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

UNHCR
The UN Refugee Agency

The United Nations High Commissioner for Refugees' (UNHCR) Public Health and HIV Section's guiding principles and five strategic plans for 2008-12 represent an effort by UNHCR to clearly outline its principles and strategies in the five sectors of HIV and AIDS, malaria control, nutrition and food security, reproductive health, and water and sanitation. They aim to ensure that prevention, care and treatment policies and programmes meet international standards during all phases of the displacement cycle. The strategic plans outline the overall objectives and main strategies in the context of UNHCR's mandate to protect refugees, internally displaced persons (IDPs), returnees and other persons of concern (PoCs) to UNHCR. They will be used to guide operations in camp and non-camp settings, urban and rural situations, as well as in local integration and returnee situations during the period of 2008-2012.

The five sectors were chosen for a variety of reasons including their importance and perceived gaps in the past. Many other sectors including including child health, with an emphasis on integrated management of childhood illness, and primary health care as well as diseases such as tuberculosis, acute respiratory tract infections and diarrhoea are also of great importance to UNHCR and are part of its core public health programmes.

Numerous process, outcome and impact indicators have been chosen for each plan to measure its progress. These core indicators are not an exhaustive list to monitor UNHCR's public health and HIV programmes. Many other indicators including programme performance monitoring indicators will be collected and used at country level. Realisation of these strategic objectives will require accountability at various levels of management. This accountability will be most important at the country and field level through the processes of the programme planning cycle and result-based management. The strategic plans will be modified at regional level to reflect the specific and unique context of each region and sub-region.

Policies and programmes among the five sectors clearly overlap, as shown in the annex entitled Cross-Reference of Indicators. Integrated, coordinated and complimentary interventions among all five sectors are needed to have successful public health and HIV policies and programmes. UNHCR must continue to work closely and constructively with Governments, sister UN agencies, other international organizations, non-governmental organizations, bilateral and multilateral donors, the private sector, and most importantly, the refugees, IDPs, returnees and other PoCs to UNHCR to ensure the successful implementation of public health and HIV policies and programmes.

The Guiding Principles and Strategic Plans consist of seven sections:

I. Guiding Principles

II. HIV and AIDS Strategic Plan

III. Malaria Control Strategic Plan

IV. Nutrition and Food Security

V. Reproductive Health

VI. Water and Sanitation

VII. Cross-Reference of Indicators

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UNHCR's Guiding Principles

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GUIDING PRINCIPLES FOR UNHCR'S PUBLIC HEALTH AND HIV SECTION

INTRODUCTION

The Office of the United Nations High Commissioner for Refugees (UNHCR) was established on December 14, 1950 by the United Nations General Assembly. The agency is mandated to lead and co-ordinate international action to protect refugees and resolve refugee problems worldwide. Its primary purpose is to safeguard the rights and well-being of refugees. It strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another State, with the option to return home voluntarily, integrate locally or to resettle in a third country.

UNHCR is an impartial organisation, offering protection and assistance to refugees and other persons of concern (PoCs; see below for explanation) on the basis of their needs and irrespective of their race, religion, political opinion or gender. In all of its activities, UNHCR pays particular attention to the needs of children and seeks to promote the equal rights of women and girls.

The 1951 Refugee Convention and its 1967 Protocol are the cornerstones of modern refugee protection, and the legal principles they enshrine have permeated into countless other international, regional and national laws and practices governing the way refugees are treated. In its efforts to protect refugees and to promote solutions to their problems, UNHCR works in partnership with governments, regional organizations, international and non-governmental organizations (NGOs). UNHCR is committed to the principle of participation, believing that refugees and others who benefit from the organisation's activities should be consulted over decisions which affect their lives.

Public health is the science and practice of protecting and improving the health of a community. Public health and HIV are inextricably interlinked with protection and human rights. The public health of refugees and other displaced persons is a priority for UNHCR.

In 2007, the Public Health and HIV Section was created in the Division of Operational Services. Public health is used in the broad sense to include health, reproductive health, child health, nutrition, food security, water and sanitation. The section's objectives are to reduce morbidity and mortality and to enhance the quality of life among refugees, asylum seekers, internally displaced persons (IDPs), returnees and other PoCs to UNHCR.

PERSONS OF CONCERN TO UNHCR

1) **Refugee:** The 1951 Refugee Convention describes refugees as people who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution because of their race, religion, nationality, membership of a particular social group or political opinion. People fleeing conflicts or generalized violence are also generally considered as refugees, although sometimes under legal mechanisms other than the 1951 Convention.

2) **Asylum Seeker:** Someone who has made a claim that he or she is a refugee, and is waiting for that claim to be accepted or rejected. The term contains no presumption either way - it simply describes the fact that someone has lodged the claim. Some asylum seekers will be judged to be refugees and others will not.

3) **Internally Displaced Person (IDP):** Someone who has been forced to move from his or her home – because of conflict, persecution (i.e. refugee-like reasons); or because of a natural disaster or some other unusual circumstance of this type. Unlike refugees, however, IDPs remain inside their own country. UNHCR is the lead agency for protection, shelter and camp management/coordination under the humanitarian reform process. UNHCR actively participates in all clusters, including the health, nutrition and WASH clusters. UNHCR is the lead technical agency for HIV and AIDS among displaced persons (i.e. refugees and IDPs) according to the UNAIDS division of labour. In this respect, UNHCR takes an active lead role in HIV and AIDS among IDPs.

4) **Returnee:** A person who was a refugee, but who has recently returned to his/her country of origin. When a refugee decides to go home, it is usually because the threat or danger that had caused him/her to leave his/her place of habitual abode has significantly diminished or the danger in the place of refuge has become greater than the risk of returning home. The term "returnee" is a descriptive term that acknowledges the fact that returning refugees are in need of certain assistance, and sometimes protection, during an interim period until they have re-integrated into their communities. When refugees re-enter their country, as returnees, they are no longer entitled to the full protection afforded by international law to refugees. However, elements of that law, and of the mandate of the UNHCR, focus on achieving "durable solutions" and a return in "safety and dignity". Defining the period of time in which a person can continue to be identified as a returnee is difficult and will be different according to each specific situation.

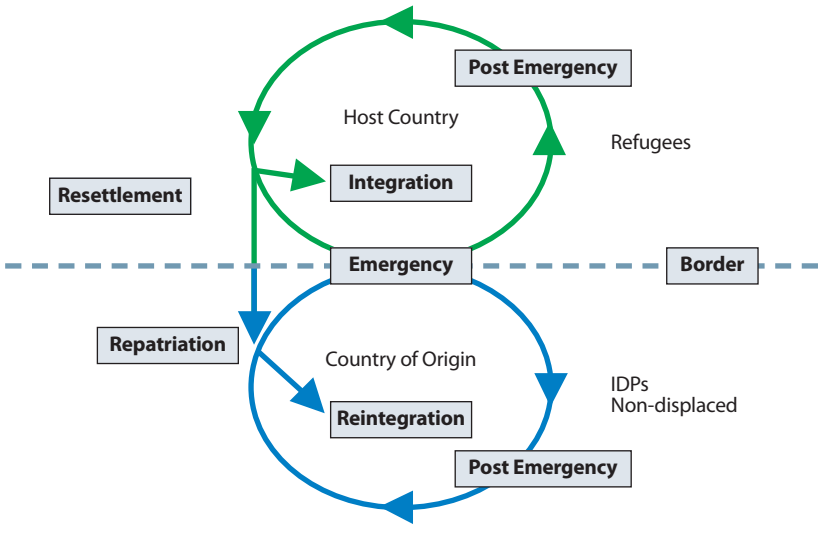
5) **Stateless Person:** Someone who is not considered as a national by any State under its domestic law. Although stateless people may sometimes also be refugees, the two categories are distinct and both groups are of concern to UNHCR.

6) **Surrounding host populations:** Although not officially considered PoCs to UNHCR, surrounding host populations are also directly and indirectly affected by the presence of refugees and IDPs. Thus, when making policy and implementing programmes, this community must also be considered in all of the settings and scenarios discussed below.

