GLOBAL STRATEGY FOR PUBLIC HEALTH

Public Health - HIV and Reproductive Health - Food Security and Nutrition Water, Sanitation and Hygiene (WASH)

A UNHCR Strategy 2014-2018

UNHCR
The UN Refugee Agency

Division of Programme Support and Management
United Nations High Commissioner for Refugees
Case Postale 2500
1211 Geneva 2, Switzerland
www.unhcr.org

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Cover photo: Lebanon / Syria border / UNHCR / A. Branthwaite / August 2006
Back cover photo: Kenya / Dadaab / UNHCR / S. Modola / October 2011

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ACRONYMS

ANC	Antenatal Care
ART	Anti-Retroviral Treatment
CMAM	Community-based Management of Acute Malnutrition
FAO	Food and Agriculture Organization
FBM	Food Basket Monitoring
EPI	Expanded Programme on Immunization
GAM	Global Acute Malnutrition
GIS	Geographic Information System
GPS	Global Positioning System
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HPV	Human Papilloma Virus
IASC	Inter-Agency Standing Committee
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IPSAS	International Public Sector Accounting Standards
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
JAM	Joint Assessment Mission
LLITNs	Long- Lasting Insecticide Treated Nets
MAM	Moderate Acute Malnutrition
MDGs	Millennium Development Goals
MHPSS	Mental Health and Psychosocial Support
M&E	Monitoring and Evaluation
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
PDM	Post-Distribution Monitoring
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PTSD	Post-Traumatic Stress Disorder
SAM	Severe Acute Malnutrition
SGBV	Sexual and Gender-Based Violence
SOP	Standard Operating Procedure
STI	Sexually-Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UN-HABITAT	United Nations Human Settlements Programme
UNHCHR	United Nations High Commissioner for Human Rights
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization

Ethiopia / Somali refugees / UNHCR / J. Ose / June 2012

VISION

UNHCR aims to ensure that all refugees are able to fulfil their rights in accessing life-saving and essential health care, HIV prevention, protection and treatment, reproductive health services, food security and nutrition, and water, sanitation and hygiene services.

Kenya / Refugees from Somalia / UNHCR / E. Hockstein / December 2008

STRATEGY AT A GLANCE

GUIDING PRINCIPLES

- Protection
- Age, Gender and Diversity
- Equity
- Access
- Sustainability
- Community empowerment
- Appropriateness and reliability

STRATEGIC APPROACHES

- Partnerships and coordination
- Capacity-building
- Communication and advocacy
- Integrated approaches
- Measurement
- Innovation

SCOPE OF IMPLEMENTATION

- All refugee settings in low and middle-income countries
- Refugee camps, settlements, rural and urban out-of-camp populations.
- Most aspects applicable to all persons of concern to UNHCR and host communities

STRATEGIC OBJECTIVES 2014-2018
UNHCR AND PARTNERS WILL:

Public Health

1. **Improve access to quality primary health care programmes**
2. **Decrease morbidity from communicable diseases and epidemics**
3. **Improve childhood survival**
4. **Facilitate access to integrated prevention and control of non-communicable diseases, including mental health services**
5. **Ensure rational access to specialist referral care**
6. **Ensure integration into national services and explore health financing mechanisms**

Food Security & Nutrition

1. **Enhance prevention of undernutrition and micronutrient deficiencies including anaemia**
2. **Increase effective treatment of acute malnutrition**
3. **Collect, analyse and use current food security and nutrition data**

Uganda / UNHCR / Frederic NOY / November 2012

HIV and Reproductive Health

1. **Reduce transmission of HIV using a protection and rights-based approach**
2. **Facilitate universal access to antiretroviral therapy**
3. **Facilitate the elimination of mother-to-child transmission of HIV**
4. **Improve access to comprehensive reproductive, maternal and newborn health services**
5. **Increase use of innovative and appropriate technologies in reproductive health services**

Water, Sanitation and Hygiene

1. **Improve safe access to water of sufficient quality and quantity**
2. **Improve safe access to quality sanitation**
3. **Improve hygiene practices**
4. **Improve WASH in hospitals, health and nutrition centres, schools and other institutions.**

HOW TO REACH RESULTS:

- Integrate services into national systems whenever feasible
- Robust contingency planning and emergency response that focuses on integration and sustainability of services
- Reinforce partnerships specifically with government line ministries
- Create synergies with other sectors from onset
- Develop and implement standard operating procedures for public health sectors
- Use data from TWINE, SENS and WMS systems to make evidence-based decision
- Promote and use innovative and appropriate technologies for diagnosis, treatment and monitoring
- Capitalise on health financing opportunities to address needs
- Increase HCR and partner expertise

WHO HAS A ROLE TO PLAY?

- Refugee communities
- Government including relevant line ministries and host communities
- UNHCR at all levels and sectors
- Donor community
- UN agencies and other international organisations
- National and international NGOs, including faith-based organisation
- Academic and research institutions
- Private sector

Yemen / IDPs / UNHCR / H. Macleod / November 2009

INTRODUCTION

THE UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES' (UNHCR) GLOBAL STRATEGY FOR PUBLIC HEALTH ENCOMPASSES FOUR MAJOR RELATED SECTORS THAT ARE OF VITAL IMPORTANCE IN PROVIDING PROTECTION AND SERVICES TO REFUGEES AND OTHER PERSONS OF CONCERN.

These are public health itself; human immunodeficiency virus (HIV) and reproductive health; food security and nutrition; and water, sanitation and hygiene (WASH).

The range of this Strategy is broad. Not only does it cover virtually all major health issues, it is relevant in practically all settings where UNHCR operates in low-income, middle-income and high-income countries. The focus of this strategy is on refugees, but in some contexts may apply or be adapted to asylum-seekers, stateless persons, internally displaced persons and in returnee settings. The proportion of these persons of concern and decisions on levels of assistance varies according to the country in question and the general context.

The strategy follows and builds upon UNHCR's Strategic Plans for Public Health for 2008 – 2012.[1]

All UNHCR public health programmes for refugees are anchored on the principles of primary health care (PHC). The first objective of the Strategy's six public health strategic objectives is to improve access to quality PHC services.

1 UNHCR Public Health and HIV Section's Guiding Principles and Strategic Plans for HIV and AIDS, Malaria Control, Nutrition and Food Security, Reproductive Health, Water and Sanitation. 2008 – 2012. http://www.unhcr.org/4b224d5f9.pdf.

The second is to decrease morbidity from communicable diseases and epidemics; the third is to improve childhood survival; the fourth is to improve access to prevention and control of non-communicable diseases (NCDs), including mental health services; and the fifth is to improve access to specialist care and to national health systems.

The HIV and reproductive health strategic objectives relate to prevention, protection and treatment, especially for mothers and newborns, including the use of innovative technologies in women's health. The food security and nutrition strategic objectives relate to the prevention of under-nutrition and micronutrient deficiencies, effective treatment of acute malnutrition, and effective provision of up-to-date food security information and analysis. The WASH strategic objectives aim to ensure that refugees have safe access to water of sufficient quality and quantity, and to improved sanitation and hygiene, including in schools, health facilities and other institutions.

This Strategy is a stand-alone document. But its broad scope and its wealth of health data makes it a very useful resource and companion to three other related UNHCR Strategies for 2014-2018: on settlement and shelter; energy; and livelihoods. All four reflect UNHCR's heightened interest and renewed commitment in helping refugees work towards self-reliance through structured programmes and innovative approaches; and they all share a common structure of vision, guiding principles and strategic approaches.

Colombia / returned IDPs / UNHCR / B. Heger / May 2010

GUIDING PRINCIPLES

1. **PROTECTION:** UNHCR is the United Nations body mandated to lead and coordinate international action to protect refugees and work with governments to secure solutions. Its primary purpose is to safeguard the rights and well-being of refugees. This includes ensuring access to services, including to health services, nutrient-rich food and safe water and sanitation. UNHCR's public health programmes are underpinned by universal human rights principles. The 1951 Refugee Convention states that refugees should enjoy access to health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). The Universal Declaration of Human Rights of 1948(Article 25) and Articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights also call for all people, including refugees, to enjoy the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control as well as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. In November 2002, the Committee on Economic, Social and Cultural Rights adopted General Comment No. 15 on the right to water in Article I stating that the human right to water is indispensable for leading a life in human dignity. It is a prerequisite for the realization of other human rights.[2]

2. **Age, Gender and Diversity (AGD):** Gender equality and respecting the rights of all refugees of all ages and backgrounds are central to the work of UNHCR. Special measures to ensure inclusiveness and accessibility for specific groups of concern, including women, adolescent girls and boys, the elderly, the young, people with disabilities, people who are lesbian, gay, bisexual, transsexual or intersex, and women and men belonging to national or ethnic, religious and linguistic minorities or indigenous groups will continue. UNHCR will ensure that women and girls access services as effectively as men and boys.[3]

3. **Equity:** UNHCR seeks to ensure that all refugees can access quality public health, reproductive health and HIV, food security and nutrition, and WASH services, while prioritizing assistance to those most in need. Special assistance, including cash assistance or waiving of fees, will be established for vulnerable refugees so that they can access services equitably. Efforts will be made to identify and lessen the effects of stigmatization of any individual. Services should be appropriate to the context in which they are provided. These include ensuring and facilitating access to minimum essential services in emergency contexts and different levels of comprehensive services. Refugees must be consulted in the design and implementation of essential service packages to ensure that these services are appropriate and sustainable. Overall, services should be similar to those take into account the services provided in the country of origin and the country of asylum, while ensuring that emergency standards are met.

4. **Access:** Refugees will have access to services at a similar level to those of host communities. Refugees will be able to access clearly defined packages of essential, cost-effective primary and emergency health, nutrition and WASH services. Refugees will continue to have access to a package of potable water and sanitation that meet minimum service provision standards close to their dwellings, and remain involved in designing the priority hygiene components of an integrated WASH package. In addition, UNHCR relies on partners to provide services that complement government services where there are significant gaps in service provision, lack of capacity or need for temporary additional support to be provided; this will ensure refugee access to reproductive health, nutrition, food security, HIV, mental health, specialist care programmes, water, sanitation while advocating for and where applicable enabling governments to provide such services. The rationalization of services is supported by identifying and supporting a select number of quality public health service providers and facilities for primary and emergency health, for nutrition, for specialist health care providers and for additional WASH services if the national infrastructure capacity is insufficient. Limiting the number of potential service providers and services enhances cost-efficiency and effectiveness, and allows more manageable monitoring, evaluation and quality control process.

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2 http://www.unhchr.ch/tbs/doc.nsf/0/a5458d1d1bbd713fc1256cc400389e94/$FILE/G0340229.pdf

3 UNHCR, Age, Gender and Diversity Policy, 8 June 2011. http://www.unhcr.org/refworld/docid/4def34f6887.html

5. **Sustainability:** To ensure sustainability, UNHCR will ensure that the services in the various public health and WASH sectors are integrated within national systems whenever feasible. UNHCR supports relevant government ministries, regional departments and municipalities (e.g. health and water), and national AIDS control programmes and other vertical programmes (such as tuberculosis and malaria) to enable refugees and surrounding host populations to access similar services while avoiding the development of parallel systems whenever possible; this helps to ensure sustainability for refugees as well as host communities when refugees are no longer present.

6. **Community empowerment:** Refugees should be empowered and capacitated at all stages to participate in programme planning, needs assessment, implementation and monitoring and evaluation in order to design acceptable, appropriate, sustainable and culturally-sensitive programmes. They should be guided by principles of confidentiality, safety, security, respect, dignity and non-discrimination. Three strongly interlinked approaches are applied: a participatory approach; a community-based approach; and a rights based-approach, as in UNHCR operations worldwide. This participatory process should feed into developing the four components of the public health policy and interventions in this plan so that it will take into consideration refugees' needs, requirements and diverse profiles within the framework of international standards and human rights.

7. **Appropriateness and reliability:** UNHCR prioritizes high quality, cost-effective, evidence-based services in public health. Essential health care takes precedence over referral to more specialized medical care. Each country programme sets limits on the extent of services that UNHCR can support, especially for specialized care. UNHCR takes value-for-money into consideration by comparing the costs of delivering similar services. Wherever available national service delivery programmes are chosen in preference to setting up parallel services. The food security status of refugees (especially women and children) will be met through clearly understanding the context and responding with appropriate food assistance packages (e.g. food, cash and/or vouchers) and maintain an adequate access and availability to nutritious food and enable refugees to avoid resorting to risky coping strategies. The rationalization of services is supported by identifying and supporting a select number of quality service providers and facilities for primary and emergency health, nutrition, specialist health care providers and for additional WASH services if the national infrastructure capacity is insufficient. Integration into national services, limiting the number of potential service providers and services enhances cost-efficiency and effectiveness, and allows more manageable monitoring, evaluation and quality control process.


The Philippines / Island of Mindanao / Returnees / UNHCR / S. Petit / October 2011

STRATEGIC APPROACHES

1. PARTNERSHIPS AND COORDINATION

UNHCR coordinates with a diverse range of Government, UN, international organisations, national and international NGOs, and faith-based partners in its refugee operations to ensure the availability of quality public health services for refugees. The Agency will continue to strengthen technical innovation and quality by establishing links with other partners, such as academic institutions and the private sector and foundations. UNHCR is committed to the principle of participation, believing that refugees should be consulted on decisions which affect their lives. Public health programs require collaboration between and synergies among various divisions, bureaux, and regional and country offices within the organization. The integrated cross-sectoral approaches ensure that public health strategies optimize the well-being of refugees. Gender and gender-based violence, child protection, education, shelter and settlement, livelihood and environmental issues should be mainstreamed throughout the process of delivering quality and accessible public health interventions.

