10%, whilst 8/74 (10.8%) were above the emergency threshold of ≥ 15%. These results represent an improved situation regarding the proportion of sites above the emergency threshold compared to 2017 where this was 21.4%, but a large decrease in proportion of sites meeting GAM targets in 2018 compared to 2017. The 2018 data falls short of the target of 77% of the surveyed sites recording GAM <10%. The proportion of sites in 2018 in an emergency situation was far higher in 2018 compared to in 2017 at 35% compared to 16% in 2017. 2018 also saw many new sites included such as those from Sudan. Sites where GAM is ≥ 15% were recorded in 6 locations in Gambella, Ethiopia and in Sudan.

Comparing the 2018 results to previous years, improvements in GAM were noted in 22/70 (31.4%) sites in Bangladesh, Chad, Ethiopia, Kenya, South Sudan and Sudan. Deterioration in GAM was noted



Brazil: A mother breastfeeds her new-born baby. © UNHCR/Genangely Pinero

in only 1/70 (1.4%) sites in a camp receiving new refugees in Tanzania.

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. Stunting amongst children 6 – 59 months of age met the standard of <20% in 23/74 sites (31.1%) whereas just as many sites 22/74 (29.7%) registered stunting prevalence above the critical level of  $\geq 40\%$ . The proportion of sites meeting stunting standards has improved slightly from 2017 to the end of 2018. The majority of sites, for which we have previous data for comparative purposes, show that the prevalence of stunting is stable or persistently high with no significant change (39/70 sites 55.7%). Improvement in stunting was noted in 18/70 sites (25.7%) in Bangladesh, Chad, Ethiopia, Kenya, South Sudan, Sudan and Tanzania. Deterioration of stunting was observed in a much greater proportion of sites than in previous years 13/70 sites (18.6%) compared to 5.7% in 2017 in Ethiopia, Kenya, Nepal, Niger and South Sudan.

Anaemia in children 6 – 59 months old is used as a measure of iron deficiency and general micronutrient status. Only 3/68[1] (4.4%) met the standard of <20%, whilst 32/68 (47.1%) were under the critical level of < 40%. This means that over half of the sites exhibited anaemia levels of the critical  $\geq 40\%$  threshold 36/68 sites (52.9%). The majority of sites, for which we have previous data for comparative purposes, show that the prevalence of anaemia is stable but persistently high (29/64 sites 45.3%). However it is concerning that in 8/64 sites (12.5%) anaemia is significantly higher than previous surveys, although this is a lower proportion than in 2017 the trend in sites in some countries (Bangladesh, Ethiopia, Kenya, Nepal and Tanzania) is still concerning.

Although these nutrition survey results show that the indicators of long term nutrition status of anaemia and stunting are of particular concern amongst refugee children, with an alarming sense of deterioration in stunting, it is worth noting that there have been statistically significant improvements in stunting in 18/70 (25.7%) of the sites and in anaemia in 26/64 sites (40.6%).



Of the 65 sites where exclusive breastfeeding was reported, 63.1% (41/65) met the UNHCR target of  $\geq 70\%$  of children 0-5 months who received only breastmilk during the previous day. This is quite an improvement compared to the levels observed in 2015 and 2016 (53.1% and 54.6% respectively) and a stable situation compared to 2017 where the proportion was 63.9%. This is an encouraging improvement since 2015 and previously and links in to the work that field teams and partners have been doing on infant and young child feeding.

The indicator of GAM is very sensitive to changes in the environment, living conditions, health care access and food security situation, displacement and as such can fluctuate year on year depending on the context. This makes direct comparisons challenging if there have been major changes in context. It is, however, an extremely useful indicator for measuring the severity of a situation and planning for programmes in consequence.

Deteriorating circumstances in terms of food and non-food assistance in many operations are clearly having negative consequences on populations' ability to cope, a late term indicator of this being deterioration in GAM prevalence. Once this happens, populations have often exhausted their normal coping strategies and are forced to resort to potentially harmful or risky practices to meet their basic and essential needs. This obviously sets populations back and it takes a lot of time to recover lost assets and regain an acceptable nutrition level. Although there were no surveys conducted in Eastern Chad in 2018, the camps further north are an example of where GAM prevalence has dramatically deteriorated since 2015.