SCENARIOS

The influx of refugees into the country of asylum impacts not only their lives but also the lives of the host community (as do IDPs). Refugees and IDPs typically arrive in their host communities after fleeing their homes at the start of conflict or natural disaster. This begins a period often fraught with instability and sometimes frequent movement which is commonly referred to as the cycle of displacement (see figure below). The cycle has been simplied to include three main stages of transition, though additional movement may occur during this period and subgroups among the population may be in different phases of transition. Displacement scenarios are often not linear in nature (e.g. acute emergency followed by post-emergency followed by voluntary repatriation) and may vary even within one country; the humanitarian community generally divides displacement scenarios into phases. Each phase has different public health and HIV priorities.

DISPLACED PERSONS' CYCLE OF DISPLACEMENT:[1]



1 UNHCR and UNAIDS. Strategies to support the HIV-related needs of refugees and host populations. UNAIDS Best Practice Collection. Geneva. October 2005

1) **Acute Emergencies:** There are numerous definitions of the acute phase of an emergency using number of persons displaced, time from onset of emergency and increased mortality (often a doubling of the pre-emergency baseline). This scenario may be marked by extreme hardships, including deprivation of housing, food, and security not to mention public health and HIV services. The main objective in this scenario is to provide the basic lifesaving interventions to prevent excess mortality and morbidity.

2) **Post-Emergency/Stable settings:** This scenario is more stable and can last for months to many years and even decades (prolonged or protracted situations). In this situation, mortality rates should have decreased and basic needs (e.g. food, water, shelter) should have been met. During this period infectious diseases can be contained and additional, more comprehensive interventions should be provided. These may include psychosocial services, comprehensive reproductive health and HIV services, and projects to improve food security, among many others.

3) **Durable Solutions: Repatriation, Local Integration and Resettlement:** In the third and final scenario, refugees prepare to: 1) voluntary repatriate to their country of origin; 2) locally integrate in their host country; or 3) resettle to a third country; preparations for the scenario of durable solutions must begin long in advance and require strong coordination with Governments, other UN agencies and NGOs. Advocacy, integration with existing systems, continuity of care, capacity building and numerous other factors need to be undertaken in these situations.

SETTINGS

1) **Camp:** These settings are the traditional situations in which UNHCR has worked in the past. It is *relatively* easier to provide public health and HIV services to displaced persons in camps than in non-camp settings because they are usually in circumscribed areas where persons can be registered and provided with services. Refugees in camp settings are often wholly dependent on UNHCR and its partners for all services. UNHCR's implementing and operational partners[2] often find it easier to work in camp-like settings than non-camp settings for some of the reasons listed above. However, over the last decade, displaced persons are increasingly found in non-camp settings.

2) **Non-camp**
   i) **Urban settings:** Refugees residing in urban areas are of diverse origins and background. They frequently include a high proportion of displaced persons from rural areas who have moved to cities in preference to other locations because education and employment opportunities may be better. Many urban refugees are unskilled, and live in precarious situations. In many settings, only the most vulnerable persons are registered with UNHCR; it is complex and resource

2 The implementation of UNHCR's assistance and protection projects is often entrusted to an implementing partner who receives funds from UNHCR. These are usually specialised government departments or agencies, other members of the United Nations system, non governmental and intergovernmental organizations. An organisation that works in co-ordination with UNHCR but does not receive funding is referred to as an "operational partner".

intensive to manage such large numbers of individual cases. Assistance to urban refugees varies according to context and funds. Whenever possible, UNHCR and its partners should support Governments and refugees to integrate into existing public health and HIV services (this is also a guiding principle for all displaced persons' situation).

ii) **Non-urban settings:** In some situations, refugees are located in non-urban and non-camp settings (e.g. Uganda). In these settings, refugees live among host populations in village-like settings in an integrated fashion. UNHCR favours such settings but they are, unfortunately, rare due to host Government restrictions.

DURABLE SOLUTIONS

1) **Voluntary Repatriation:** This remains the durable solution sought by the largest number of refugees. Its realization is, however, complex and challenging. Core components for return include physical safety, legal safety, material safety and reconciliation. These are often not yet in place and delay voluntary repatriation. Ensuring sustainable return is possible and is first and foremost the responsibility of the countries of origin towards their own people. It also requires coherent and sustained action and support by the international community. UNHCR's overriding priorities when it comes to return are to promote the enabling conditions for voluntary repatriation, to ensure the exercise of a free and informed choice, and to mobilize support to underpin return.

2) **Local Integration:** Local integration is a legal process whereby refugees are granted a progressively wider range of rights and entitlements by the host State that are broadly commensurate with those enjoyed by its citizens. These include freedom of movement, access to education and the labour market, access to public relief and assistance including health facilities, the possibility of acquiring and disposing of property, and the capacity to travel with valid travel and identity documents. Over time the process should lead to permanent residence rights and in some cases the acquisition, in due course, of citizenship in the country of asylum. It is also an economic process whereby refugees become progressively less reliant on State aid or humanitarian assistance, attaining a growing degree of self-reliance and becoming able to pursue sustainable livelihoods, thus contributing to the economic life of the host country. Finally, it is also a social and cultural process of acclimatization by the refugees and accommodation by the local communities, that enables refugees to live amongst or alongside the host population without discrimination or exploitation, and contribute actively to the social life of their country of asylum.

3) **Resettlement:** A fundamental objective of resettlement policy is to provide a durable solution for refugees unable to voluntarily return home or to remain in their country of refuge. A decision to use the resettlement option should be based on what difference, if any, this option would make in addressing the immediate and long term problems and needs of the individual refugee or groups of refugees. States are encouraged to ensure that resettlement runs in tandem with a more vigorous integration policy aimed at enabling refugees having durable residence status to

enjoy equality of rights and opportunities in the social, economic and cultural life of the country. Resettlement countries generally require certain medical tests for some infectious diseases including tuberculosis. Some countries require test for HIV, this has protection and human rights implications that must be addressed.[3] UNHCR clearly states that HIV status should not adversely affect resettlement claims. The resettlement of persons with medical needs is challenging and resettlement opportunities are limited. Specific criteria for medical resettlement exist and must be carefully followed.[4]

GUIDING PRINCIPLES

1) **Human rights:** Refugees should enjoy access to public health services equivalent to that of the host population (Article 23, Refugee Convention of 1951). Under international law, everyone has the right to the highest standards of physical and mental health (Article 12, International Covenant on Economic Social and Cultural Rights, 1966); this includes a right to be free from hunger and mal-nutrition and to adequate food, nutrition and clean, safe drinking water including in emergency situations. UNHCR has a specific note for HIV and AIDS.[5] Refugees, like all persons, should be adequately informed, actively make their own decisions and provide their consent to the services provided to them. Respect for confidentiality and privacy must be ensured.

2) **Uniqueness:** Refugees and other PoCs to UNHCR are unique groups which often have special needs due to their circumstances (e.g. trauma and violence including sexual violence, different languages and cultures, issues related to durable solutions, dependency upon external support and limited economic opportunities). Existing policies, guidelines and protocols for persons in resource-poor settings may need to be modified accordingly and in some cases specifically developed.[6,7]

3) **Age, Gender and Diversity:** All policies and programmes must respect gender equality and the rights of all refugees and other PoCs of all ages and backgrounds. Particular attention must be paid to those who have traditionally been excluded and the most disenfranchised, that is, women, children, older persons, persons with disabilities and minority groups. An emphasis should be placed on women and children.

3 Note on HIV/AIDS and the Protection of Refugees, IDPS and Other Persons of Concern, UNHCR. Geneva. April 2006.

4 UNHCR. Chapter 4: UNHCR criteria for determining resettlement as the appropriate solution (pg IV/10). Geneva. November 2004.

5 Note on HIV/AIDS and the Protection of Refugees, IDPS and Other Persons of Concern, UNHCR. Geneva. April 2006.

6 UNHCR. Chapter 4: UNHCR criteria for determining resettlement as the appropriate solution (pg IV/10). Geneva. November 2004.