UNHCR coordinates strongly with relevant government ministries on public health, nutrition services and WASH programmes together with other UN agencies such as WHO, UNICEF and UNFPA. The agency ensures that contingency plans are in place for potential large-scale influxes of refugees. The organisation aims for regular national refugee health coordination meetings with these ministries, and ensures that operational health and nutrition and WASH coordination meetings are conducted with all partners working on these refugee sectors at a decentralized level. UNHCR's partnership with the World Food Programme (WFP) is a cornerstone for the organization's operations, and directly contributes to the health and nutritional well-being and food security of refugees. It has broader positive impacts in other areas such as education, energy and livelihoods. UNHCR, as a UNAIDS co-sponsor and co-lead of the Interagency Task Team to address HIV in humanitarian emergencies, works towards achieving the vision of *Zero New Infections*, *Zero Discrimination* and *Zero AIDS-Related Deaths* and is at the forefront of the response to HIV among conflict-affected and displaced populations. UNHCR will work closely with important WASH actors and in urban settings will develop strategies closely aligned with Government line ministries, UNICEF and UN-Habitat to ensure that refugees will have access to WASH services.

2. CAPACITY-BUILDING

UNHCR will ensure that staff, partner organizations, local governments, refugees and host communities benefit from public health knowledge generation as direct participants or in-direct beneficiaries. A timely, adequate and effective public health response is part of UNHCR's emphasis on improving emergency response to refugee emergencies and ensuring good coordination. The public health strategy will be incorporated in UNHCR's multi-sectoral contingency plans. Public health/Nutrition and WASH coordinators will form an integral part of the core emergency UNHCR response team from the onset of the response in medium to large-scale emergencies.

For technical leadership and coordination, UNHCR's Public Health, Nutrition and WASH officers, as well as standby partners deployed in UNHCR's operational areas will require specific technical skills, but equally important, coordination and leadership skills. At country level, UNHCR will work closely with governments and partners, to ensure that staff working in the public health, HIV, reproductive health, food security, nutrition and WASH, will be included in on-going country training, such as organised by Ministry of Health and other authorities. UNHCR operations will ensure that any training organized by UNHCR or its partners, will benefit the national staff working in the surrounding areas. Specific programmes developed to capacity-building of refugees and the surrounding national populations will be implemented.

3. COMMUNICATION AND ADVOCACY

UNHCR will communicate information on and advocate for public health strategies, programmes, and related activities to internal and affiliated staff, partners, governments, refugees and host communities. Effective communication mechanisms must be in place to improve access to essential services, to ensure information accessibility and to improve the health and nutrition status of refugees. Communication strategies must ensure that refugees and key services providers are aware of their rights and obligations, as well as opportunities and services that are available to them. Key to successful advocacy is the constant flow of information among the refugee community, host community, humanitarian actors, development actors and the Government. Achievements against strategy expected outputs will be published through the UNHCR website (www.unhcr.org), dissemination of reports and other means of communication.

4. INTEGRATED APPROACHES

The public health status of refugees is integral to many sectors. Consider the links, for example, with protection, SGBV, education, livelihoods, energy, environment, shelter and settlement. The Public Health Section will work with all other sectors in the organization at the headquarters, regional and country levels to collaborate and coordinate activities. UNHCR will ensure that the services in the public health and WASH sectors for refugees are integrated within national systems, whenever feasible, to ensure their sustainability. UNHCR supports relevant government ministries (e.g. health and water) and national AIDS control programmes to enable refugees and surrounding populations to access services.

5. MEASUREMENT

All programmes are planned, assessed, monitored and evaluated on the basis of available quality health, nutrition and WASH information. All public health programmes collect and interpret data in UNHCR's global health information toolkit, *Twine* (http://twine.unhcr.org/app/). UNHCR's Health Information System, (HIS) is currently available in two versions – one for camps and the other for out-of-camp (urban and rural) setting. They are used to collect health information from partners providing services to refugees and compiling mortality data. These standardized tools make it possible to design, monitor and evaluate public health and HIV programmes and provide evidence-based information that is used for programme monitoring and policy formulation. All indicators for this strategy are found in the Twine online toolkit of reports and databases drawn from survey and assessment data.

UNHCR has developed and introduced important improvements to the quality of assessment and monitoring in the area of nutrition through standardized expanded nutrition surveys (SENS) and accompanying guidelines (http://www.sens.unhcr.org). The WASH monitoring system is a tool for tracking key WASH indicators at household and community levels in refugee camp settings. The tool also monitors trends in diseases related to hygiene and sanitation conditions in camps. The WASH monitoring system will be further rolled out in key countries. A standardized knowledge attitude and practices survey has been developed for use as a tool for measuring hygiene behaviour in refugee camp settings and to improve WASH programmes accordingly. To improve the collection of data, UNHCR will further introduce the use of smart phones for field surveys in both camp and out-of-camp settings. Technology will also be employed for dissemination of messages and information sharing for mass communication purposes as well as facilitating and monitoring nutrition and food assistance programmes.

Using these tools, UNHCR builds up the evidence base for all its public health activities and promoting quality standards in its different operational areas.

6. INNOVATION

UNHCR continues to draw inspiration from its history and tradition, but is equally committed to finding creative and innovative solutions to energy solutions that improve the wellbeing and dignity of refugees in an evolving world. Maintaining vigilance and dynamism to address sectoral challenges requires a continuous modernization of working methods and application of new and innovative technologies. New approaches to developing sustainable, scalable public health models that aim to increase access to affordable, effective and quality health-care services where there are significant unmet needs and resource limitations are important. The public health sector will continue to adapt innovative approaches to expand appropriate health insurance schemes, develop community-based communication and information sharing systems for health and hygiene promotion, and screening and prevention programmes. Disease surveillance and control measures will be further integrated into the information management structures at all levels to enable real-time monitoring and response. The further expansion of cash-based initiatives will focus on various sectors, particularly on food security and nutrition, but will also include hygiene and health promotion. In the WASH sector, there will be a focus on improving methods for the mapping and modelling of water and sanitation services, as well as on the use of new investment and research for the sector. Links with research and academic institutions will continue.

Turkey / Syrian refugees / UNHCR / A. Branthwaite / September 2012

STRATEGIC OBJECTIVES AND ENABLING ACTIONS

UNHCR'S PUBLIC HEALTH GUIDING PRINCIPLES LAY THE FOUNDATION FOR A HOLISTIC APPROACH THAT PRIORITISES EQUITABLE ACCESS TO APPROPRIATE QUALITY SERVICES, WHICH ARE MONITORED FOR EFFECTIVENESS. STRATEGIC APPROACHES ARE ALSO PROVIDED IN THE DOCUMENT. THESE APPROACHES ARE NECESSARY IN ORDER TO ACHIEVE THE STRATEGIC OBJECTIVES.

The guiding principles, strategic approaches and strategic objectives and outlined in this Strategy will allow UNHCR to meet its global strategic priorities or GSPs in these sectors. These include:

- Addressing major causes of morbidity and mortality
- Providing adequate reproductive health care
- Reducing malnutrition and anaemia
- Meeting international standards in WASH

The following sections describe the overall goals of the Strategy for public health, HIV and reproductive health, food security and nutrition, and WASH. These are followed by strategic objectives and enabling actions that will guide the sectors during the five-year period of the strategy. No detailed exhaustive list of enabling actions and activities is provided. The strategy does not repeat existing standards, approaches and activities that should be available for refugees in all situations, but rather focuses on newer and innovative areas that will be further developed over the next five years.

The strategy sets out a framework for monitoring, and outputs and indicators are provided to measure performance in all four sectors at the country level. These are the key indicators that will be collected in emergencies, longer-term refugee situations, for camp and out-of-camp settings. Achieving the objectives of the Strategy requires accountability at different levels of the organization. The Strategy will be modified at regional and sub-regional levels to reflect the specific and unique context of each region or sub-region. Furthermore the Strategy will support the country offices to adapt and develop their operational planning. Annual reports will be published to monitor the progress.

Turkey / Syrian refugees / UNHCR / A.Branthwaite/ September 2012

PUBLIC HEALTH STRATEGY

CONTEXT AND SITUATIONAL ANALYSIS

Ensuring access to health care is a key component of UNHCR's protection activities as well as a programming priority. UNHCR's public health programmes are delivered within a public health and community development framework, with an emphasis on primary health care (PHC) and support for secondary and occasionally tertiary hospital care. The principal objective of UNHCR's public health programmes is to minimize mortality and morbidity and improve quality of life of refugees.

UNHCR's public health programmes for refugees are anchored on the PHC principles as contained in the Alma Ata Declaration which defines primary health care as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination".[4]

In practice, PHC components vary according to context but should be available at first contact with the health system and on a continuous basis. PHC incorporates the tasks of medical diagnosis and treatment, psychological assessment and management, personal support, communication of information about illness, prevention, and health maintenance. Depending on the setting, PHC may be provided by a nurse, family physician or other type of health worker.

4 Declaration of Alma Ata. International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. Available at: http://www.who.int/publications/almaata_declaration_en.pdf

Since 2008 mortality rates in refugee camps have been improving, however refugee emergencies in 2011 had an impact on the mortality rates, as reflected in the Table 1, below.

TABLE 1: PROPORTION OF COUNTRIES MEETING MORTALITY STANDARDS, 2008-2012

	Standard	2008	2009	2010	2011	2012
CMR	< 0.75 / 1,000 / month	89%	100%	100%	93%	100%
U5MR	< 1.5 / 1,000 / month	92%	90%	100%	96%	100%
NNMR	< 20 / 1,000 live births	89%	100%	100%	100%	100%

Source: UNHCR Health Information System

In the period 2008 to 2012, overall malaria-related mortality among refugees decreased globally. In 2008, malaria ranked as the top cause of crude proportional mortality; however, for the first time in 2010, it no longer represented the leading cause and was replaced by acute respiratory tract infections. In 2011, malaria ranked the third overall cause of mortality among camp-based refugees. Some countries achieved significant progress in reducing the number of malaria cases, including Cameroon and Guinea, while in some others, such as Tanzania, Uganda and Zambia, the cases rose. This development reinforces the need to keep up the momentum on all malaria control activities and incorporate new scientific development in the field.

Since 2010, acute upper and lower respiratory infections (URTI and LRTI) have been the most important cause of mortality and continue to pose high morbidity burdens among refugee populations globally. Among the causes of high morbidity and mortality in refugee populations are overcrowding, harsh climatic conditions with poor shelter and the lack of adequate facility to treat severe cases, and delayed case findings because of poor treatment-seeking behaviour. Progress on reducing deaths from pneumonia will require improved coordination and collaboration with the shelter,[5] energy[6] and WASH sectors among others, increasing the number as well as training and retention of health workers, adapted interventions, sustained provision on essential medicines, and increasing the number of facilities to treat severe cases. Table 2, below, shows the overall morbidity patterns.

5 See UNHCR's Global Strategy for Settlement and Shelter, 2014-2018.

6 See UNHCR's Global Strategy for Safe Access to Fuel and Energy (SAFE), 2014-2018.

TABLE 2: TRENDS IN OVERALL MORBIDITY PATTERNS, 2008, 2010 AND 2012

2008		2010		2012		N	%
1	URTI	1	URTI	1	URTI	640,678	21%
2	LRTI	2	Malaria	2	Malaria	441,144	14%
3	Malaria	3	LRTI	3	LRTI	342,248	11%
4	Watery diarrhoea	4	Watery diarrhoea	4	Intestinal worms	194,901	6%
5	Skin disease	5	Intestinal worms	5	Watery diarrhoea	194,597	6%
6	Intestinal worms	6	Skin disease	6	Skin disease	187,334	6%
7	Eye disease	7	Eye disease	7	Eye disease	102,884	3%
8	Injuries	8	Injuries	8	Injuries	73,303	2%
9	Chronic disease	9	Chronic disease	9	Chronic disease	59,839	2%
	Other		Other		Other	859,215	28%

Source: UNHCR Health Information System

The Expanded Programme on Immunization (EPI) is considered to be the most cost-efficient preventive intervention to reduce childhood morbidity and mortality. Refugee children often miss their vaccination in their country of origin due to conflict and disruption of services. In the asylum country, giving full EPI coverage to refugees often takes time, leaving children unprotected for a longer period. UNHCR, along with UNICEF and WHO, is striving to bring refugee children under coverage of the national EPI programme. UNHCR will seek to place renewed emphasis on this important public health activity in its 2014-2018 Strategy.

Tuberculosis (TB) control programmes are invariably disrupted in conflict situations because of the unavailability of services, delayed treatment-seeking and discontinuation of treatment. A recent analysis of data from several refugee situations has demonstrated high TB burdens in refugee camps.[7] The current Strategy would thus place renewed emphasis on TB control among refugee populations.

Refugees often suffer from various mental health problems due to atrocities faced before or during displacement, including violence, separation, torture, killing, massive destruction, sexual and gender-based violence (SGBV) and child soldiering. This trauma is often compounded by a generalized sense of hopelessness among refugees, absence of employment opportunities, and social dysfunction. Refugees are also frequently diagnosed with symptoms of post-traumatic stress disorder, depression, psychosomatic complaints and anxiety. Addressing these mental health concerns and ensuring an adequate response is often problematic due to the very difficult geographical and political situations in which refugees find themselves, as well as lack of resources to mount an adequate response.

7 Kinbrough W et al. The burden of tuberculosis in crisis-affected populations: a systematic review. Lancet Inf Dis;12:950-65, 2012.

Non-communicable diseases (NCDs) such as cardiovascular diseases, diabetes mellitus, and chronic respiratory diseases are the leading causes of death and disability worldwide, but remain an area of neglect so far. Much of the disability and mortality attributed to non-communicable diseases is preventable, but the '25 by 25' goal[8] will not be met without a major focusing of resources and political commitment to addressing these diseases. Morbidities from NCDs are accelerating globally and advancing in every region; refugee populations have not been spared. Data from refugee camps in Asia and Africa show that the NCD burden and unknown conditions ranges between 34 and 62% in these often remote locations. Cardiovascular, digestive, respiratory and musculoskeletal disorders are among the major NCDs that have been reported. The reported burden is higher in females for both regions.