While the causes of malnutrition vary, food insecurity is a significant factor. Many UNHCR operations have suffered increasing cuts to food assistance over the past few years and there is an increasing trend in the number of countries affected. Cuts to food assistance are particularly worrying as refugees often have limited other legal options to increase their income or access to food. Many resort to potentially harmful coping strategies to meet their basic needs which can increase protection risks such as pulling children out of school to work and selling sex. UNHCR continues to monitor food security of refugees through nutrition surveys. UNHCR and the World Food Programme continue to jointly fundraise for operations of concern

including Cameroon, Chad, Ethiopia and Mauritania. Meanwhile the Agencies are collaborating to target (and prioritize) those most in need recognizing that in some operations, needs are not being met.

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. 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, MHPSS, malaria prevention and treatment, deworming, improved IYCF and maternal and child health), 2) promotion of the IYCF framework, 3) advocacy for well-balanced food rations 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.

In Ethiopia, a reinforced collaboration with UNICEF and the Ministry of Health has resulted in refugee need for treatment products for severe acute malnutrition being transitioned and included in national procurement and distribution plans. There has been progress on improving the monitoring of malnutrition treatment programmes with the deployment of the revised nutrition modules in the integrated refugee Health Information System (IRHIS) in many operations. In line with the CRRF some very large operations such as Chad and the Democratic Republic of Congo (DRC) are planning to include nutrition status monitoring in out-of-camp situations where refugee and host populations are mixed, or amongst villages surrounding refugee camps – these surveys will be deployed in early 2019. In Bangladesh, concerted efforts to scale up treatment services for severe acute malnutrition together with partners, as well as improvements in access to health care, improved coverage of food assistance and improvements in the shelter, environmental and WASH conditions have resulted in significant improvements in GAM. The nutrition treatment programmes however remain highly fragmented and not integrated into health care systems.