7 UNHCR. Antiretroviral medication policy for refugees. Geneva. January 2007.

4) **Participation:** Refugees and other PoCs should be empowered at all stages to participate in policy making, programme planning, implementation and monitoring and evaluation in order to design acceptable, appropriate, sustainable and culturally sensitive policies and programmes. These must take into consideration beneficiaries' needs, requirements and diversity within the framework of international standards and human rights. Participation of organisations working with the PoCs and Government line ministries/focal points should be ensured.

5) **Multi-Sectoral:** Policies and programmes are operationally interdependent and, thus, must be multi-sectoral in nature linking those sectors within the Public Health and HIV Section as well as outside of the section. This integrated approach is essential towards ensuring complimentary and comprehensive programmes that should help ensure a higher level of sustainability in the long term.

6) **Multi-Partner:** The section must build upon current UNHCR partnerships in delivering its programmes through implementing and operational partners, Governments, sister UN agencies, international agencies and other organisations when appropriate.

7) **Integration:** Public health and HIV policies and programmes should be integrated with other programmes in UNHCR (linked to multi-sectoral principle above) as well as with those surrounding the PoCs (e.g. Government and host community programmes).

8) **Quality of Services:** Refugees and other PoCs to UNHCR should receive services of sufficient quality as listed below. To monitor quality, functioning public health information systems must be in place and used and appropriate feedback provided.
   i) **Availability:** Appropriate services exist for the community.
   ii) **Accessibility:** Those who need existing services should be able to obtain them regardless of status, gender, age, marital status, race, religion, sexual orientation and disability. During the emergency phase, services should be free of charge. During the post-emergency phase, services should be affordable to PoCs. This depends upon the context. In refugee camps, services are generally provided free of charge while in urban settings, refugees generally follow the situation in the host country; however, in all situations, there needs to be a system to ensure that vulnerable populations can access appropriate services regardless of cost. Accessibility also refers to service hours, registration procedures, and location of services including referral hospitals (e.g. ensuring women have access to emergency obstetrical care, including Ceasarean sections in an appropriate timeframe).
   iii) **Equity:** Different populations or segments of populations in a geographical area who need services can obtain them in a similar manner. In most circumstances, host communities should have access to services provided to refugees in camps, and refugees should have access to government services available to host communities in non-camp settings. Systems to examine the equity of services for women and children should be available.

iv) **Appropriateness:** Prevention, care and treatment services are provided according to context while unnecessary or harmful services are not provided. This includes minimum essential services in the emergency scenario and different levels of comprehensive services in the post-emergency scenario according to context. Continuity of services in the durable solution scenario is essential. Overall, services should be similar to those provided in the country of origin and host country. However, minimum essential services must be provided in all situations regardless of availability in host communities. If not available in the latter, UNHCR must advocate for their provision and provide such services to the host community within its means to do so. In developed country displaced settings, sophisticated secondary and even tertiary care may need to be provided depending on context and funds. Prioritisation is essential in these circumstances, and wide scale availability of primary health care, including obstetric care and prevention services must be prioritised.

v) **Acceptability:** Services provided meet the expectations of the community accessing them. This includes but is not limited to confidentiality, informed consent and choice of services.

vi) **Effectiveness:** Services bring about positive change in public health status of people. This requires trained and competent staff among UNHCR and its partners. Algorithms, protocols, policies and guidelines should follow host country protocols unless shown to be ineffective or they do not meet international standards. If the latter occurs, internationally accepted algorithms, protocols, policies and guidelines should be followed by UNHCR while advocating for a change in national equivalents.

vii) **Efficiency:** Services are provided at lowest possible cost while fulfilling the other components of quality of services in a timely manner.

9) **Sustainability:** Policies and programmes should be created and implemented with sustainability and durable solutions kept in mind as the ultimate goal. Various issues must be considered including appropriate technology, capacity building, and use of local skills and knowledge.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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APR	Annual Protection Reports
ART	Antiretroviral Therapy
DHRM	Division of Human Resource Management
GBV	Gender Based Violence
GSO	Global Strategic Objectives
HCT	HIV Counselling and Testing
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
HIS	Health Information System
HIVIS	HIV Information System
IDP	Internally Displaced Person
IEC	Information, Education, and Communication
IP	Implementing Partner
MSRP	Management Systems Renewal Project
NSP	National Strategic Plan
OP	Operational Partner
PEP	Post-Exposure Prophylaxis
PH	Public Health
PLHIV	People Living with Human Immunodeficiency Virus
PoCs	Persons of Concern
S&I	Standards and Indicators
STI	Sexually Transmitted Infections
TB	Tuberculosis
UBW	Unified Budget and Workplan
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

EXECUTIVE SUMMARY

UNHCR's Strategic Plan for HIV and AIDS (2008-2012) outlines the overall objectives and main strategies to address HIV and AIDS within the context of UNHCR's mandate to protect refugees, internally displaced persons (IDPs) and other persons of concern (PoCs). It is also designed to ensure that UNHCR's operations benefit from national and international standards in HIV prevention, treatment, care and support policies and programmes. As a UNAIDS Cosponsor, UNHCR is committed to harmonise its HIV and AIDS programmes with those of other agencies in accordance with the UNAIDS 2007-2010 Strategic Framework[1]. This Strategic Plan also contributes to the achievement of the Millennium Development Goal to reverse the spread of HIV by 2015, including the promotion of universal access by 2010. Its indicators are consistent with those endorsed by the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS.

The Strategic Plan aims to guide operations in camp, urban and other non-camp settings as well as in local integration and returnee situations during the period of 2008-2012 (see 2008-12 guiding principles). It is built upon lessons learned from the two previous Strategic Plans on HIV, AIDS and Refugees (2002-04 and 2005-2007).

1 See UNAIDS Three Ones and Global Task Team recommendations to harmonise international AIDS funding.

OVERALL STRATEGIC OBJECTIVE:

To support and promote HIV and AIDS policies and programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

HIV AND AIDS STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection** - To ensure that the human rights of UNHCR's PoCs are protected in HIV prevention, treatment, care and support programmes.

2. **Coordination and Integration** - To coordinate, advocate for and effectively integrate HIV policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Prevention** - To reduce HIV transmission and morbidity through scaling up effective prevention interventions to UNHCR's PoCs with an emphasis on community participation, especially among women, children and people with special needs, to ensure they have access to HIV prevention information and services.

4. **Care, Support and Treatment** - To ensure that PoCs living with HIV have access to timely, quality and effective care, support and treatment services including access to anti-retroviral therapy at a level similar to that of the surrounding host populations.

5. **Durable Solutions** - To develop and incorporate HIV strategies and interventions into policies and programmes for durable solutions in order to mitigate the long term effects of HIV and AIDS.

6. **Capacity Building** - To build and strengthen HIV knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

7. **Assessments, Surveillance, Monitoring and Evaluation and Operational Research** - To ensure that data on UNHCR's PoCs are reflected in national HIV surveillance, monitoring and evaluation systems; to monitor and report on a regular basis PoCs' access to HIV prevention and treatment programmes; to evaluate programme performance and achievements using a results-based management approach; and to conduct operational research on new approaches to providing HIV prevention and treatment services to PoCs.

INTRODUCTION

There are an estimated 20.8 million refugees and other displaced persons globally,[2] many of whom reside in countries heavily affected by AIDS. Approximately four million of these persons live in sub Saharan Africa. Displacement as a result of conflict or other disasters can increase vulnerability to HIV by reducing access to HIV prevention services, information, and commodities. Basic HIV-related health care may not be available and people may become vulnerable to HIV infection. In addition, social support networks are often disrupted, exposure to sexual violence may be increased, and poverty may lead to the exchange of sex in return for food or shelter.[3] However, displacement may reduce the transmission of HIV due to reduced mobility to high prevalence areas; isolation and inaccessibility of some displaced populations; and in some circumstances, especially in the post-emergency phase, the availability of better protection and other HIV-related services than in countries or areas of origin.[4] The extent to which UNHCR's PoCs are adversely affected by HIV has been increasingly examined in recent years. There is now adequate evidence demonstrating that in many situations HIV prevalence among populations affected by conflict and displacement is not necessarily higher than that of the surrounding host population; on the contrary it is lower in many settings.[5]

UNHCR's Strategic Plan for HIV and AIDS outlines the objectives and strategic actions for HIV protection, prevention, treatment, care and support for PoCs. It defines the principles underlining UNHCR's work on HIV and AIDS. It also lists core indicators by which progress against strategic actions will be measured in order to ensure that UNHCR meets internal and international standards. Wherever possible, linkages have been made between these strategic plan indicators and those of UNGASS and UNAIDS' Unified Budget and Workplan (UBW).