Proper monitoring of the health situation and access to healthcare of the refugee population remains amongst the highest priorities. The UNHCR integrated online public health information platform (TWINE) will centralize wider public health information of refugees to inform public health decision-making.

STRATEGIC OBJECTIVES AND ENABLING ACTIONS

Objective 1: Improve access to quality primary health care programmes

UNHCR supports Ministries of Health to ensure that refugees have access to curative and preventative health-care services, regardless of whether they are living in refugee camps or out-of-camp and urban situations in low- or middle-income countries.

Fees for accessing health services depend upon the context, but UNHCR advocates that they should not be higher than the fees paid by nationals. Furthermore, vulnerable refugees should be identified and a suitable safety net provided for them to ensure access to preventative and curative health services. Certain essential services, such as childhood vaccinations, antenatal and delivery care, communicable disease control and care for acute life-threatening emergency conditions should be provided free of charge. In situations where these are not provided as part of minimum health-care package and where feasible, they should either be offered by other partners or covered under insurance schemes.

For out-of-camp refugees, UNHCR will continue to monitor PHC access in these contexts through the use and further development of prospective surveillance, and also by developing a simple set of tools to understand how these health services are being used, as well as an urban health information system for UNHCR-supported clinics.

8 Commitment by the UN high-level meeting on NCDs to reducing relative mortality by 25% by 2025.

In refugee camps, public health programmes will continue to emphasize the quality of these programmes. This will focus on ensuring that universal precautions are met; essential quality medicines are available; national clinical protocols are adhered to and that laboratories are functioning and providing quality services; and that qualified staff are trained and retained. The balanced scorecard and laboratory quality assurance tool will be used to assess quality. Additional easy-to-use quality monitoring tools for services at the primary health care level will be developed, and will support UNHCR and partners to continue to monitor and adjust programmes to meet these standards and adapt to the needs of the refugee population.

In the period 2014-2018, UNHCR will expand the vital role that the community-based health workforce plays in all phases of emergency risk management (prevention, preparedness, response and recovery); and promote the scale-up of community-based health workforces by recognizing all those who make up this workforce, and training and equipping them for interventions. A review of innovative initiatives in the domain and an operational guidance for refugee situations will be developed to support country operations to improve community-based health programming. Linkages with hygiene promotion, reproductive health and nutrition are crucial.

Objective 2: Decrease morbidity from communicable diseases and epidemics

Communicable diseases are the major cause of mortality and morbidity among refugees, especially during the emergency phase. The main causes of morbidity and mortality in emergencies are diarrhoeal diseases, including cholera and shigellosis, acute respiratory infections, measles and malaria in areas where it is endemic. Other communicable diseases, such as meningococcal meningitis, dengue and dengue haemorrhagic fever, influenza-like illnesses, hepatitis A and E have also caused outbreaks over the last few years with considerable morbidity and mortality.

During the period of the Strategy, UNHCR will further build upon a systematic approach to the control of communicable diseases. As an effective response will depend on adequate level of preparedness, renewed emphasis will be placed on epidemic preparedness and response. Measures will be taken to ensure that all refugee camps have updated outbreak preparedness and response plans in place so that immediate alerts are embedded in national early warning systems for outbreaks and effective multi-sectorial preventative and response programmes are established, ensuring strong linkages to the WASH sector. Furthermore, UNHCR will strengthen and support the cross-border surveillance mechanism to ensure early detection and management of outbreaks of diseases targeted for eradication (e.g. polio, measles). Synchronised vaccination activities in border areas between hosting countries and country of origin will be sought.

Although malaria is no longer the leading cause of mortality among refugees, recent data shows a rising trend in the number of malaria cases in many refugee settings. Comprehensive malaria control programmes, including appropriate preventive interventions and a treatment policy based on latest efficacy models, remain an operational priority in this Strategy period. UNHCR will continue to advocate for access to national malaria control programmes, as well as support from donors, such as the UN Foundation, for the preventative elements of the control programme. Monitoring of the utilization of long- lasting insecticide treated nets (LLITNs) is also included as a module in the SENS survey.

Acute respiratory infections are the leading cause of mortality and morbidity among refugee children aged under 5 years. Control programmes with community sensitization, early case finding and proper case management will therefore be strengthened. Cross-sectoral preventive activities will be promoted, including the provision of adequate shelter and blankets, drainage of stagnant water, and the reduction of residual smoke through proper cooking-energy provision.

While overall mortality levels have fallen for TB, the TB burden remains enormous. Refugees may be at increased risk of TB or inadequate detection and treatment due to health service disruption caused by conflict in their country of origin and subsequent displacement. Refugees, in general, can be enrolled in well-established national TB treatment programmes. During the period of the Strategy, UNHCR will work strongly to ensure an early response during emergency phases and continue to advocate for access to treatment, improved screening, including linkages to the HIV programmes, and advocate for access to treatment for multi-drug resistant TB and extensively drug-resistant TB.

Objective 3: Improve childhood survival

Across the world, millions of children in resource-poor settings continue to die needlessly from common preventable infectious diseases, such as diarrhoea, pneumonia and malaria. Refugee children bear a disproportionately higher risk than all other age groups. Ensuring the healthy growth and development of refugee children is a prime UNHCR concern. Studies have shown that rapid and sustained progress can be made in reducing neonatal and under-five mortality with effective public health measures.

During the period of this Strategy there will be a strong focus on ensuring that all refugee children have access to full EPI and improved diagnosis and treatment of childhood infections; this will be achieved through the use of updated clinical protocol, the establishment of linkages with national Integrated Management of Childhood Illness (IMCI) approaches, as well as strengthened linkages to nutrition and reproductive health programmes. UNHCR will continue to emphasize the critical role of community-based health interventions in addressing childhood illnesses.

Integrated management of childhood illness is an approach to child health that focuses on the well-being of the whole child. This approach aims to reduce death, illness and disability, and to

promote improved growth and development among children aged under 5 years. It includes both preventive and curative elements that are implemented by families and communities, as well as by health facilities. The IMCI strategy seeks to improve case management skills of healthcare staff, overall health systems and family and community health practices.

In health facilities, the IMCI strategy promotes the accurate identification of childhood illnesses in outpatient settings, ensures appropriate combined treatment of all major illnesses, strengthens the counselling of caretakers and speeds up the referral of severely ill children. In the home setting, it promotes appropriate care-seeking behaviours, improved nutrition and preventative care and the correct implementation of prescribed care.

Linkages to nutrition and reproductive health programmes are critical for infant survival. UNHCR will therefore seek to ensure that all children receiving nutritional treatment can benefit from interventions that improve general health, such as completing the EPI vaccinations, deworming and growth monitoring. Sick children and siblings of malnourished children, can benefit from a nutrition follow-up, as well as preventive and curative health interventions. In essence, all children that go to a health facility should be screened for undernutrition and referred as appropriate (particularly to community-based management of acute Malnutrition or CMAM).

Objective 4: Facilitate access to integrated prevention and control of NCDs, including mental health services

NCDs are major global causes of mortality and morbidity but have so far remained relatively neglected. Disability and mortality attributed to NCDs are largely preventable. Among these are people with mental disorders that do not receive appropriate first-line supportive therapy and treatment.

During the 2014-2018 period, UNHCR will further strengthen its mental health programmes, with the roll-out for a model of interventions for mental health and psychosocial support (MHPSS) programmes, focusing on the primary health care level and establishing multi-sectoral referral mechanisms to ensure that the needs of different stakeholders are promoted in a balanced manner and within a coherent resource use framework.

CASE STUDY - INTEGRATION OF MENTAL HEALTH PRIMARY HEALTH CARE PROGRAMMES IN YEMEN

Based on a 2008 assessment, which found 7-10% of refugees in need of mental health and psychosocial support (MHPSS), UNHCR Yemen initiated MHPSS interventions in Kharaz camp and Basateen Aden urban refugee settlement. The aim was to integrate MHPSS into the primary health care programme and reduce referrals and admissions to specialized hospitals. MHPSS services at the primary health care level are supported by visiting psychiatrists and clinical psychologists. Drop-in centres for psychosocial support were set up at the community-level. Patient assessments include psychological and social vulnerability criteria. The referral system was set up to facilitate two-way referral between primary care providers, counsellors, psychologists and specialized psychiatrists, keeping with MHPSS best practice and UNHCR guidance. The Yemeni MHPSS programme shows that MHPSS interventions are feasible to integrate into primary health care and community-levels.

Pakistan / A doctor examines Adila at a UNHCR free eye clinic in Karachi as her anxious father looks on / UNHCR / D.A. Khan / May 2012

UNHCR will further support the development of an integrated approach that will target all major common risk factors of cardiovascular diseases, diabetes mellitus, and chronic respiratory diseases as the most cost-effective way to prevent and control them. This integrated approach will focus on treating chronic diseases at the primary health care level. There will be a strong preventative component to reduce referral to costly secondary and tertiary health care. For refugee operations in urban settings UNHCR will explore initiatives for delivery of MHPSS and NCD services appropriate to the context.

Objective 5: Ensure rational access to specialist referral care

Medical referral care is an essential part of health services. While the primary health care strategy is the core of all interventions, access to secondary health care is equally important. The different settings of UNHCR operations bring with them a wide variety of disease patterns and burdens, as well as options to access medical referral care. However, essential health care packages take precedence over referral to more specialized medical care. Each country programme sets limits on the extent of services that UNHCR can support, especially for specialized care. A general practice model is promoted in which the majority of consultations are handled within PHC services, with referral for more complex problems. Based on the overall UNHCR principles and guidance for medical referral care,[9] UNHCR country operations will establish country-specific standard operating procedures (SOPs) for medical referral care that stipulate UNHCR access and coverage conditions.

Objective 6: Ensure integration into national services and explore health financing mechanisms

Increasingly, UNHCR takes value-for-money into consideration by comparing the costs of delivering similar services. Wherever national service delivery programmes are available, these are chosen in preference to setting up parallel services for refugees. Examination of existing systems to assess if they can be better integrated into national systems should be done at the field level. Increased linkages with Ministries of Health and relevant UN agencies who work closely with these Ministries should be undertaken.

To promote sustainability, a full understanding of the health financing mechanisms relevant to the health services accessed by refugees should be assessed and understood according to the specific context where refugees are located. Any health financing schemes, including insurance schemes, need to be combined with a mechanism to financially protecting the poor and other potentially vulnerable persons and groups to enable them to access health services. Clear and objective eligibility criteria have to be designed to identify these persons and groups.

9 UNHCR's principles and guidance on referral health care for refugees and other persons of concern. http://www.unhcr.org/pages/49c3646cdd.html

MONITORING

Objective	Output objective	Indicator	Unit	Emergency standard[i]	Post-emergency standard	Camp[ii]	Out-of-camp
Improve access to quality primary health care programmes	Increased access to primary health care	Health utilization rate	New visits/ person/year	1 to 4	1 to 4	Yes	Yes
	Improved community-based health programming	Proportion of community-based health workers to population	Number	1:<1,000	1:<1,000	Yes	Yes
	Improved quality of diagnosis	Percentage of laboratories meeting the laboratory evaluation standard	Percentage of laboratories achieving >60% score		100%	Yes	Yes
	Improved quality of care	Percentage of health facilities meeting the balanced scorecard assessment standard	Percentage of health facilities achieving >60% score	100%		Yes	Yes
		Percentage of health facilities meeting the balanced scorecard assessment standard	Percentage of health facilities achieving >90% score		100%	Yes	Yes
Decrease morbidity from communicable diseases	Improved outbreak response	Does the operation have an outbreak response plan	Yes/No	Yes	Yes	Yes	No
	Decreased malaria incidence	Number of long lasting insecticide treated nets (LLITN) distributed	Number	1 LLITN/ 2 persons	1 LLITN/ 2 persons	Yes	No
		Incidence of malaria among children aged <5 years	Cases/1000/ month	Variable	Variable	Yes	No
		Proportional morbidity of malaria among children aged <5 years	Cases/total <5 years X 100	Variable	Variable	No	Yes
	Decreased watery diarrhoea incidence	Incidence of watery diarrhoea among children aged <5 years	Cases/1000/ month	Variable	Variable	Yes	No
		Proportional morbidity of watery diarrhoea among children aged <5 years	Cases/total <5 years X 100	Variable	Variable	No	Yes
	Decreased pneumonia incidence	Incidence of pneumonia among children aged <5 years	Cases/1000/ month	Variable	Variable	Yes	No
		Proportional morbidity of pneumonia among children aged <5 years	Cases/total <5 years X 100	Variable	Variable	No	Yes
		Incidence of pneumonia ≥ 5 years	Cases/1000/ month	Variable	Variable	Yes	No
		Proportional morbidity of pneumonia ≥ 5 years	Cases/total ≥5 years X 100	Variable	Variable	No	Yes
	Improved TB treatment outcome	Tuberculosis success rate	%	Variable	Variable	Yes	No