# WATER, SANITATION AND HYGIENE

2018 ANNUAL  
GLOBAL OVERVIEW



**36**

COUNTRIES



**272**

SITES

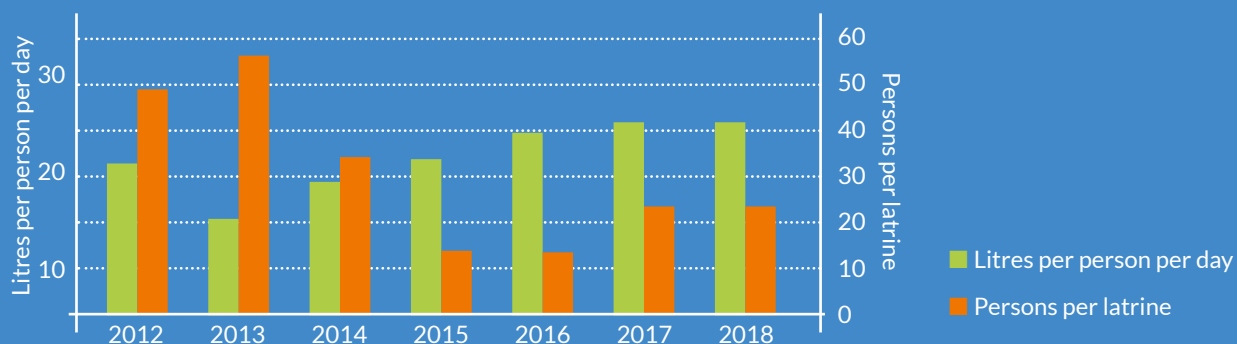
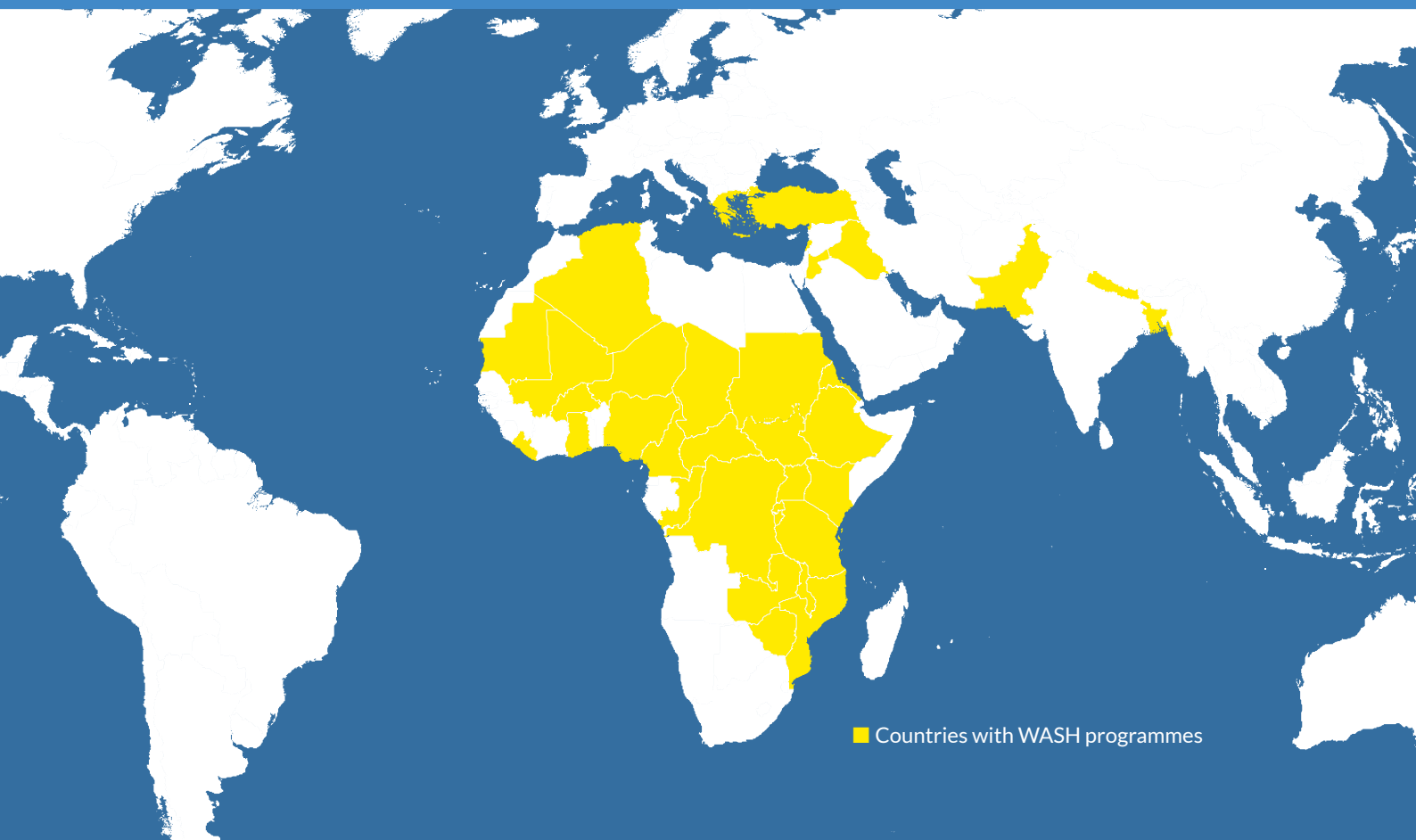
**22.2**

SITES AVERAGE LITRES  
PER PERSON PER DAY



**22**

PERSONS  
PER LATRINE



	LPPPD	LATS
Algerie	13.3	6.6
Angola	22	5
Bangladesh	15.9	29.1
Burkina Faso	17.6	22.8
Burundi	21.9	9.9
Cameroon	13	18.4
Central Af. Rep.	13.7	124
Chad	17.5	10
Congo DR	18.7	18.7
Djibouti	14.5	9.9
Eritrea	15	7
Ethiopia	13.9	14.4
Ghana	193.4	15.2
Greece	93	12.2
Iraq	78.7	5.1
Jordan	35.6	6.5
Kenya	27.2	6.6
Lebanon	44.2	6.8
Liberia	20	22
Malawi	7	7
Mali	18.6	N/A
Mauritania	21.4	26.4
Mozambique	20.2	10
Nepal	26	5
Niger	12.4	33.1
Nigeria	22.8	23.3
Pakistan	14.5	10.6
Rep. Congo	11.7	108
Rwanda	18.5	22
South Sudan	20.9	10.9
Sudan	17.3	18.1
Tanzania	23.3	8.2
Turkey	40	N/A
Uganda	15.4	9.1
Zambia	21.8	28.4
Zimbabwe	20	23

## STANDARDS

**WATER** 20 lpppd  
**LATRINES** 20 lats

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 access to adequate and equitable sanitation and hygiene services, both at home and in public spaces including market places, schools, and health care facilities.