The foundation for the UNHCR HIV and AIDS Strategic Plan for 2008 -2012 is supported by the following documents and policy statements:

- UNHCR, Refugees, HIV and AIDS: Strategic Plans 2002-04 and 2005-07
- UNAIDS and UNHCR, Policy Brief on HIV and Refugees, 2007
- UNHCR, Policy on antiretroviral medication, 2007
- Southern African HIV Clinician's Society and UNHCR, Clinical guidelines for antiretroviral therapy management for displaced populations, 2007
- UNAIDS, UBW 2008-2009 Performance Monitoring and Evaluation Framework, 2007
- UNAIDS, Practical Guidelines for Intensifying Prevention: Towards Universal Access, 2007
- WHO, Scaling Up Towards Universal Access, 2007
- UNAIDS, Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators, 2007

2 UNHCR (2006) *State of the World's Refugees 2006: Human Displacement in the New Millennium*, Geneva.

3 UNAIDS and UNHCR (2005) *Strategies to support the HIV related needs of refugees and host populations*, Geneva.

4 Hynes, M., Sheik, M., Wilson, H. and Spiegel, P. (2002) Reproductive Health Indicators and Outcomes among Refugee and Internally Displaced Persons in Post-emergency Phase Camps. JAMA, 288(5):595-603.

5 Spiegel PB, Bennedsen AR, Claass J, et al. Prevalence of HIV infection in conflict-affected and displaced people in seven sub-Saharan African countries: a systematic review. Lancet 2007;369(9580):2187-95.

- UNHCR Executive Committee Conclusions (No. 107 (LVIII) - 2007)
- UNHCR, Note on HIV/AIDS and the Protection of Refugees, Internally Displaced Persons and Other Persons of Concern, 2006
- UNAIDS, Setting National Targets for Moving Towards Universal Access by 2010: Operational Guidance, 2006
- Interagency Standing Committee, Guidelines for HIV/AIDS interventions in emergency settings, 2005
- UNAIDS and UNHCR, *Strategies to support the HIV-related needs of refugees and host populations*, UNAIDS Best Practice Collection, 2005
- UNAIDS, *The Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors*, 2005
- UNAIDS, UNAIDS *Technical Support Division of Labour, Summary and Rationale*, 2005
- WHO and UNHCR, *Clinical Management of Rape Survivors*, 2004
- UNAIDS, *The Three Ones: Key principles*, 2004
- Executive Committee. A/AC/96/987, Decision Para 24, 2003

HIV and AIDS are also highlighted in UNHCR's Global Strategic Objectives[6] (Box 1).

Box 1: HIV and AIDS in UNHCR's Global Strategic Objectives

Global Strategic Objective 3 - Realising the social and economic well-being of persons of concern, with priority given to:

3.1. Reducing malnutrition, and major risks to the health of populations of concern, notably malaria, HIV/AIDS and inadequate reproductive health services.

Performance Targets:

3.1.2. The percentage of populations of concern to UNHCR with access to culturally appropriate HIV and AIDS information-education-communication (IEC) materials is increased.

3.1.3. The percentage of populations of concern benefiting from antiretroviral therapy (ART) when ART is available to surrounding local host populations is increased.

Global Strategic Objective 4 - Responding to emergencies in a timely and effective manner, with priority given to:

4.2. Meeting the needs of women, children and groups with specific needs in emergency situations.

Performance Target:

4.2.2. Emergency protection and assistance interventions in the first three months of an emergency increasingly respond to age, gender and diversity considerations including specific interventions for women, children and groups with special needs.

An interim assessment of all indicators and targets in this plan will be undertaken after 2009.

6 UNHCR Global Appeal, 2007 *UNHCR's global strategic objectives*

GOALS AND OBJECTIVES

OVERALL HIV/AIDS GOAL FOR 2008-12:

To support and promote HIV and AIDS policies and programmes in order to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

HIV AND AIDS STRATEGIC OBJECTIVES:

1. **Protection** - To ensure that the human rights of UNHCR's PoCs are protected in HIV prevention, treatment, care and support programmes.

2. **Coordination and Integration** - To coordinate, advocate for and effectively integrate HIV policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Prevention** - To reduce HIV transmission and morbidity through scaling up effective prevention interventions to UNHCR's PoCs with an emphasis on community participation, especially among women, children and people with special needs, to ensure they have access to HIV prevention information and services.

4. **Care, Support and Treatment** - To ensure that PoCs living with HIV have access to timely, quality and effective care, support and treatment services including access to anti-retroviral therapy at a level similar to that of the surrounding host populations.

5. **Durable Solutions** - To develop and incorporate HIV strategies and interventions into policies and programmes for durable solutions in order to mitigate the long term effects of HIV and AIDS.

6. **Capacity Building** - To build and strengthen HIV knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

7. **Assessments, Surveillance, Monitoring and Evaluation and Operational Research** - To ensure that data on UNHCR's PoCs are reflected in national HIV surveillance, monitoring and evaluation systems; to monitor and report on a regular basis PoCs' access to HIV prevention and treatment programmes; to evaluate programme performance and achievements using a results-based management approach; and to conduct operational research on new approaches to providing HIV prevention and treatment services to PoCs.

STRATEGIES AND INDICATORS OF ACHIEVEMENT

UNHCR will monitor its progress against the seven HIV and AIDS strategic objectives over the 2008-2012 period through a rigorous monitoring and evaluation system at global, regional, national and camp levels. To strengthen this system, UNHCR will also make use of the UNAIDS' UBW performance monitoring framework. The following core set of **48 indicators** will be tracked as a measure of progress against the strategic objectives. These core indicators are not an exhaustive list to monitor and evaluate UNHCR's HIV programmes, many others including programme performance monitoring indicators will be collected and used at country level. Realisation of these strategic objectives will require accountability at various levels of management. This accountability will be most important at the country and field level through the processes of the programme planning cycle and results based management.

Table 1 summarises the strategies and indicators of achievement. It provides explicit definitions for and essential information on how the indicators will be measured at the global, regional and country operational levels.

Table 2 provides summaries of how the indicators of achievement will be reported. This includes information on targets, periodicity, applicable strategic objectives, sources of measurement, and relationships with global indicators.

UNHCR will obtain data on HIV from the following main sources:

1. UNHCR's Health Information System (HIS)
2. UNHCR's HIV Information System (HIVIS)
3. UNHCR's Standards and Indicators (S&Is)
4. UNHCR's Annual Protection Reports (APRs)
5. UNHCR's Global Strategic Objectives (GSOs)
6. Joint population-based surveys conducted by national authorities, UNHCR and other humanitarian agencies in coordination with Operational and Implementing Partners.
7. Joint Assessment Missions conducted with other UN agencies and non-governmental organisations.
8. UNHCR's Financial Systems using Management Systems Renewal Project (MSRP)

Table 1: Key Strategies and Indicators of Achievement

STRATEGIC OBJECTIVE 1: PROTECTION	To ensure that the human rights of UNHCR's PoCs are protected in HIV prevention, treatment, care and support programmes.
Key Strategies	**Indicators of Achievement**
(1.1) Ensure that the HIV status of an asylum seeker does not constitute a bar to accessing asylum procedures, nor constitute grounds for refoulement.	**(1.1.1)** % of countries with ≥10,000 refugees that have legislation protecting the rights of HIV positive asylum seekers.
(1.2) Ensure protection from mandatory testing of PoCs.	**(1.2.1)** % of countries with ≥10,000 refugees or IDPs that have legislation protecting PoCs from mandatory testing for HIV.
(1.3) Ensure that UNHCR's PoCs have access to antiretroviral therapy (ART) at a level similar to that of the surrounding population.	**(1.3.1)** % of countries where PoCs benefit from therapy (ART) when it is available to surrounding local populations.
(1.4) Ensure that gender -based violence (GBV) prevention and response activities are promoted, supported and coordinated within HIV programmes.	**(1.4.1)** % of countries that have integrated GBV prevention and response activities into HIV activities.
(1.5) Ensure children amongst UNHCR's PoCs access primary and secondary education.	**(1.5.1)** % of refugee children by sex enrolled in grades 1-6. **(1.5.2)** % of refugee children enrolled by sex in grades 7 -12.
(1.6) Ensure HIV status is not a barrier for resettlement.	**(1.6.1)** % of resettlement countries that provide automatic waiver to refugees who test positive for HIV.
Indicators 1.1.3, 1.2.1, 1.4.1, 1.4.2 and 1.5.1 from the Reproductive Health Strategic Plan also apply. Indicator 1.1.1 from the Nutrition and Food Security Strategic Plan also applies.	