Objective	Output objective	Indicator	Unit	Emergency standard[i]	Post-emergency standard	Camp[ii]	Out-of-camp
Improve child survival	Increased coverage infant (0-12 months) vaccination	Full vaccination coverage	%		≥95%	Yes	No
	Measles coverage in emergencies	Measles vaccination coverage[iii]	%	≥95%		Yes	No
	Improved management of childhood illnesses (IMCI)	Has the operation adopted standardized clinical protocols for <5 infections (IMCI or other)?	Yes/No		Yes	Yes	Yes
Facilitate access to integrated chronic disease prevention and control and provide mental health services	Improved care of chronic diseases	Does the operation use standard clinical protocols for diabetes and hypertension?	Yes/No		Yes	Yes	Yes
	Improved care of mental illness	Has the operation adopted at least 7 of 11 recommendations in the checklist for MHPSS Interventions[iv]	Yes/No		Yes	Yes	Yes
Improve access to specialist care and access to national health systems	Improved access to specialist care	Is the referral system governed by SOPs?	Yes/No	Yes	Yes	Yes	Yes
Ensure integration into national services and explore health financing mechanisms	Access to national health systems	Do refugees have access to national health services equally to the national population?	Yes/No	Yes	Yes	Yes	Yes

i In this strategic plan an emergency is arbitrarily defined as the first six months after the population movement has stabilized. However, this definition is context specific and should only serve as general guidance.

ii Not all indicators will be collected in all refugee situations; this table indicates if indicators are collected in refugee camps and or out of camp situations (Yes or No).

iii Note that in acute emergencies, measles immunization may increase beyond 6 months to 15 years, as is the standard. Depending on the vaccination status of the population the age category may increase.

iv See UNHCR Operational Guidance for MHPSS programming in Refugee Operations (UNHCR, 2013) http://www.unhcr.org/525f94479.html

KEY UNHCR REFERENCES

1. Ensuring access to health care: operational guidance on refugee protection and solutions in urban areas. UNHCR 2011. http://www.unhcr.org/4e26c9c69.html
2. Principles and guidance for referral health care for refugees and other persons of concern. UNHCR 2009. http://www.unhcr.org/pages/49c3646cdd.html
3. Essential medicines and medical supplies - policy and guidance. UNHCR 2013. http://www.unhcr.org/527baab09.html
4. A guidance note on health insurance schemes for refugees and other persons of concern to UNHCR. UNHCR 2012. http://www.unhcr.org/4f7d4cb1342.html
5. Public health equity in refugee and other displaced persons settings. UNHCR 2010. http://www.unhcr.org/4bdfe1699.html
6. Operational guidance on mental health & psychosocial support programming for refugee operations. UNHCR 2013. http://www.unhcr.org/525f94479.html
7. Epidemic preparedness and response in refugee camp settings: a pocket guide for Public Health Officers. UNHCR, 2011. http://www.unhcr.org/4f707f509.html
8. Guidance for public health interventions for repatriation. UNHCR 2011. http://www.unhcr.org/4f7080349.html
9. Community-based health workforce: an evidence-based guidance for refugee situations. UNHCR 2014 (forthcoming)
10. Guidance on mortality data collection and reporting in refugee situations. UNHCR 2014 (forthcoming)

Uganda / UNHCR / Frederic Noy / November 2012

Jordan / Syrian Refugees / UNHCR / Jared J. Kohler / September 2013

HIV AND REPRODUCTIVE HEALTH

CONTEXT AND SITUATIONAL ANALYSIS

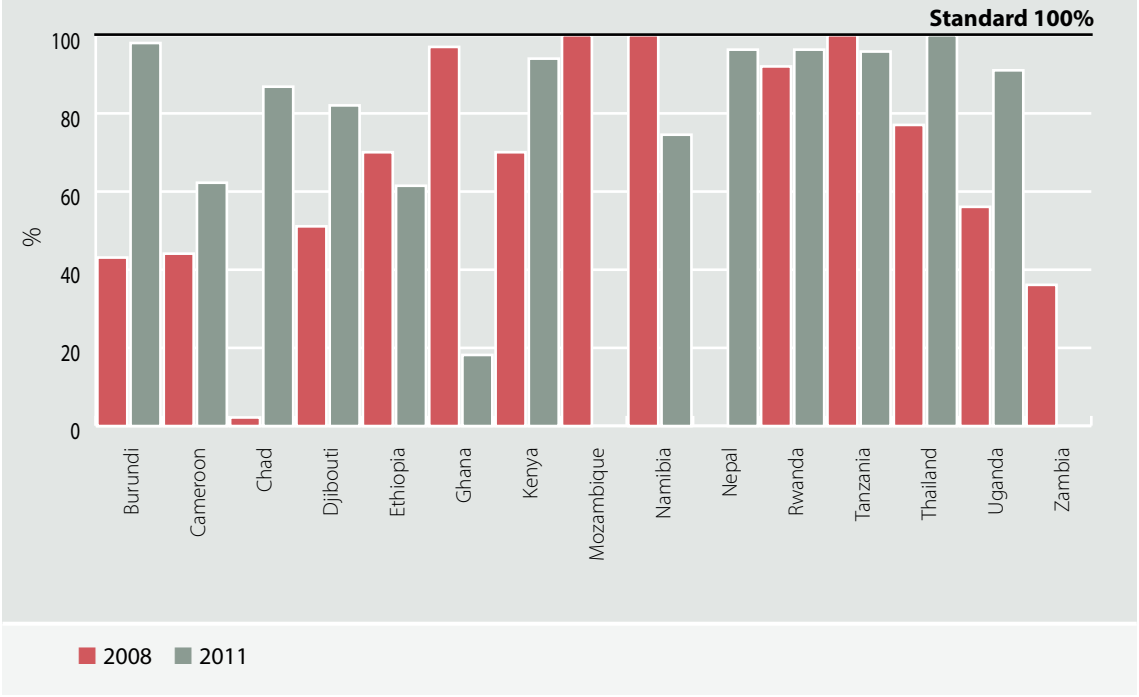
Ensuring universal access to HIV protection, prevention, care, treatment services and comprehensive integrated reproductive, maternal, newborn health services in order to prevent morbidity and mortality due to HIV and reproductive health issues are key components of UNHCR Protection and assistance activities. UNHCR's HIV and reproductive health programmes are delivered within a framework of public health, and protection and community development.

Significant progress has been made in improving access to comprehensive HIV and reproductive health services for refugees through UNHCR's Strategic Plans for Public Health 2008-2012. However, challenges remain and new issues arise. The components of the programme where standards have not been met have become high priority areas for the 2014-2018 Strategy.

In 2012, 53% of countries where UNHCR operates had legislation protecting the rights of HIV-positive asylum seekers compared to 51% in 2008. Similarly, the proportion of countries with legislation protecting refugees from mandatory HIV testing increased from 63% to 65% between 2008 and 2012. Advocacy has led to great improvements in access for persons of concern to antiretroviral therapy (ART) at a level similar to that of the surrounding population. The number of countries in which refugees have equal access to ART increased from 79% to 88% between 2008 and 2012. UNHCR has expanded the availability of post-exposure prophylaxis (PEP) and will continue to do so, with the objective of ensuring 100 per cent access to all refugees within 72 hours after a rape incident occurs. Further efforts are needed in this area.

Between 2008 and 2012, the overall percentage of women with access to prevention of mother-to-child transmission (PMTCT) increased, even though operations did not necessarily meet the 100% standard. Figure 1 shows PMTCT coverage comparisons between 2008 and 2012 in 15 countries.

FIGURE 1: PREVENTION OF HIV MOTHER-TO-CHILD TRANSMISSION COVERAGE, 2008 AND 2012

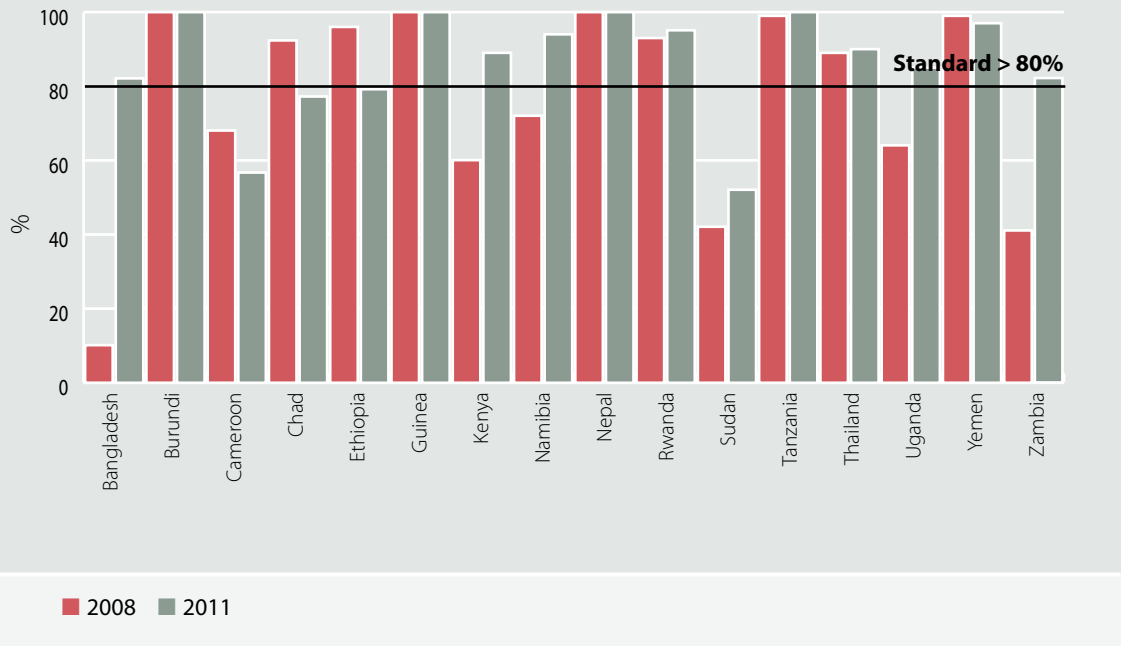


HIV Care and Treatment: Access to ART for refugees has improved since 2008 through consistent advocacy for the inclusion of refugees into National AIDS Programmes, as well as through improved identification of people in need of treatment and efficient referral to health facilities providing such treatment. By the end of 2012, 93% of refugees had access to ART at a level similar that of the surrounding population compared with 79% in 2008.

In spite of these achievements, many operations still need to increase their efforts to reach standards and ensure access to comprehensive HIV protection, prevention, care and treatment programmes. Stigma at country and individual level is still a major obstacle to access to HIV services.

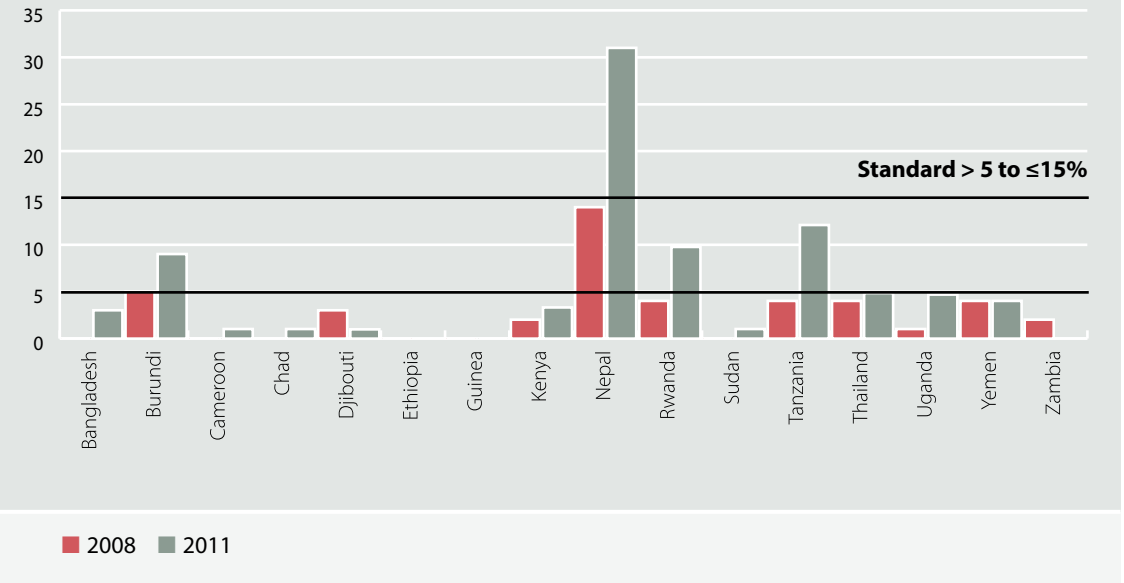
Comprehensive Reproductive Health Services: The number of countries in which at least 80% of deliveries took place in a health centre increased from 48% to 83% from 2008 to 2012. In 2008, 38% of operations were able to meet the standard of at least 90% of deliveries being attended by skilled personnel compared with 61% in 2012. Between 2008 and 2012, there was an increase from 6% to 60% of countries where 5-15% of deliveries were performed by caesarean section, implying more complications that were promptly detected, referred and appropriately managed. These two issues are illustrated in the two figures (Figures 2 and 3).

FIGURE 2: PROPORTION OF DELIVERIES IN A HEALTH CENTRE, 2008 AND 2012



The proportion of operations achieving at least 90% coverage of complete antenatal care (ANC) fell from 48% to 23% between 2008 and 2012; this was attributable to, among others, a rise in the number of ANC visits (from three to four) that had not been included in all country protocols, and high staff turnover.

FIGURE 3: DELIVERIES BY CAESAREAN SECTION, 2008 AND 2012



Access to prevention and treatment of sexually transmitted infections (STIs) increased. At the end of 2012, 90% of operations had standard STI case management protocols in place compared with 85% in 2008. During 2008-2012, coverage of syphilis screening for pregnant women during ANC increased in eight out of 21 (38%) countries.

STRATEGIC OBJECTIVES AND ENABLING ACTIONS

Objective 1: Reduce transmission of HIV using a protection and rights-based approach

UNHCR will continue to anchor its HIV programme in protection and human rights principles and focus on the strong links between protection, education and livelihoods activities. UNHCR will continue its advocacy with countries of asylum to prevent refugees being subjected to any form of mandatory HIV testing and that they do not face the risk of *refoulement*. UNHCR will advocate strongly for the inclusion of refugees and persons of concern in national HIV strategic plans.