Access to adequate and safe WASH services contributes to UNHCR's health objectives: reducing morbidity and mortality. In addition, WASH services are a prerequisite to ensuring UNHCR's core protection mandate, as these services are necessary for a safe and dignified life. In alignment with the "participation revolution" of the Grand Bargain and UNHCR's Accountability to affected population, WASH interventions are designed using participatory approaches. With the roll out of the Global Compact for Refugees, UNHCR is emphasizing WASH solutions which ease pressure on host communities and utilise robust technologies that reduce long term operations and maintenance costs and environmental impact.

UNHCR faces many challenges including aging WASH infrastructure in camps and settlements, limited capacity of local government in protracted situations, and scarce water resources in many areas. This is combined with budgetary constraints in many operations. In response to these challenges, UNHCR works with implementing and operating partners to maximize efficiency through data driven decision making. In 2018, UNHCR continued to roll out the WASH monitoring information system (WASH MIS) which has household service level data as well as community level asset registers. UNHCR performs trainings and capacity building workshops with staff and partners in how to collect, analyse, and utilise data from the WASH MIS.

The average litres per person per day globally was at 20.2 litres. In 2018 a total of 31 water supply systems were rehabilitated and upgraded to solar or solar hybrid. The average number of persons per latrine was 22. No change could be observed compared to 2017. This exceeds the post-emergency standard of 20 ppl and the recommendation to provide latrine access at household level to improve hygiene and mitigate protection risks. In 2018, UNHCR continued to promote "waste to value" sanitation technologies, building additional urine diversion dry toilets in Ethiopia. In total there are 3,500 toilets serving 17,000 refugees, reducing the contamination of soil and groundwater and producing a soil conditioning fertiliser.





Mali. New well brings fresh hope and water to Gao neighbourhood. © UNHCR/Lucy Beck

In Ethiopia the solarization of 13 water supply systems in the country has contributed to a cleaner environment by reducing carbon dioxide and particle emissions from diesel generators and also reduced operating costs with estimated annual savings of 50% or more.

a low-cost, mature and scalable system for water monitoring. Further trials are planned to use this method as a “basis for payment” system for water trucking contractors.

## Innovation and WASH

During 2018 the UNHCR WASH has carried out comprehensive field trials of real-time water monitoring technologies in the West Nile Region of Uganda and Northern Iraq. The aim of the trials were to pilot various real-time technical solutions for water tanker and water reservoir remote monitoring with the goal of improving the effectiveness of UNHCR’s water trucking programming globally. As part of the pilots a total of ten (10) water monitoring devices were installed across refugee settlement from six (6) different companies including TankMatix, HummBox, Libelium, Tekelek, DecentLabs and Kerlink. The devices deployed a range of technologies for remote monitoring including: 3G, 4G, LoRaWAN (Long Range Wide Area Network), Ultrasound, Wave Pulse Radar, and Piezometric Pressure. The field trials were extremely successful and UNHCR has selected LoRaWAN Internet of Things technology together with low-cost ultrasonic water monitoring nodes as

## Global Compact on Refugees

As part of the work on the GCR, UNHCR is rethinking its WASH programmatic response imploring new technologies and approaches. In Lebanon UNHCR is using an area based approach programming. Focusing on underserved urban/ peri-urban areas with the objective of achieving protection outcomes and peaceful coexistence between refugees and host community by building the capacity of local authorities and supporting them with financing for an integrated multi-sectoral response. In Ethiopia and Uganda UNHCR is making a transition from direct provision of WASH services to facilitating access by working with stakeholders at the national and local level through the formation of Public Utilities to provide services and public water boards to set tariffs and inform regulation.