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 2: COORDINATION AND INTEGRATION	To coordinate, advocate for and effectively integrate HIV policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
Key Strategies	**Indicators of Achievement**
(2.1) Ensure that HIV/AIDS policies and programmes are coordinated and integrated i. within countries. ii. within UNHCR. iii. within international system.	**(2.1.1)** % of countries with active HCR participation in Joint UN Theme Group on HIV. **(2.1.2)** % Annual Protection Reports reporting on HIV/AIDS. **(2.1.3)** % of all UNAIDS global strategies between 2008-12 that include refugees and IDPs. See also **1.1.1 -1.4.1**.
(2.2) Ensure that HIV/AIDS policies and programmes for IDPs are coordinated and integrated within humanitarian reform process.	**(2.2.1)** % of countries that have been "clusterized"[7] according to humanitarian reform process and that include HIV/AIDS as cross-cutting issue.
(2.3) Advocate for the inclusion of HCR's PoCs in donor proposals.	Number of countries with HCR's PoCs (≥10,000 persons) benefiting from additional HIV funding sources from: **(2.3.1)** Presidents Emergency Plan for AIDS Relief. **(2.3.2)** World Bank regional proposals and initiatives. **(2.3.3)** Global Fund for AIDS, Tuberculosis and Malaria. **(2.3.4)** UNAIDS Programme Acceleration Fund.
(2.4) Strengthen HCR HIV coordination capacity and supervision with relevant stakeholders (e.g. host country authorities, IPs and OPs, and refugee representatives).	**(2.4.1)** Number of HCR HIV coordinators. **(2.4.2)** Number of HIV coordination meetings held per year.
(2.5) Ensure sufficient resources provided to supporting HCR's HIV and AIDS activities.	**(2.5.1)** Amount of resources spent by HCR for HIV and AIDS programmes (USD/person/yr) . See also **2.3.1-2.3.4**.
(2.6) Advocate to ensure inclusion of refugees and IDPs in HIV National HIV/AIDS Strategic Plans (NSPs).	**(2.6.1)** % of countries with ≥10,000 refugees that have included refugees in NSPs among those countries that will update their plans between 2008–2012. **(2.6.2)** % of countries with ≥10,000 IDPs that have included IDPs in NSPs among those countries that will update their plans between 2008–2012.
(2.7) Ensure that PoCs are included into participatory assessments and age, gender and diversity analysis as part of HCR's operations management cycle.	**(2.7.1)** % of countries that have conducted participatory assessments as part of the operations management cycle.
Indicator **2.2.2**. from the Reproductive Health Strategic Plan also applies.	

7 A cluster is a group of agencies, organisations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, protection, camp coordination and camp management, education, shelter, health and water and sanitation.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 3 PREVENTION	To reduce HIV transmission and morbidity through scaling up effective prevention interventions to UNHCR's PoCs with an emphasis on community participation, especially among women, children and people with special needs, to ensure they have access to HIV prevention information and services.
Key Strategies	**Indicators of Achievement**
(3.1) Ensure that HCR's PoCs have access to cultural appropriate HIV information materials on prevention and treatment in a language and format they can understand.	**(3.1.1)** % countries that have access to culturally appropriate HIV and AIDS information, education, communication materials. See also **1.4.1, 1.5.1, 1.5.2**.
(3.2) Ensure safe blood supply in refugee camp settings.	**(3.2.1)** % of refugee operations that provide blood transfusions which screen blood for HIV in a quality-assured manner.
(3.3) Ensure universal precautions practiced by health workers in refugee camp settings.	**(3.3.1)** % refugee operations where universal precautions are satisfactorily.[8]
(3.4) Ensure access to programmes for prevention and treatment of sexually transmitted infections (STIs).	**(3.4.1)** Incidence of male urethral discharge - by age. **(3.4.2)** Incidence of genital ulcer disease – by age and sex. **(3.4.3)** % of clients tested for syphilis with a positive result -by age and sex. **(3.4.4)** % of partners/contacts of STI patients that were notified and treated –by age and sex.
(3.5) Increase access to HIV Counselling and Testing (HCT) for UNHCR's PoCs.	**(3.5.1)** % of countries where PoCs have access to HCT.
(3.6) Ensure establishment of linkages between the HIV, STI and Tuberculosis (TB) programmes.	**(3.6.1)** % of HCT clients referred from STI and TB services.
(3.7) Increase HIV prevention education and access to condoms, harm reduction, STI and HCT services for most at risk populations amongst HCR's PoCs.	**(3.7.1)** % countries addressing at least one of the most-at-risk populations (sex workers, injecting drug users, men who have sex with men) with appropriate HIV prevention programmes.
(3.8) Increase access to Prevention of Mother to Child Transmission programmes for UNHCR's PoCs.	**(3.8.1)** % countries, when indicated, where pregnant women and the infant received antiretroviral medication to reduce the risk of mother to child transmission of HIV See also **1.3.1**.
(3.9) Ensure Post Exposure Prophylaxis (PEP) is available to all survivors of rape amongst HCR's PoCs.	**(3.9.1)** % countries reporting provision of PEP to survivors of rape within 72 hours of rape.
(3.10) Ensure access to male and female condoms.	**(3.10.1)** % of refugee operations where sufficient[9] number of male and female condoms are distributed.
Indicators **1.2.1, 1.2.2** and **3.6.1** from the Malaria Strategic Plan also apply. Indicators **3.1.1-3.1.4, 3.2.1, 3.2.2, 3.2.4, 3.3.1** and **3.5.1** from Reproductive Health Strategic Plan also apply. Indicators **3.3.2** and **3.3.3** from the Nutrition and Food Security Strategic Plan also apply.	

8 Satisfactory universal precautions refer to a set of procedures to minimise the risk of infection and includes for this indicator a sufficient supply of needles, syringes, and gloves, defined as no stock out of >1 week at anytime during the past year.

9 Sufficient number of male and female condoms = 0.5/per person/per month.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 4 **CARE, SUPPORT AND TREATMENT**	To ensure that PoCs living with HIV have access to timely, quality and effective care, support and treatment services including access to anti-retroviral therapy at a level similar to that of the surrounding host populations.
Key Strategies	**Indicators of Achievement**
(4.1) Provide treatment for opportunistic infections for People Living with HIV (PLHIV) who are POCs for UNHCR	**(4.1.1)** % of countries with major HIV programmes that provide trimethoprim-sulfamethoxazole prophylaxis for children. **(4.1.2)** % of countries with major HIV programmes that provide trimethoprim-sulfamethoxazole prophylaxis for adults.
(4.2) Ensure PLHIV have access to supplementary feeding programmes.	**(4.2.1)** % of countries where HCR's PLHIV have access to supplementary feeding programmes.
(4.3) Ensure that HCR's PoCs have access to ART at level similar to that of the surrounding population.	See **(1.3.1).**
Indicators **4.1.2, 4.2.1** and **4.2.3** from the Nutrition and Food Security Strategic Plan also apply	

STRATEGIC OBJECTIVE 5: **DURABLE SOLUTIONS**	To develop and incorporate HIV strategies and interventions into policies and programmes for durable solutions in order to mitigate the long term effects of HIV and AIDS.
Key Strategies	**Indicators of Achievement**
(5.1) Advocate for and establish local integration and repatriation policies and programmes that include appropriate prevention and treatment interventions for HIV/AIDS.	**(5.1.1)** % of countries of return and countries with local integration that have provisions for continuation of ART for refugees and other PoCs that require it. **(5.1.2)** % of operations where refugees are provided with appropriate returnee HIV packages in areas with a generalised HIV epidemic. **(5.1.3)** % of operations where HIV policies and programmes have been designed and integrated in exit strategies (integration areas or areas of return).
(5.2) Coordinate and share HIV and AIDS information to governments, UN agencies and other humanitarian organisations during repatriation.	**(5.2.1)** % of countries undertaking major repatriation operations that collect and share HIV programme information about refugees and other PoCs in areas of return with government and organisations involved in HIV policies and programmes.
Indicator **4.1.1** from the Malaria Strategic Plan also applies. Indicators **4.1.1** and **4.1.3** from the Reproductive Health Strategic Plan also apply. Indicators **5.1.1** and **5.1.2** from the Nutrition and Food Security Strategic Plan also apply.	