UNHCR plans to target young people (10-24 years) in refugee camps as they have special HIV-related prevention and response needs. The HIV programme for young people will focus on evidence-informed combination prevention interventions adapted to specific localities and contexts. These will include awareness raising on sexual and reproductive health and HIV through formal sexuality and life-skills education in schools and in non-formal settings; through peer-led approaches and campaigns, as well as promoting universal access to male and female condoms, providing youth-friendly HIV prevention and response services in health clinics, and empowering youth and youth-led organizations to champion HIV prevention in refugee camps.

With newer models of improving uptake of HIV testing and counselling services, UNHCR will support the introduction of those models in refugee camps with limited coverage in these areas. Emphasis will continue to be placed on strengthening quality-assured testing and counselling services at multiple entry points in the health system, and at community level, guided by the HIV prevalence. Care is taken to ensure that the voluntary and confidential nature of these services and privacy concerns are respected at all times.

Objective 2: Facilitate universal access to antiretroviral therapy

With the release of the 2013 WHO consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV and its implications for national ART programmes, UNHCR will continue to advocate, work with and support Ministries of Health and National AIDS Councils to ensure that refugees benefit from newly-adopted national protocols. When treatment and prevention programmes are well established, UNHCR will focus on scaling-up testing services, early detection of HIV and rapid enrolment in care and treatment.

Equal emphasis will be placed on ensuring adherence to treatment as much as access to treatment. This will entail developing simple evidence-informed guidance notes for promoting adherence in refugee settings and supporting effective adherence monitoring mechanisms. Global experience and UNHCR's own experience suggests that loss to follow-up remains high among clients who are in the pre-ART phase. In addition to supporting adherence measures for ART clients, emphasis will be placed on retaining clients in the pre-ART phase until they become eligible for ART.

UNHCR will work closely with Ministries of Health, National AIDS Councils and partners in promoting and expanding the use of point of care and other simplified platforms for diagnosis and treatment monitoring.

Equitable access to ART will be ensured for children, vulnerable groups among men and women with a particular focus on key populations. In order to increase access to quality and sustainable treatment, ART services will be provided in a decentralized manner and integrated with prevention and other health programmes. Efforts will likewise be put into further strengthening access to prophylaxis and treatment for opportunistic infections, with particular emphasis on TB/HIV co-infection.

Community systems, including networks of people living with HIV and AIDS, will be strengthened to facilitate their active engagement in developing testing and counselling strategies, service design and delivery, adherence and provision of care and support, including nutrition support for the affected communities.

CASE STUDY - CONTINUATION OF ANTIRETROVIRAL THERAPY FOR IVORIAN REFUGEES IN LIBERIA

Effective delivery of HIV services during the influx of Ivorian refugees in Liberia in April 2011 was undertaken through collaborative efforts of the government, NGOs, development partners and UNHCR. At the onset of the emergency, the priority action was to identify those who were already on ART in order to ensure that they continue their treatment. Information on the need of not interrupting ART and where to access services was delivered at the registration centres. Furthermore, community health workers were mobilized to conduct outreach and awareness in communities that were receiving refugees. They provided information on availability of services. By the end of 2011, there were 132 refugees who were on ART; 70 % were newly initiated in Liberia and 30 % were continued from treatment that began in Ivory Coast.

Objective 3: Facilitate the elimination of vertical transmission of HIV

Given the overwhelming evidence on the need to treat HIV-positive pregnant women to prevent and eliminate mother to child transmission, UNHCR will advocate for inclusion of refugees in national roll-out plans. UNHCR will support capacity-building of partners to be able to effectively provide appropriate elimination of mother-to-child transmission regimens according to national protocols.

UNHCR will work with partners and ensure that a full panoply of services to support the elimination of mother-to-child transmission are provided, including universal access to voluntary counselling and testing for pregnant women and access to appropriate ART regimens for pregnant women and exposed babies, including adherence counselling, counselling on infant feeding practices and early infant diagnosis and follow-up testing at 18 months. The full range of elimination of mother-to-child transmission services will be firmly integrated within strengthened maternal and child health systems including focused ANC and skilled birth attendance at delivery.

Objective 4: Improve access to comprehensive reproductive, maternal and new-born health services

UNHCR recognizes that comprehensive reproductive, maternal and newborn services have an impact not just on individuals, but also on the family and the community at large. It will therefore continue to emphasize this area through a community-centred approach.

At the onset of a refugee emergency, programmes are expected to support minimum essential high impact interventions before comprehensive activities are initiated. The Minimum Initial Service Package or MISP for reproductive health lists those priority interventions. As soon as the situation has stabilized and the MISP is in place, programmes will support the establishment of comprehensive reproductive health programmes.

The main components of such a programme would comprise:

The full scope of maternal and child health services, including focused ANC, access to supplementary feeding programmes including macro and micro-nutrients, delivery by skilled birth attendants in institutions with adequate facilities including emergency referral, access to safe blood and caesarean sections, post-natal care, including post-partum family planning counselling and early newborn and

CASE STUDY - MATERNAL DEATH AUDIT IN DADAAB, KENYA

Since 2008, UNHCR monitors all maternal deaths in refugee camps with the goal of improving maternal outcomes in refugee populations. In 2012, a comprehensive review of maternal deaths was carried out in the Dadaab refugee camps in Kenya. Eclampsia was identified as the leading cause of death. Furthermore a refusal to consent for procedures was a critical contributor to most of the maternal deaths. Based on the findings, birth plans were introduced in Dadaab to ensure consent for procedures and prepare the pregnant women and their families for the delivery. Furthermore, clinical staff received additional training on the management of complications, including pre-eclampsia and eclampsia.

neonatal care. All efforts will be made to minimize delays in access to maternal health services. In refugee camp settings, in the event of a maternal death, an audit will be conducted within 48 hours.

Preventing and managing fistula in refugee settings will be accorded high priority and addressed by improving skilled birth attendance at delivery, early detection of fistula and providing primary/secondary/tertiary care as needed for the woman.

Child spacing/family planning measures will be introduced to meet current unmet needs. UNHCR will work with key stakeholders and use the widest spectrum of family planning methods in health clinics to be provided with quality counselling and by trained healthcare workers. Various community mobilization strategies, including partnering with men, will be used to increase uptake of family planning services.

Evidence-informed *adolescent sexual and reproductive health* services which include quality, gender-sensitive youth-friendly information and services for young people (10-24 years) in both school and out-of-school settings will be provided. This will be achieved with full participation of young people and involvement of teachers, parents and community leaders. This approach aims to encourage the integration of youth centres with health centres. Evidence-informed peer approaches to promote behaviour change and increase uptake of services will also be supported in refugee situations.

Prevention and treatment of STIs will continue to be a high strategic priority. A syndromic approach, e.g. treatment of symptoms, to managing STIs will be strengthened through awareness-raising, training, ensuring availability of drugs and supplies, display of protocols and carrying out prescription audits. Partner tracing, voluntary HIV counselling and testing for STI patients and their partners, venereal disease research laboratory and rapid plasma regain testing during ANC will be actively pursued. Presumptive treatment for high-risk groups will also be encouraged.

Sexual and gender-based violence remains both a protection and a public health challenge and combating it requires the adoption of an integrated approach involving health, protection and community-based protection. In line with the UNHCR Strategy for action against SGBV,[10] UNHCR will strengthen the referral systems and SOPs for clinical management of rape survivors. Clinical staff will be trained in clinical management of rape survivors and awareness of the population on early reporting, availability of services and referral pathways would be improved. Harmful traditional practices, such as early marriage and female genital mutilation, have a substantial impact on human rights and public health. Strong collaborative efforts involving protection and the health sector will be made to address these issues through a long-term strategic approach. The plan will support capacity-building of partners with qualified agencies with a record of success in these areas.

10 Action against Sexual and Gender-Based Violence; an updated strategy, June 2001 http://www.unhcr.org/4e1d5aba9.pdf

Objective 5: Make progress in the use of innovative and appropriate technologies in women's health

Global evidence suggests that a majority of maternal and child deaths could be prevented if women's rights are respected and if greater access to skilled care is available during pregnancy, childbirth and postpartum. Apart from the risk of maternal mortality, girls and women also pass through significant health challenges in their life cycle. Current tools and models of care for girls and women have not managed to address these challenges adequately.

In the last few years, new approaches to developing sustainable, scalable models for providing health care in countries where significant unmet needs have emerged including new solutions and innovative models that increase access to affordable and quality healthcare services for girls and women.

Under the Strategy, country operations will be supported to provide prevention and primary level care for gynaecological conditions, such as cervical cancer and breast cancer. Where national screening programmes exist and affordable treatment is feasible, screening for reproductive cancers will be undertaken.

UNHCR will seek to enhance linkages with national human papillomavirus (HPV) vaccination programmes for young children – a programme that is currently being rolled out through the Global Alliance for Vaccines and Immunization campaign in ten countries in sub-Saharan Africa and South-East Asia.

Furthermore, UNHCR will explore the potential to roll-out text/SMS message technology to share information and reminders on appointments, such as the next ANC visit.

Tanzania / Lukama village / UNHCR / B. Bannon / November 2008

MONITORING

Objective	Output objective	Indicator	Unit	Emergency standard[v]	Post-emergency standard	Camp[vi]	Out-of-camp
Reduce transmission of HIV using a protection and rights-based approach	Refugees are not discriminated upon because of their HIV status	Advocacy for legislation protecting the rights of HIV positive refugees?	Yes/No	Yes	Yes	Yes	Yes
	Reduced sexual transmission of HIV	Access of refugees to male condoms?	Yes/No	Yes	Yes	Yes	Yes
Facilitate universal access to antiretroviral therapy	Improved early detection of HIV	Equal access to VCT services as host nationals ensured?	Yes/No		Yes	Yes	Yes
		Do refugees have equal access to provider initiated testing & counselling?	Yes/No		Yes	Yes	Yes
		Proportion of TB patients tested for HIV	%		100%	Yes	No
	Universal access to ART for those eligible for treatment	Equal access to ART services as host nationals ensured?	Yes/No	Yes	Yes	Yes	Yes
		Number of refugees receiving ART	Number		Yes	Yes	No
Facilitate the elimination of vertical transmission of HIV	Scale-up and strengthen Elimination of mother to child transmission	PMTCT coverage	%		100%	Yes	No
		Equal access to maternal and newborn services as host nationals ensured?	Yes/No	Yes	Yes	Yes	Yes
Improve access to comprehensive reproductive, maternal and newborn health services	Emergency Obstetrical and Neonatal Care is available and accessible 24 hours/ 7days per week and referral care is established.	Proportion of births attended by skilled personnel	%	≥90%	100 %	Yes	Yes
		Proportion of births conducted by caesarean section	%	>5 - <15%[vii]	>5 - <15%	Yes	Yes
		Does the operation have an obstetric fistula and referral programmes	Yes/No		Yes	Yes	Yes
	Improved newborn care and survival	Are ambu bags for neonatal resuscitation available in all health facilities?	Yes/No	Yes	Yes	Yes	No
	Investigation of all maternal deaths	Proportion of maternal deaths investigated within 48 hours	%	100%	100%	Yes	No

Objective	Output objective	Indicator	Unit	Emergency standard[v]	Post-emergency standard	Camp[vi]	Out-of-camp
Improve access to comprehensive reproductive, maternal and newborn health services	Improved preventive services for pregnant women, mothers and newborns	Coverage of antenatal tetanus vaccination	%		≥95%[viii]	Yes	No
		Antenatal care coverage	%		≥95%	Yes	No
		Postnatal care coverage	%		≥95%	Yes	No
	Rape survivors receive appropriate clinical care	Proportion of eligible rape survivors provided with PEP within 72 hours	%	100%	100%	Yes	Yes
	Increased family Planning uptake	Contraceptive prevalence rate	%		≥30%	Yes	No
	Reduced sexually transmitted infections	Incidence of pelvic inflammatory disease	cases/1000/month		Variable	Yes	No
		Incidence of genital ulcer disease	cases/1000/month		Variable	Yes	No
	Adolescent sexual and reproductive health improved	% of deliveries to under 18s	%		Variable	Yes	No
Make progress in the use of innovative and appropriate technologies in women's health	Improve women's health	Do refugee women have equal access to cervical cancer screening as host community	Yes/No		Yes	Yes	Yes
		Do girls < 16 years have access to HPV vaccination?	Yes/No		Yes	Yes	Yes

v In this strategic plan an emergency is arbitrarily defined as the first six months after the population movement has stabilized. However, this definition is context specific and should only serve as general guidance.

vi Not all indicators will be collected in all refugee situations; this table indicates if indicators are collected in refugee camps and or out of camp situations (Yes or No).

vii WHO recommends that the caesarean section rates should not be higher than 10-15%.

viii http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/immunization_tetanus.pdf

KEY UNHCR REFERENCES

1. Note on HIV/AIDS and the protection of refugees, IDPs and other persons of concern. UNHCR 2006. http://www.unhcr.org/444e20892.html

2. Antiretroviral medication policy for refugees. UNHCR 2007. http://www.unhcr.org/refworld/docid/45b4af612.html

3. Policy Statement on HIV Testing and Counselling in Health Facilities for Refugees, UNHCR/ WHO/UNAIDS (revision in 2014)

4. Clinical guidelines on antiretroviral therapy management for displaced populations for Southern Africa. Southern African HIV Clinicians Society, UNHCR 2007. http://www.unhcr.org/4683b0522.pdf (revision in 2014)

5. Interagency Field Manual on Reproductive Health in Humanitarian Settings. IAWG 2010. http://www.unhcr.org/4c187e5b6.html

Republic of Congo / CAR refugees / UNHCR / Louise Culot / December 2013

South Sudan / Sudanese Refugees / UNHCR / B. Sokol / August 2012

FOOD SECURITY AND NUTRITION

CONTEXT AND SITUATIONAL ANALYSIS

The goal of this sector is to improve the food security and nutrition situation of refugees, and to reduce the prevalence of undernutrition amongst refugees, especially to women, young children and other vulnerable groups, including young people, the elderly and people with special needs.