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 6: CAPACITY BUILDING AND TRAINING	To build and strengthen HIV knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
Key Strategies	**Indicators of Achievement**
(6.1) Train HCR and partner staff on HIV protocols, prevention and treatment.	**(6.1.1)** Number of HIV workshops and training events. See also **2.4.2, 2.7.1**.
(6.2) Build capacity of HCR's PoCs to participate in design, implementation, monitoring and evaluation of HIV programmes.	**(6.2.1)** % countries reporting HIV training for HCR's PoCs. See also **1.5.1, 1.5.2, 2.7.1, 3.1.1**.

STRATEGIC OBJECTIVE 7: ASSESSMENTS, SURVEILLANCE, MONITORING AND EVALUATION AND OPERATIONAL RESEARCH	To ensure that data on UNHCR's PoCs are reflected in national HIV surveillance, monitoring and evaluation systems; To monitor and report on a regular basis PoCs' access to HIV prevention and treatment programmes; to evaluate programme performance and achievements using a results-based management approach; and To conduct operational research on new approaches to providing HIV prevention and treatment services to PoCs.
Key Strategies	**Indicators of Achievement**
(7.1) Collect, analyse, and respond to essential HIV-related data on routine basis using standard case definitions.	**(7.1.1)** % refugee operations with functioning HIS, including HIV component, as defined by monthly reporting to HCR. **(7.1.2)** % camps that have undertaken HIV sentinel surveillance at least biannual basis in generalized HIV epidemic.
(7.2) Improve UNHCR programmes through joint HIV assessment[10] and monitoring missions.	**(7.2.1)** Number of countries undertaking joint HIV assessment and monitoring missions.
(7.3) Evaluate HIV control programmes on a routine basis.	**(7.3.1)** % of camps/programmes that have evaluated their coverage and quality of HIV services every 2 yrs in stable settings.
(7.4) Conduct HIV operational research, as indicated, to guide programme implementation or to address identified programmatic problems.	**(7.4.1)** Number of programmes that have conducted operational research, defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.
Indicator **6.1.1** from the Reproductive Health Strategic Plan also applies.	

10 This refers to multi-sectoral and multi-agency HIV assessments in both refugees and IDP situations

Table 2: Summary of Indicators of Achievement

INDICATORS OF ACHIEVEMENT	Target[11]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[12]
(1.1.1) % of countries with ≥10,000 refugees that have legislation protecting the rights of HIV positive asylum seekers.	100%	Biannually	1, 2	APRs	UBW[13] PO 5	Camp Non-camp
(1.2.1) % of countries with ≥10,000 refugees or IDPs that have legislation protecting PoCs from mandatory testing for HIV.	>75%	Biannually	1, 2	APRs	UBW PO 5	Camp Non-camp
(1.3.1) % of countries where PoCs benefit from antiretroviral therapy (ART) when it is available to surrounding local populations.	>85%	Annually	1, 2,3,4	GSO Country Offices HIVIS	UNGASS[14] Indicator 4	Camp Non-camp
(1.4.1) % of countries that have integrated GBV prevention and response activities into HIV activities.	>85%	Annually	1, 2,3	Country Offices	UBW PO 7	Camp Non-camp
(1.5.1) % of refugee children by sex enrolled in grades 1-6.	100%	Annually	1,3,6	S&I	UNGASS12 UBW PO 7	Camp
(1.5.2) % of refugee children enrolled by sex in grades 7 -12.	20-40/1000 pop/year	Annually	1,6	S&I	UNGASS 12 UBW PO 7	Camp
(1.6.1) % of resettlement countries that provide automatic waiver to refugees who test positive for HIV.	100%	Annually	1	APRs Resettle-ment Reports		Camp Non-camp
(2.1.1) % of countries with active HCR participation in Joint UN Theme Group on HIV.	>90%	Annually	1,2	UNAIDS	UBW PO 1	Camp Non-camp
(2.1.2) % Annual Protection Reports reporting on HIV/AIDS.	100%	Annually	1, 2	APRs	UBW PO 5	Camp Non-camp
(2.1.3) % of all UNAIDS global strategies between 2008-12 that include refugees and IDPs.	100%	Annually	1, 2	UNAIDS	UBW PO 1	Not applicable
(2.2.1) % of countries that have been "clusterized"[15] according to humanitarian reform process and that include HIV/AIDS as cross-cutting issue.	100%	Annually	2	Country Offices		Camp Non-camp

11 Target refers to the level that UNHCR intends to achieve by the end of 2012. It is based on the current situation and what HCR believes it is feasible to attain.

12 Refers to setting where indicator will ***primarily*** be measured. However, this may vary according to context. All population-based surveys could be undertaken in camp or non-camp settings; however, at this point they are primarily done in camp settings. This may change over time.

13 UBW PO = Principle Outcome of the Joint UNAIDS Budget and Workplan for 2008 and 2009

14 UNGASS = United Nations General Assembly Special Session on HIV/AIDS and provides international set of standard core indicators that measure the effectiveness of the national HIV response

15 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, education, shelter, telecommunications, food aid, health and sanitation.

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[11]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[12]
(2.3.1) Number of countries with HCR's PoCs (≥10,000 persons) benefiting from funds from the Presidents Emergency Plan for AIDS Relief.	Variable	Annually	1, 2	MSRP Country Offices HQ	UBW PO 1	Camp Non camp
(2.3.2) Number of countries with HCR's PoCs (≥10,000 persons) benefiting from regional proposals and initiatives from the World Bank.	Variable	Annually	1, 2	MSRP Country Offices HQ	UBW PO 1	Camp Non camp
(2.3.3) Number of countries with HCR's PoCs (≥10,000 persons) benefiting from HIV funds from the Global Fund for AIDS, Tuberculosis and Malaria.	Variable	Annually	1, 2	MSRP Country Offices HQ	UBW PO 1	Camp Non camp
(2.3.4) Number of countries with HCR's PoCs (≥10,000 persons) benefiting from UNAIDS Programme Acceleration Fund.	Variable	Annually	1, 2	MSRP Country Offices HQ	UBW PO 1	Camp Non camp
(2.4.1) Number of HCR HIV coordinators at country and regional levels.	Variable	Annually	1,2	Country Offices HQ		Camp Non-camp
(2.4.2) Number of HIV coordination meetings held per year.	Variable	Annually	1,2,6	Country Offices Regional Offices HQ		Camp Non-camp
(2.5.1) Amount of resources spent by HCR for HIV and AIDS programmes (USD/person/yr).	Variable	Annually	2	MSRP	UBW PO 1	Camp Non-camp
(2.6.1) % of countries with ≥10,000 refugees that have included refugees in NSPs among those countries that will update their plans between 2008–2012.	>80%	Biannually	2	National HIV Strategic Pans	UBW PO 7	Camp Non-camp
(2.6.2) % of countries with ≥10,000 IDPs that have included IDPs in NSPs among those countries that will update their plans between 2008–2012.	>80%	Biannually	2	National HIV Strategic Pans	UBW PO 7	Camp Non-camp
(2.7.1) % of countries that have conducted participatory assessment as part of the operations management cycle.	>75%	Annually	2,6	Country Offices		Camp Non-camp
(3.1.1) % countries that have access to culturally appropriate HIV and AIDS information, education, communication materials.	>95%	Annually	1,3,6	GSO Country Offices HIVIS	UBW PO 7	Camp
(3.2.1) % of refugee operations that provide blood transfusions which screen blood for HIV in a quality-assured manner.	100%	Annually	3	Country Offices HIVIS	UNGASS 3 UBW PO 7	Camp

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[11]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[12]
(3.3.1) % refugee operations where universal precautions are satisfactorily applied.	100%	Annually	3	Country Offices HIVIS	UBW PO 7	Camp
(3.4.1) Incidence of male urethral discharge – by age.	Variable	Monthly, Annually	3	Country Offices HIVIS HIS	UBW PO 7	Camp
(3.4.2) Incidence of genital ulcer disease – by age and sex – by camp, country and region.	Variable	Monthly, Annually	3	Country Offices HIVIS HIS	UBW PO 7	Camp
(3.4.3) % of clients tested for syphilis with a positive result -by age and sex.	Variable	Monthly, Annually	3	Country Offices HIVIS HIS	UBW PO 7	Camp Non camp
(3.4.4) % of partners of STI patients that were notified and treated –by age and sex.	Variable	Monthly, Annually	3	Country Offices HIVIS HIS	UBW PO 7	Camp Non camp
(3.5.1) % of countries where PoCs have access to HCT.	>90% in generalized epidemics	Annually	3	Country Offices HIVIS HIS	UNGASS 8 UBW PO 7	Camp Non-Camp
(3.6.1) % of HCT clients referred from STI and TB services.	Variable	Annually	3	Country Offices HIVIS	UNGASS 8 UBW PO 7	Camp Non-camp
(3.7.1) % countries addressing at least one of the most-at-risk populations (female sex workers, injecting drug users, men who have sex with men) with appropriate HIV prevention programmes.	>75%	Annually	3	Country Offices HIVIS	UNGASS 9 UBW PO 7	Camp Non-camp
(3.8.1) % countries, when indicated, where pregnant women received antiretroviral medication to reduce the risk of mother to child transmission of HIV.	>90% in generalized epidemics	Monthly, Annually	1, 3	HIVIS HIS	UNGASS 5 UBW PO 7	Camp Non camp
(3.9.1) % countries reporting provision of PEP to survivors of rape within 72 hours of rape.	100%	Monthly, Annually	3	HIS	UBW PO 7	Camp Non-camp
(3.10.1) % of refugee operations where sufficient number of male and female condoms are distributed.	>75%	Annually	3	HIS	UNGASS 17,18,19 and 20	Camp
(4.1.1) % of countries with major HIV programmes that provide trimethoprim-sulfamethoxazole prophylaxis for children.	>75%	Annually	4	HIS	UBW PO 7	Camp Non camp

16 Satisfactory universal precautions refers to a set of procedures to minimize the risk of infection and includes for this indicator a sufficient supply of stock of needles, syringes, and gloves defined as no stock out of >1 week at anytime during the past year

17 Sufficient number of male and female condoms = 0.5/per person/per month

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[11]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[12]
(4.1.2) % of countries with major HIV programmes that provide trimethoprim-sulfamethoxazole prophylaxis for adults.	>75%	Annually	4	HIS	UBW PO 7	Camp Non camp
(4.2.1) % of countries where UNHCR's PLHIV have access to supplementary feeding programmes.	>80%	Annually	4	Country Offices HIVIS	UBW PO 7	Camp
(5.1.1) % of countries of return and countries with local integration that have provisions for continuation of ART for refugees and other PoCs that require it.	100%	Annually	1, 5	GSO Country Offices	UNGASS indicator 4 UBW PO 7	Camp Non-camp
(5.1.2) % of operations where refugees are provided with appropriate returnee HIV packages, in areas with a generalised HIV epidemic.	100%	Annually	5	Country Offices	UBW PO 7	Camp Non-camp
(5.1.3) % of operations where HIV policies and programmes have been designed and integrated in exit strategies (integration areas or areas of return).	100%	Annually	1, 5	Country Offices	UBW PO 7	Camp Non-camp
(5.2.1) % of countries undertaking major repatriation operations that collect and share HIV programme information about refugees and other PoCs in areas of return with government and organi-sations involved in HIV policies and programmes.	100%	Annually	1, 5	Country Offices	UBW PO 7	Camp Non-camp
(6.1.1) Number of HIV workshops and training events.	Variable	Annually	2, 6	Country Offices Regional Offices HQ	UBW PO 4 UBW PO7	Camp Non-camp
(6.2.1) % countries reporting HIV training for HCR's PoCs.	100%	Annually	1, 3, 6	Country Offices	UBW PO 4 UBW PO7	Camp Non camp
(7.1.1) % refugee operation with functioning HIS, including HIV component, as defined by monthly reporting to HCR.	100%	Annually	7	HIS	UBW PO 3	Primarily camp with emphasis to include non camp
(7.1.2) % camps that have undertaken HIV sentinel surveillance at least on a biannual basis in generalized HIV epidemic.	>75%	Annually	7	Country Offices HQ	UBW PO 3	Camp
(7.2.1) Number of countries undertaking joint HIV assessment and monitoring missions.	Variable	Annually	7	Country Offices HQ	UBW PO 3	Camp Non-camp
(7.3.1) % of camps/programmes that have evaluated their coverage and quality of HIV services every 2 yrs in stable settings.	100%	Biannually	7	Country Offices HQ	UBW PO 3, 7	Camp
(7.4.1) Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.	Variable	Annually	7	Country Offices Regional Offices HQ	UBW PO 3	Camp Non-camp

Notes

UNHCR
The UN Refugee Agency

UNHCR's Strategic Plan for Malaria Control

2008 - 2012

UNHCR
The UN Refugee Agency

Table of contents

List of Acronyms

ACT	Artemisinin-based Combination Therapy
ANC	Antenatal Care
APR	Annual Protection Report
DOT	Directly Observed Therapy
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
GMP	Global Malaria Programme
HIS	Health Information System
HQ	Headquarters
IDP	Internally displaced person
IEC	Information, Education, and Communication
IM	Intramuscular
IP	Implementing Partner
IPTp	Intermittent Preventive Treatment in pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
IV	Intravenous
LBW	Low Birth Weight
LLIN	Long Lasting Insecticidal Net
MDG	Millennium Development Goal
MoH	Ministry of Health
MSRP	Management Systems Renewal Project
NGO	Non-Governmental Organization
OP	Operational Partner
P. falciparum	*Plasmodium falciparum*
PoCs	Persons of Concern
RDT	Rapid Diagnostic Test
RBM	Roll Back Malaria
S&I	Standards and Indicators
SP	Sulfadoxine-pyrimethamine
SPR	Slide Positivity Rate
TFC	Therapeutic Feeding Centre
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

EXECUTIVE SUMMARY

Malaria continues to be the number one cause of illness and death among many refugee populations. Control strategies for malaria among refugees and other displaced populations have not kept apace of recent global changes.

The context of malaria control has changed over the past decade. There is now near global resistance to low cost antimalarial drugs and the AIDS epidemic is expanding. At the same time, new tools for effective treatment and prevention have been developed: rapid diagnostic tests, quick-acting antimalarial drugs, long-lasting insecticidal nets, and intermittent preventive treatment in pregnancy. A global movement for improved malaria control has emerged.

This document outlines the strategic objectives for the United Nations High Commissioner for Refugees (UNHCR) to bring programmes for refugees and other displaced populations in line with global standards as part of UNHCR's human rights obligations to protect refugees from illness and death. The Strategic Plan aims to guide operations in camp, urban and other non-camp settings as well as in local integration and returnee situations, during the period of 2008-2012 (see 2008-12 guiding principles). It is built upon lessons learned from the previous Malaria Strategic Plan (2005-2007).

OVERALL STRATEGIC OBJECTIVE:

To support and promote malaria policies and control programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, Internally Displaced Persons (IDPs), returnees and other Persons of Concern (PoCs) to UNHCR.