Displacement is a major shock for people and is often associated with a complete rupture of their livelihoods and loss of entitlements leading to undernutrition and food insecurity. In refugee operations, protection, food security and nutrition are closely intertwined. Forcibly-displaced people need to acquire food and other basic items and services every day, but many aspects of refugee settings make this challenging and risky. Host government policy often makes it illegal for refugees to work or to own property or businesses. Encampment policies restrict freedom of movement of refugees, including access to markets. Livelihoods can be further restricted by a number of factors, thereby negatively affecting food security and nutrition. These include limited access to pastoral and arable lands, natural resources, attrition of knowledge and skills, limited transportation facilities and situations of generalized poverty.[11] Displacement is increasingly affecting both for rural and urban populations. Food security and nutrition operations will build on growing experience working with displaced urban populations to address the different challenges and food security and nutrition needs.

In such environments, refugees struggle to pursue livelihoods and become even further impoverished without them. Before arriving in their country of asylum, refugees often travel for days in precarious conditions, further compromising their physical health and safety and putting them at increased risk of disease, malnutrition and death. Productive assets, such as cash savings or transportable goods, are rapidly eroded and access to some of their human and social capital is lost.

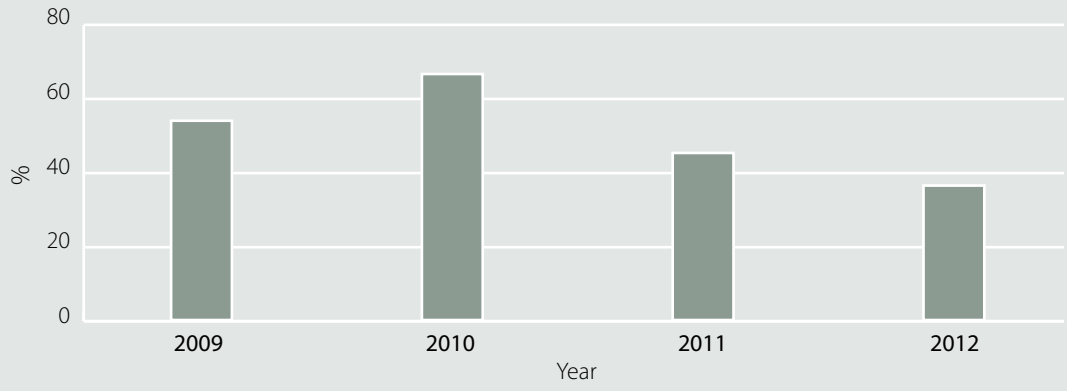
11 See UNHCR's Global Strategy for Livelihoods, 2014-2018.

Households and individuals that used to be 'better off' slip into poverty, while the poor become more vulnerable and risk facing acute food insecurity and malnutrition.

As a consequence, acute malnutrition and stunting is highly prevalent in many emergency and post-emergency refugee situations around the world, especially among young children. This is often exacerbated by challenging environmental, sanitation and shelter conditions at the onset of displacement. In 2012, almost two-thirds (63%) of the camps and settlements surveyed showed global acute malnutrition (GAM) levels of 10% or more among infants and children aged between 6-59 months.[12]

Acute malnutrition among children aged under-five, together with mortality, is a main indicator for the overall health and nutrition of a population. The principal causes for acute malnutrition are inadequate food intake and utilization, sub-optimal infant and young child feeding (IYCF) and care practices, and morbidity often linked to environmental, hygiene and shelter concerns. In addition, micronutrient deficiencies, notably anaemia, are common across refugee populations, including in post-emergency contexts, in large part because of inadequate food intake and communicable diseases, such as malaria. This is illustrated in Figure 4.

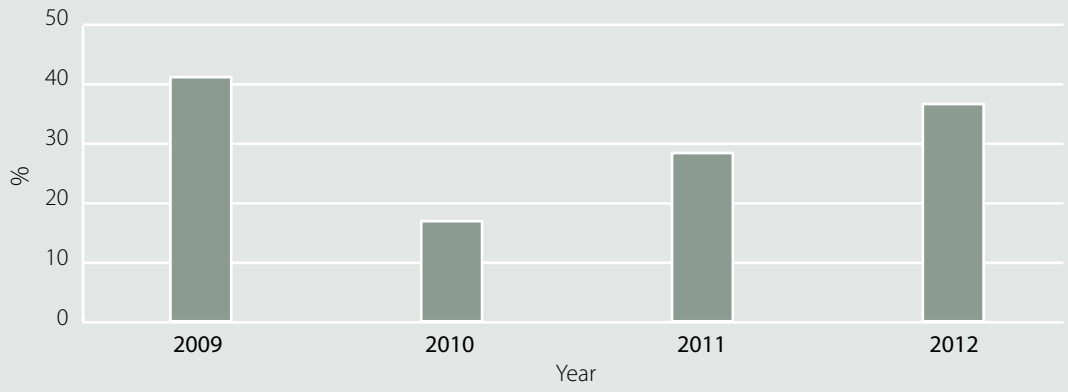
FIGURE 4: PROPORTION OF SURVEYED SITES WHERE GAM PREVALENCE AMONG CHILDREN 6 – 59 MONTHS OLD MEETS STANDARDS OF < 10%, 2009-2012



12 UNHCR reporting to BPRM 2009-2012. Source: UNHCR's nutrition survey database.

In 2012, 63% of the camps and settlements surveyed showed anaemia levels of 40% or above among infants and children aged between 6-59 months (Figure 5).[13] Malnutrition and micronutrient deficiencies can lead to irreversible developmental delays, stunting, and death with impacts on short-term survival and long-term economic and productive capacity.

FIGURE 5: PROPORTION OF SURVEYED SITES WHERE ANAEMIA PREVALENCE (HAEMOGLOBIN < 11G/DL) AMONG CHILDREN 6 – 59 MONTHS OLD IS < 40%, 2009-2012



Food security and nutrition interventions aim to improve the immediate food security and nutritional well-being of refugees, mainly by tackling the immediate and underlying causes of malnutrition. This is done through: (a) effective prevention of undernutrition and micronutrient deficiencies through the provision of access to food, cash and/or vouchers to the general population, and special nutritional products for vulnerable groups, as well as the promotion of and support to adequate infant and young child feeding and care practices; (b) treatment of acute malnutrition ensuring quality treatment projects and sufficient coverage; (c) provision of up-to-date food security and nutrition information and analysis, thereby enabling appropriate and needs-based programming; and (d) effective food security and nutrition response in emergencies. The food security and nutrition sectors also work in close collaboration with livelihoods, to provide longer term solutions and to promote self-reliance among refugees.

13 UNHCR reporting to BPRM 2009-2012. Source: UNHCR's nutrition survey database.

STRATEGIC OBJECTIVES AND ENABLING ACTIONS

Objective 1: Effective prevention of undernutrition and micronutrient deficiencies

Effective prevention of undernutrition and micronutrient deficiencies are optimally achieved through the provision of, and ensuring access to, adequate foods, as well as the promotion of adequate IYCF and care practices. Prevention is also assured through the improvement of the WASH situation and health conditions and improved shelter and livelihoods opportunities.[14]

Access to adequate food is provided through a variety of means. At the onset of an emergency, it is often provided through food assistance, in most cases in collaboration with the WFP. Specific projects for the prevention of undernutrition namely blanket feeding for young children and pregnant and lactating women using special nutritional products or fortified blended foods are put in place where the prevalence of acute malnutrition is high or where there are aggravating risk factors. Use of other micronutrient-rich products is initiated where micronutrient deficiencies, including anaemia and stunting, are high.

Providing adequate food assistance in the form of in-kind food aid or cash-based assistance during the first days of displacement is essential for ensuring the nutritional well-being of refugee populations during this critical period. Although in the initial stages of an emergency when registration of refugees is getting underway, management of food assistance according to UNHCR norms may be challenging, these activities need to be appropriately organized as soon as possible. Not doing so increases the risk of food insecurity and malnutrition and issues related to protection.

CASE STUDY - RESPONSE TO ANAEMIA IN KAKUMA, KENYA

Anaemia in Kakuma refugee camp in Kenya has been regularly measured since 2003 showing unacceptable levels in children under 5 years old. In 2008 the anaemia strategy was activated to ensure improved coordination between nutrition and reproductive health programmers, as well as tp reinforce diagnosis and treatment of anaemia and acute malnutrition. Concerted efforts were made in malaria prevention and control, improvement in infant and young child feeding and acre practices, the use of specialized nutrition products and improved detection and treatment of malnutrition, improved vaccination programmes and WASH interventions. Remarkable anaemia reductions have been recorded in Kakuma since the initiation of the anaemia strategy in 2008. Total anaemia has reduced from 73% in October 2008 to 34.4% in November 2012, representing a 53% decrease overall. The most impressive reductions have been observed in the more clinically meaningful moderate and severe anaemia levels which have reduced by virtually 70% with almost inconsequential levels of severe anaemia.

14 See UNHCR's Global Strategy for Livelihoods, 2014-2018 and UNHCR's Global Strategy for Settlement and Shelter, 2014-2018.

In areas where there is an established nutrient gap in the diet to meet the requirements of special groups, such as children aged 6-23 months, pregnant and lactating women, implementation of blanket supplementary feeding programmes or use of special micronutrient products will be recommended.

UNHCR will continue to promote the expanded use of cash and vouchers among refugees. Increasingly, where markets are functional and refugees have access to them, UNHCR provides cash and/or vouchers to refugees, to increase their purchasing power to access nutritious, diversified and culturally appropriate foods.[15] Cash and vouchers also provide important protection dividends as they, among others, provide refugees with a choice and helps add a measure of normality to their life through economic empowerment and market inclusion. In addition, agriculture and homestead food production, including vegetable gardening and safe animal rearing, is promoted wherever possible through provision of inputs and adapted training.

Promoting and supporting adequate IYCF and care practices play a key role in preventing malnutrition and micronutrient deficiencies. Sensitization, demonstrations and other interventions, such as baby and child-friendly spaces and community-based support networks, are put in place to promote and support feeding and care practices that maximize survival and reduce morbidity in children less than 24 months. These include, but are not limited to: timely initiation of exclusive breastfeeding, exclusive breastfeeding for six months; continued breastfeeding to 24 months and beyond; and introduction of safe, adequate and appropriate complementary foods at 6 months as well as support (psychosocial or otherwise) to mothers of young children.

Protection and promotion of appropriate IYCF in emergencies at the initial stage of an emergency helps to save the lives of the most vulnerable infants and young children aged under two years. This will be the case even in situations where global acute malnutrition is not of particular concern in the given emergency. In 2013, infant and young child feeding in emergencies was rarely an early feature of emergency nutrition programming and is an action that needs to be strengthened.

UNHCR will also increasingly look for local and culturally-adapted solutions for the prevention of undernutrition. These include enhancing access to fresh milk among pastoral populations and promoting other traditional practices that may have positive nutritional outcomes, such as consumption of locally available traditional, seasonal or wild foods as well as supporting traditional food preparation techniques that enhance bioavailability of nutrients in foods. Improvement of IYCF practices will also be a major focus over the strategy period.

UNHCR will continue to improve the timeliness of food security and nutrition interventions in refugee emergencies and strive to strengthen preparedness and planning. Beginning with the provision of food rations or prepared meals, where needed, in the first days of displacement alongside collection and documentation of regular and meaningful data in order to determine needs and trends. This

15 An introduction to Cash-Based interventions in UNHCR operations, 2012 http://www.unhcr.org/515a959e9.pdf

will lead to more timely and effective food security and nutrition programming. In addition, timely and adequate coordination and organization of nutrition services will be assured during large influx emergencies.

Objective 2: Effective treatment of acute malnutrition

Treatment options for acute malnutrition exist either through services provided in refugee camps or through national programmes; however, there is a substantial variation in treatment outcomes and project quality in the different scenarios. Treatment of acute malnutrition in refugee situations should be managed using the principles of community-based management of acute malnutrition (CMAM), according to relevant national treatment guidelines or WHO protocols where there are no recent CMAM treatment guidelines.

Treatment of severe acute malnutrition (SAM) will be provided through inpatient and outpatient platforms and, wherever possible, in collaboration with UNICEF, in order to secure the supply of severe acute malnutrition treatment products and training. Treatment of moderate acute malnutrition (MAM) using outpatient modalities will be provided, with WFP normally providing the food products required for the treatment of moderate acute malnutrition. Community involvement and awareness in the identification of malnourished individuals, and their inclusion and retention in the treatment of acute malnutrition is crucial in the success of this programme, as well as in obtaining effective coverage. Establishing and maintaining strong linkages between the different components of the CMAM programmes, as well as with health and preventative services are key features of any effective treatment programme.

In emergency situations where GAM levels are high, it is important to ensure optimal organization and coordination of services among all partners and to maintain communications with and raise awareness among the refugee population.

CASE STUDY - MILK KITCHEN

UNHCR has a strict policy on the acceptance, distribution and use of milk products in refugee settings, which protects young children from illness due to contamination of milk products. UNHCR also recognizes the nutritional importance of milk and milk products as well as their added socio-cultural value, especially in pastoral populations who make up a large proportion of refugees worldwide in e.g. Kenya, Niger, Burkina Faso, Mauritania, South Sudan and the lack of milk in these refugee situations.

As a way of reconciling the need to protect young infants from the dangers of using milk products in refugee situations, a project of milk kitchens is being designed. The milk kitchen concept will offer a glass of milk to young children on a regular basis within a child-friendly space environment which also promotes early childhood development programmes, to be consumed on site under appropriately hygienic situations. The programme will draw upon the available livestock amongst both the refugee and host population thereby, not only improving the diet of the young children, but supporting refugee and surrounding population livelihoods through increasing outlets for the milk products and ensuring good veterinary care and control of the herds. The concept is currently being considered in Burkina Faso.

UNHCR will continue to strengthen programmes to treat acute malnutrition, with a particular focus on improving community activities and linkages with related services and seeking appropriate solutions for the management of acute malnutrition in refugees living in out-of-camp situations. Monitoring of ongoing treatment programmes will be systematic, with documentation through an improved nutrition module in the HIS. Regular coverage surveys will be promoted, especially in high GAM situations.

Objective 3*:* Effective provision of up-to-date food security and nutrition information and analysis (to enable appropriate and needs-based programming)

UNHCR has developed a number of tools to provide information on the food security and nutrition status of refugees and implemented them in most refugee operations worldwide. Analysis and information obtained through surveys, studies and monitoring feed directly into programming in order to ensure that food security and nutrition programmes are based on needs and evidence. UNHCR will continue to promote the use of the SENS (http://www.sens.unhcr.org) in refugee operations on a regular basis, preferably annually. The SENS is the reporting standard for UNHCR's global strategic priorities and is based on internationally accepted methods for anthropometric data collection at the population-level, and also includes information on health, anaemia, IYCF, food security, WASH and mosquito net coverage.

Measures will be taken to ensure that anthropometric screening and rapid Joint Assessment Missions (rapid JAMs) are conducted together with WFP in a systematic and in a timely manner in all new emergencies. Measures will likewise be established to ensure that recommendations from assessments and surveys, including SENS and joint assessment missions, are followed up. Monitoring of on-going operations, e.g. through post-distribution monitoring (PDM) and food basket monitoring (FBM), will be formalized to allow for timely implementation changes, where required.

UNHCR-WFP guidance on JAMs (http://www.unhcr.org/521612d09.html) is a key tool for assessing the food security situation among refugees and is used systematically in joint activities with WFP. Practical guidance was updated in 2013 and now also includes rapid JAM guidance, which provides a methodology for a rapid food security assessment in new refugee emergencies.

MONITORING

Objective	Output objective	Indicator	Unit	Emergency standard[ix]	Post- emergency standard	Camp[x]	Out- of-camp
Improve the food security and nutrition situation of refugees, and reduce the prevalence of undernutrition among refugees, especially women, young children and vulnerable people	Reduce prevalence of global acute malnutrition	Global acute malnutrition	Prevalence (%)	<10%	<10%	Yes	Yes
	Reduce prevalence of chronic malnutrition (stunting)	Stunting	Prevalence (%)		< 20%	Yes	Yes
	Reduce prevalence of anaemia in infants and children aged between 6 - 59 months	Anaemia (children aged between 6-59 months)	Prevalence (%)		< 20%[xi]	Yes	Yes
	Reduce prevalence of anaemia among non-pregnant women aged between 15 and 49 years	Anaemia among non-pregnant women aged 15-49 years	Prevalence (%)		< 20%	Yes	Yes
Effective prevention of undernutrition and micronutrient deficiencies	Improve adequate dietary diversity	Percentage of households not consuming any vegetables, fruit, meat, eggs, fish/ seafood and milk/ milk products	Proportion of households		<10%*	Yes	Yes
	Improve access to adequate foods without resorting to negative coping strategies	Proportion of households not using negative coping strategies	Proportion of households		>50%*	Yes	Yes
	Improve provision of continued and predictable food assistance	Occurrence of pipeline breaks during the past year	Yes/No	No	No	Yes	No
	Improve coverage of special nutrition products for prevention of undernutrition in young children (LNS/ MNP/FBF)[xii]	Coverage of special nutrition products for prevention of undernutrition in young children (LNS/MNP/FBF)	Coverage (%)	>70%	>70%	Yes	Yes
	Improve IYCF practices	Timely initiation of breastfeeding	Proportion of children 0-23 months who were put to breast within one hour of birth	≥70%*	≥80%*	Yes	Yes
	Improve IYCF practices	Exclusive breastfeeding under 6 months	Proportion of infants 0-5 months who received only breast milk during the previous day	≥70%*	≥70*	Yes	Yes

Objective	Output objective	Indicator	Unit	Emergency standard[ix]	Post- emergency standard	Camp[x]	Out- of-camp
Effective treatment of acute malnutrition	Improve MAM treatment outcomes	MAM treatment programme recovery	Recovered (%)	>75%	>75%	Yes	Yes
	Improve SAM treatment outcomes	SAM treatment programme recovery	Recovered (%)	>75%	>75%	Yes	Yes
	Improve coverage of SAM treatment programmes	SAM treatment programme coverage	Coverage (%)	>90%	>90%	Yes	No
Effective provision of up-to-date food security and nutrition information and analysis (to enable appropriate and needs-based programming)	Improve nutrition needs assessment and nutrition status monitoring	A population-based nutrition survey conducted?	Yes/No	Yes[xiii]	Yes [xiv]	Yes	Yes
	Improve food security needs assessment	JAM conducted according to recommended schedule?	Yes/No	Yes	Yes	Yes	Yes
	Improve emergency nutrition needs assessment	Rapid MUAC screening of children aged under 5 years has been conducted and report produced?	Yes/No	Yes	Yes	Yes	Yes
	Improve emergency food security needs assessment	Rapid food security needs assessment has been conducted and report produced?	Yes/No	Yes	Yes	Yes	Yes
	Improve post-distribution monitoring (PDM)	PDM has been conducted during the last year and report produced?	Yes/No	Yes	Yes	Yes	Yes
	Improve food basket monitoring (FBM; where receiving in-kind food aid)	FBM has been conducted during the last year and report produced?	Yes/No	Yes	Yes	Yes	Yes

* As no standard targets exist for these indicators, the indicator targets are developed based on technical consultations and review of current refugee populations. These targets may be subject to adjustments as more evidence is gathered.

ix In this strategic plan an emergency is arbitrarily defined as the first six months after the population movement has stabilized. However, this definition is context specific and should only serve as general guidance.

x Not all indicators will be collected in all refugee situations; this table indicates if indicators are collected in refugee camps and or out of camp situations (Yes or No).

xi Using future experiences and data generated from UNHCR SENS surveys this may be modified to reflect moderate and severe anaemia for both children and non-pregnant women of reproductive age.

xii LNS: Lipid-based nutrition supplements, MNP: Micronutrient powders and FBF: Fortified blended foods.

xiii As early as possible in the first 6 months of an emergency

xiv During the past 12 months

KEY UNHCR REFERENCES

1. UNHCR's policy related to the acceptance, distribution and use of milk products in refugee settings. UNHCR 2006. http://www.unhcr.org/4507f7842.html

2. Operational guidance on the use of special nutritional products related to reduce micronutrient deficiencies and malnutrition in refugee situations. UNHCR 2011. http://www.unhcr.org/4f1fc3de9.html

3. Guidelines for selective feeding: the management of malnutrition in emergencies. UNHCR and WFP 2011. http://www.unhcr.org/4b7421fd20.html

4. Joint Assessment Missions. UNHCR and WFP 2013. http://www.unhcr.org/521612d09.html

    a. A practical guidance to planning and implementation

    b. Technical guidance sheets

    c. Rapid JAM

5. UNHCR's standard operating procedures for the handling of breast milk substitutes in refugee situations. UNHCR 2014 (forthcoming)

South Sudan / UNHCR / L. Isla / June 2013

Kenya / IDPs in Showground site, Nakuru / UNHCR / H. Caux / May 2008

WATER, SANITATION AND HYGIENE (WASH)

CONTEXT AND SITUATIONAL ANALYSIS

The water, sanitation and hygiene sector aims to ensure that refugees have safe access to water of sufficient quality and quantity and to improved sanitation and hygiene and improved WASH services in institutions, including schools and health facilities.

All refugees are assured the basic right to water and sanitation facilities and hygiene promotion and practices to reduce morbidity and mortality, as well as enhance their protection, dignity and quality of life. The WASH sector promotes a demand-led approach that puts people rather than engineering at the heart of the interventions. In addition, the WASH sector addresses specific cultural and social needs to ensure that minimum standards are met, and that both the quality and quantity of water and sanitation are enhanced to reduce the likelihood of a negative impact on protection and health status. UNHCR is also committed to WASH solutions, which are efficient in reducing long-term operational costs.

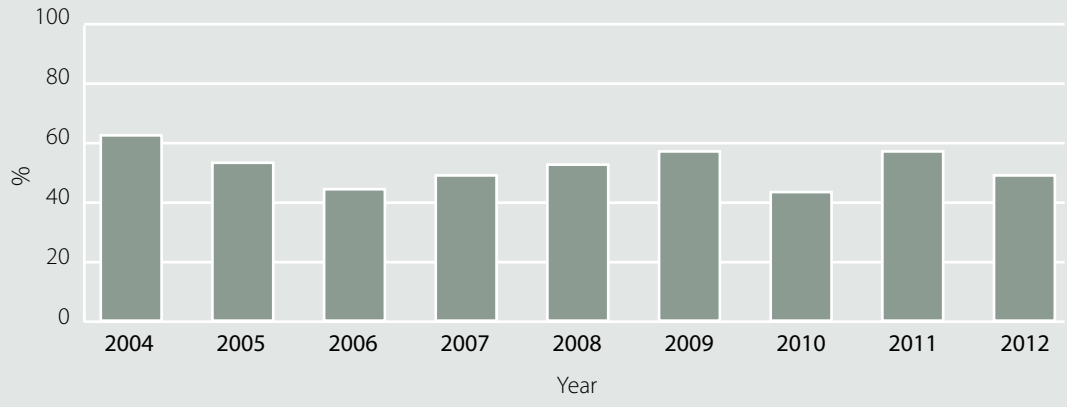
In refugee camps, as in most parts of the world, women and children primarily bear the burden of collecting water. Children sent to fetch water are often diverted from their school activities, which affects their academic performance. Long walking distances and excessive queuing time at water points can have high social costs in the form of lost opportunities for productive work, adversely impacting health and exposing refugee women and children to potential harassment.

Provision of accessible and adequate WASH interventions has positive effects across numerous important areas of intervention:

- *Protection*: Long distances to water points can put young girls and women at risk of sexual violence.
- *Nutrition*: A woman drawing 80 litres of water for her family from a well and carrying it to their home 200 metres away (often uphill from the well) uses approximately 17% of the standard ration of 2,100 Kcal/day just to accomplish this task.
- *Education*: 42% of children attending school in one Ugandan refugee camp had their schooling interrupted due to water collection.
- *Food security and livelihoods*: Women who spend their time collecting water are missing opportunities to participate in more productive activities.
- *Environment*: Non-sustainable usage of water resources can potentially overexploit groundwater resources.

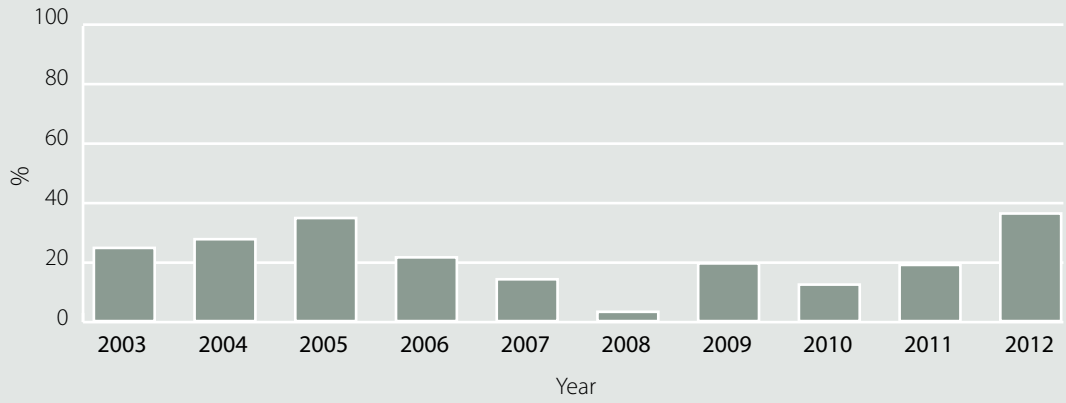
WASH activities have been increasingly prioritized by UNHCR. In 2012, 25 out of 49 (51%) refugee camps met the standard of providing an average of ≥20 litres of drinking water per person per day (Figure 6). This standard describes the overall quantity of water distributed to refugees and not the quantity of water consumed by the household, which is less than the quantity that has been distributed; this is due to losses within the distribution system, leakages, improper use and illegal connections.

FIGURE 6: PERCENTAGE OF REFUGEE CAMPS MEETING STANDARD OF PROVIDING AN AVERAGE OF >20 LITRES PER PERSON PER DAY, 2004-2012



Excreta disposal is an essential element of any WASH programme as it reduces the potential contamination of water sources, provides a healthier environment, guarantees privacy and reinforces human dignity. In 2012, only 18 of 49 (37%) refugee camps met the minimum standard of having at least 80% of households with access to latrines (Figure 7). As can be seen from this figure, the percentage of camps meeting this important standard has remained below the 40% since 2003. As with the water standards, there are wide fluctuations within countries and between camps over the past ten years.

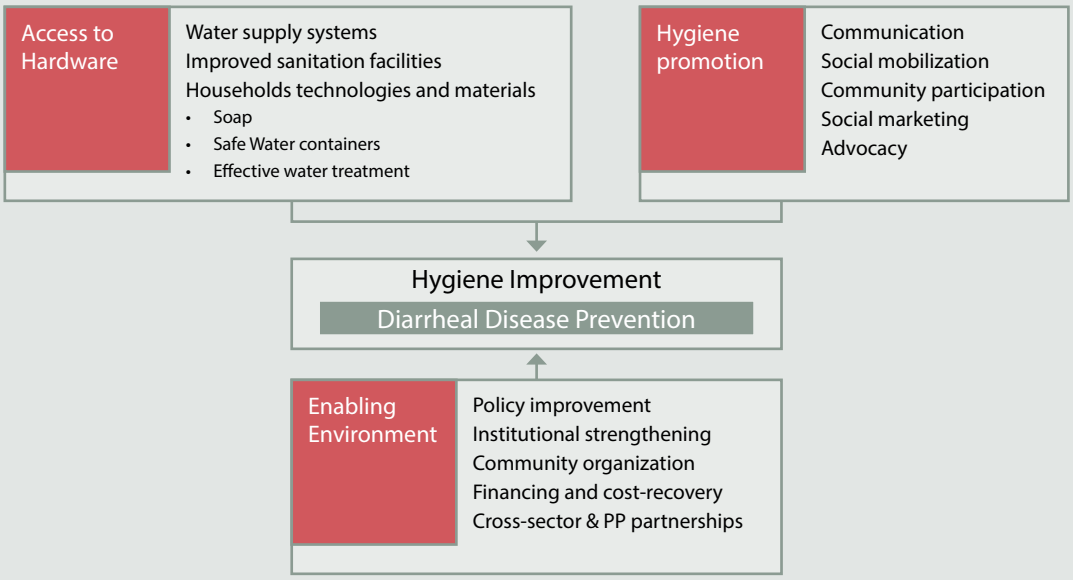
FIGURE 7: PERCENTAGE OF CAMPS MEETING STANDARD OF >80% OF HOUSEHOLDS WITH ACCESS TO LATRINES, 2003-2012



UNHCR and partners use the hygiene improvement framework to build effective WASH programmes (Figure 8).[16] The hygiene improvement framework is a comprehensive framework developed on the basis of lessons learnt from USAID's Environmental Health Project, which aims to prevent childhood diarrhoea.

16 Available at: http://www.ehproject.org/PDF/Joint_Publications/JP008-HIF.pdf

FIGURE 8: THE HYGIENE IMPROVEMENT FRAMEWORK



UNHCR hygiene promotion guidelines aim to strengthen effective hygiene promotion to maximize health benefits in the use of water and sanitation facilities.

STRATEGIC OBJECTIVES AND ENABLING ACTIONS

Objective 1: Refugees have safe access to water of sufficient quality and quantity

Access to sufficient amount of potable water translates into several complementary actions, which include 'hardware' and 'software' components.

Planning, mapping and modelling of water supply systems will constitute the baseline for potential future upgrading, enlargements, optimization and modernization of any water infrastructure. Water facilities should be designed so that sustainability issues (operation and maintenance) and long-term considerations are properly addressed – including back-up systems (such as alternative water sources, spare generators and pumps). Joint planning and implementation with site-planning and settlement programmes are critical.[17]

17 UNHCR's Global Strategy for Settlement and Shelter, 2014-2018.

Often, one of the factors causing the deterioration of water infrastructure is the poor and non-systematic operation and maintenance of the water facilities, mostly due to inadequate planning and budget constraints. Operation and maintenance should be included in any operational plan and programme budget as first priority.

Monitoring is another key aspect to reinforce, so that water supply alert systems can be activated, allowing for a timely response to water production disruptions and avoiding water shortages. Alerting systems are required for any refugee camp with a population above 5,000 and are an essential element of any water safety plan.

As part of the Strategy research efforts will focus on calculating the cost of water in refugee settings, for early cost evaluations, better planning, investments and enhanced technical quality and effectiveness in WASH operations.

Partnerships with research institutes, universities and private companies for advanced and innovative designs of water infrastructure will be continuously expanded to strengthen assessments and piloting innovative solutions in refugee situations. This will include partnerships for groundwater monitoring such as the Merti Aquifer monitoring programme in Dadaab, Kenya, and alternative solutions for water supply systems such as solar powered water pumping in Dollo Ado, Ethiopia.

Regular water quality monitoring (bacteriological and chemical) at production and household level is crucial, particularly in emergency settings. Water quality monitoring will include supply of adequate equipment to carry out tests for free residual chlorine and bacteriological and chemical analysis.

Capacity building in water supply, preventive operation and maintenance, water treatment and water quality monitoring will be promoted and implemented at the regional and country levels, with a focus on both UNHCR WASH staff and WASH partners.

Lastly, in view of the changing dynamics of displacement, UNHCR will strengthen its water response in arid and semi-arid contexts, adapted to nomadic populations, as well as in urban and other out-of-camp settings, where support to water supply interventions is needed.

CASE STUDY - MERTI AQUIFER MONITORING IN DADAAB

The collaboration between UNHCR and the University of Neuchatel has allowed for the monitoring of one the most exploited aquifer in refugee contexts, the Merti Aquifer in Dadaab, Kenya. Dadaab is hosting approximately 450,000 refugees. After 2 years from the beginning of the project in 2011, the Merti Aquifer study has resulted in the first monitoring system set up in a semi-arid zone. It includes mapping and data collection through remote sensing technology, the characterization of the aquifer features such as transmissivity, storage, water quality characteristics and knowledge of the fresh groundwater recharge mechanism e.g. how much, how, when and where, the aquifer is replenished. This has enabled a numerical catchment model for the design of sustainable water resource management. The project will result in the adjustment of water abstraction methodologies to remain within sustainable limits. It will establish best practice protocols for aquifer analysis, remote monitoring and sustainable management, where security constraints might result in limited access.

Objective 2: Refugees have safe access to quality sanitation

Improving safe access to quality sanitation as with Objective 1, also involves complementary hardware and software actions.

Enhancing safe access to sanitation requires meeting standards for privacy, safety and for locally or culturally-acceptable sanitation infrastructures. It also requires more standardized designs for sanitation facilities across similar refugees operations. Additionally, equal access to sanitation will be strengthened through the distribution of sanitation infrastructure (using mapping/geographic information system tools) and proper monitoring.

For cost-effectiveness and self-reliance purposes, more sustainable sanitation infrastructures should be implemented, promoting use of local materials and family sanitation facilities in post-emergencies contexts.

Wastewater, solid waste management and drainage should systematically be part of the sanitation programme in all refugee camps, so that wastewater evacuation systems are handled by WASH experts and the overall drainage component (runoff at cross roads) is developed in a coordinated way as part of overall site planning. Where appropriate, livelihoods programming can contribute to building businesses around solid waste (recycling and compost) and wastewater (biogas, gardening, water for livestock).[18]

The Strategy's software components will promote demand-led interventions, which put people, rather than engineering, at the centre. This entails the involvement of refugees in all phases of sanitation programming and infrastructure development (e.g. planning, design, piloting, maintenance), and, where appropriate, introducing community-led total sanitation in locations with existing refugee settlements.

Through the Strategy, UNHCR will strengthen sanitation response in urban settings by developing specific guidelines based on field experience and lessons learnt from recent experiences and through expanded partnerships with research institutes/universities and private companies for enhanced sanitation designs.

18 See UNHCR's Global Strategy for Livelihoods, 2014-2018, UNHCR's Global Strategy for Settlement and Shelter, 2014-2018, and UNHCR's Global Strategy for Safe Access to Fuel and Energy (SAFE), 2014-2018.

Objective 3: Refugees have improved hygiene

Community mobilization is critical in addressing the determinants of poor hygiene. The Strategy places particular emphasis on strengthening community mobilization to enhance the monitoring and use of water and sanitation facilities; strengthening the sense of ownership of water and sanitation infrastructures; and disseminating key messages.

Hygiene promotion in schools will also play a crucial role in promoting safe hygiene practices. Coordination between health, education and WASH will be strengthened to enhance effectiveness in hygiene and public health promotion, as well as enhance information-sharing and optimization of resources. Improved hygiene among refugees will also be achieved by developing expertise in hygiene promotion through capacity building measures and increasing the number of hygiene promoters.

Coordination with community based programmes will be strengthened to ensure increased water storage capacity at the household level through the distribution of water containers and advocacy for persons of concern to have adequate quantities of soap and basic hygiene items (including hand washing devices, such as tippy taps, and small jerrycans) to maintain hygienic conditions. This will also constitute a key action to improve hygiene and reach the hygiene promotion objective for the sector.

Increasingly, where markets are functional and refugees have access to them, UNHCR provides cash and/or vouchers to refugees, for soap and other hygiene items as well.[19]

In order to provide a baseline and monitoring tool for defining and adjusting the hygiene promotion strategy in each operation, UNHCR will increasingly roll out a standardized knowledge, attitude, and practice survey.

CASE STUDY - HANDWASHING DURING HEPATITIS E OUTBREAK IN SOUTH SUDAN

Handwashing with soap has been recognized as an important measure to disrupt enteric diseases, including pathogens that cause acute watery diarrhea and Hepatitis E. Several organizations are promoting handwashing in the South Sudan refugee camps, though up to now few studies have assessed the effects of handwashing promotion on handwashing behavior.

As part of the hygiene promotion strategy in South Sudan, a partnership with Buffalo University has developed a project that aims at describing technology and communication strategies applied by different WASH actors to increase handwashing with soap among refugees. It will explore in-depth the challenges to implementing and maintaining handwashing promotion programmes from the perspective of WASH agencies. Handwashing-related knowledge, attitudes and practices among refugees will be document and comparisons among settled and newly arrived refugees will occur. Furthermore, motivators and barriers to handwashing with soap and the examination of the acceptability of and responsiveness to applied behavior change strategies and the hardware (e.g. type of soap, handwashing facilities, and locations) among the beneficiaries population will be explored.

19 An introduction to Cash-Based interventions in UNHCR operations, 2012 http://www.unhcr.org/515a959e9.pdf

Objective 4: Improved WASH in institutions

As children are the main recipient for hygiene education, special focus needs to be given to WASH in schools and public institutions, such as hospitals, health centres and nutritional centres.

Among the main actions the WASH sector will emphasize is improved access for children to an adequate number of child-friendly WASH facilities which will also enhance school attendance, especially for girls. This includes increased access to water for drinking and handwashing.

Specific sessions and child-to-child hygiene promotion activities including drama, sketches among others will be encouraged for children to become familiar with the importance of handwashing with soap and the linkages between poor hygiene and diseases.

Strengthened collaboration with health agencies and institutions will also be encouraged to ensure minimum standards for WASH infrastructure are met in health centres, hospitals and nutritional centres, and that persons with specific needs have access to adapted sanitation facilities.

MONITORING

Objective	Output Objective	Indicator	Unit	Standard		Camp[xv xvi]	Out of Camp
				Emergency[xvii]	Post Emergency		
Supply of potable water increased or maintained	Refugees have safe access to water of sufficient quality and quantity	Litres/person/day	L/p/d	≥ 15	≥ 20	Yes	No
		Households collecting drinking water from protected water sources only	%	≥ 70%	≥ 95%	Yes	No
		Tests with 0 faecal coli-forms/100ml of water (at non-chlorinated water collection locations)	%	≥ 95%	≥ 95%	Yes	No
		Tests showing free residual chlorine >= 0.1mg/l[xviii] and NTU<5 (at chlorinated water collection locations)	%	≥95%	≥ 95%	Yes	No
		Number of persons per tap	Persons / tap	≤ 250	80-100	Yes	No
		Households collecting ≥15 litres/persons/day	%	≥ 80%	≥80%	Yes	No
		Distance from dwellings to taps/water collection locations	M	≤ 500m	≤ 200m	Yes	No
		Households with sufficient dai-ly water storage capacity (50 litres for 5 members average)	%	≥ 80%	≥ 80%	Yes	Yes

Objective	Output Objective	Indicator	Unit	Standard		Camp[xv xvi]	Out of Camp
				Emergency[xvii]	Post Emergency		
Population lives in satisfactory conditions of sanitation and hygiene	Refugees have safe access to quality sanitation	Persons per communal toilets/ latrines	Number of persons	≤ 50[xix]	≤ 20 (aiming for 1 latrine / household)	Yes	No
		Households reporting defecating in a toilet	%	≥ 60%	≥ 85%	Yes	No
		Households with access to latrines	%	≥ 60%	>=85%	Yes	No
		Communal latrines compliant with UNHCR standards (cleanable slabs, privacy & structural safety)	%	≥ 60%	>=85%	Yes	No
Population lives in satisfactory conditions of sanitation and hygiene		Households with (any type of) soap present in the house (presented within 1 minute)	%	≥ 90%	≥ 90%	Yes	Yes
		Households with knowledge of ≥ 3 of 5 critical hand-washing times	%	≥ 60%	≥ 80%	Yes	Yes
		Schools have WASH structures that are compliant with acceptable standards	%	≥ 65%	≥ 90%	Yes	No
		Health facilities have WASH structures that are compliant with acceptable standards	%	≥ 65%	≥ 90%	Yes	No

xv These standards apply only to camps. For out-of-camp settings including settlements, the national standards will be used.

xvi Not all indicators will be collected in all refugee situations, this table indicates if indicators are collected in refugee camps and or out of camp situations (Yes or No).

xvii In this strategic plan an emergency is arbitrarily defined as the first six months after the population movement has stabilized. However, this definition is context specific and should only serve as general guidance.

xviii In case of outbreaks, the free residual chlorine at water collection locations can be raised up to 1 mg/l depending on the water specific characteristics and the acceptance by the refugees.

xix This is the current Sphere standard, but UNHCR is considering reducing this standard to 30 persons per latrine in the emergency phase.

Key UNHCR References

1. WASH Manual. UNHCR 2014 (forthcoming)
2. Vector and pest control in refugee situations. UNHCR 1997. http://www.unhcr.org/49d082fe2.html
3. Guidance for UNHCR field operations on water and sanitation services. UNHCR 2008. http://www.unhcr.org/49d080df2.html

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