MALARIA CONTROL STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection:** To protect the rights of UNHCR's PoCs with specific reference to malaria.

2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate malaria control policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Access to Early Diagnosis, Prompt and Effective Treatment, and Prevention:** To ensure that UNHCR's PoCs living in the malaria endemic areas have access to early diagnosis, prompt and effective treatment, and prevention, according to international standards.

4. **Durable Solutions:** To develop and incorporate malaria control strategies and interventions into policies and programmes for durable solutions.

5. **Capacity Building:** To build and strengthen specific malaria-related knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

6. **Assessments, Surveillance, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on the status of malaria within PoCs to inform programmatic planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches and technologies in malaria control.

INTRODUCTION

Malaria remains an important cause of illness and death among refugee and displaced populations. The majority of today's refugees live in malaria endemic areas. This situation has not been reversed during the last years, on the contrary, some new factors as climate change, natural disasters and population displacement have triggered changes in mosquito behaviours and malaria epidemiological profiles in different countries. Of the almost 33 million PoCs to UNHCR in 2008, almost two-thirds (63%) live in malaria endemic areas.

Many factors may promote vulnerability to malaria illness and death among refugees. Pregnant women and young children are particularly at risk of severe illness and death, women of child bearing age and children make up the majority of the population in many refugee situations. Refugee camps are often sited on marginal lands that promote breeding sites for malaria vectors. Refugees may be malnourished, particularly in the emergency phase. Displacement may take refugees through or to areas of higher malaria endemicity than their place of origin. Control programmes may have broken down (associated with the conflict that caused population flight) or never been implemented.

A significant change in approach to malaria control, particularly in Africa, has taken place over the last decade. Funds for malaria control have become available on a scale not seen since the days of the eradication campaign 50 years ago. These new resources are being used largely to support a supply of artemisin-based combination therapy (ACT) to replace ineffective chloroquine and sulphadoxine pyrimethamine for first line treatment of malaria and for the provision of long lasting, insecticide treated bednets (LLINs).

Intermittent preventive treatment in pregnancy (IPTp) has been shown to be of significant benefit in reducing potential malaria-related pregnancy complications in moderate to high transmission settings, particularly in the camps where access of refugees to health services is good. The AIDS epidemic interacts with malaria; HIV infection increases susceptibility to malaria and has an adverse effect during pregnancy while malaria may increase the viral load of HIV infections.

The globally-accepted 'best practices' for malaria control incorporate a mixture of the SPHERE[1] common standards for intervention and World Health Organisation (WHO)-endorsed malaria specific interventions;[2] these are reflected in the eight key strategic objectives and described in detail in Table 1.

This UNHCR Strategic Plan for Malaria Control documents the vision, strategic objectives, and main strategies of UNHCR to fully integrate effective malaria control into UNHCR's overall mandate of protection of refugees and other PoCs. It also provides core indicators by which progress against these strategic objectives will be measured to ensure that UNHCR meets internal standards and complies with international standards.

1 Sphere Project, Humanitarian Charter and Minimum Standards in Disaster Response. The Sphere Project, Geneva, 2004.

2 World Health Organisation (2005). Malaria control in complex emergencies: an inter-agency field handbook. Geneva: World Health Organisation.

The foundation for the UNHCR Strategic Plan for Malaria Control 2008 – 2012 was laid by:

- UNHCR's Strategic Plan for Malaria Control 2005 – 2007.
- Global Malaria Programme. Insecticide treated malaria nets: a position statement. Geneva: World Health Organisation, 2007.
- World Health Organisation. WHO guidelines for the treatment of malaria. Geneva: World Health Organisation, 2006.
- World Health Organisation. Malaria control in complex emergencies: an inter-agency field handbook. Geneva: World Health Organisation, 2005.
- Roll Back Malaria. Strategic orientation paper on prevention and control of malaria. Geneva: World Health Organisation, 2005.

Malaria is also explicitly highlighted in UNHCR's Global Strategic Objectives for 2008-2009 (See Box 1).[3]

BOX 1: Malaria in UNHCR's Global Strategic Objectives

Global Strategic Objective 3 - Realizing the social and economic well-being of persons of concern with priority given to:

3.1. Reducing malnutrition, and major risks to the health of populations of concern, notably malaria, HIV/AIDS and inadequate reproductive health services.

Performance Target

3.1.4. The percentage of populations of concern to UNHCR in malaria endemic areas with access to artemisinin-based combination therapy (ACT) with out running out of stocks for more than one week in the previous 12 months is increased.

3.1.5. The percentage of refugee camps in malaria endemic areas with access to prevention measures (insecticide treated nets/spraying) and culturally appropriate information, education and communication (IEC) materials is increased.

Global Strategic Objective 4 - Responding to emergencies in a timely and effective manner, with priority given to:

4.2. Meeting the needs of women, children and groups with specific needs in emergency situations.

Performance Target:

4.2.2. Emergency protection and assistance interventions in the first three months of an emergency increasingly respond to age, gender and diversity considerations including specific interventions for women, children and groups with special needs.

3 UNHCR, "Biennial Programme Budget 2008-2009 of the Office of the United Nations High Commissioner for Refugees." A/AC.96/1040, 12 September 2007, Fifty-eighth session.

A variety of actors will be involved in implementing activities to achieve the strategic objectives. UNHCR will assume primary responsibility for monitoring progress against objectives and will draw up programme plans detailing roles and responsibilities of partners under the coordination of respective Ministries of Health, where appropriate (often with the support of WHO). Technical support will be provided by a variety of sources including the Centers for Disease Control and Prevention, various international organizations, WHO, UNICEF and other UN sister agencies, and academic institutions.

An interim assessment of all indicators and targets in this plan will be undertaken after 2009.

GOALS AND OBJECTIVES

OVERALL STRATEGIC OBJECTIVE:

To support and promote malaria policies and control programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

MALARIA CONTROL STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection:** To protect the rights of UNHCR's PoCs with specific reference to malaria.
2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate malaria control policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
3. **Access to Early Diagnosis, Prompt and Effective Treatment, and Prevention:** To ensure that UNHCR's PoCs living in the malaria endemic areas have access to early diagnosis, prompt and effective treatment, and prevention according to international standards.
4. **Durable Solutions:** To develop and incorporate malaria control strategies and interventions into policies and programmes for durable solutions.
5. **Capacity Building:** To build and strengthen specific malaria-related knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
6. **Assessments, Surveillance, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on the status of malaria within PoCs to inform programmatic planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches and technologies in malaria control.

STRATEGIES AND INDICATORS OF ACHIEVEMENT

UNHCR will monitor its progress against these strategic objectives over the 2008-2012 period through a rigorous monitoring and evaluation system at regional and country levels. The data will be aggregated and reported regularly at global, regional and country level. The following core of **37 indicators** will be tracked as a measure of progress against the strategic objectives. For each of these indicators many others could be suggested, particularly programme performance monitoring indicators, which are not detailed here but many of which will be collected and used at country level. Realisation of these strategic objectives will require a certain level of accountability at various levels of management. This accountability will be most important at the country and field levels through the processes of the programme planning cycle and ongoing reporting.

Table 1 summarises the strategies and indicators of achievement. It provides explicit definitions for and essential information on how the indicators will be measured at the global, regional and country operational levels.

Table 2 provides summaries of how the indicators of achievement will be reported. This includes information on targets, periodicity, applicable strategic objectives, and sources of measurement.

UNHCR will obtain data on malaria control from the following main sources:

1. UNHCR's Health Information System (HIS).
2. UNHCR's Standards and Indicators (S&Is).
3. UNHCR's Annual Protection Reports (APRs).
4. UNHCR's Global Strategic Objectives.
5. Joint Assessment Missions conducted with other UN agencies and Non-Governmental Organisations (NGOs).
6. Population-based surveys.
7. UNHCR's Financial Systems using Management Systems Renewal Project (MSRP).

Table 1. Key Strategies and Indicators of Achievement

STRATEGIC OBJECTIVE 1: PROTECTION	To protect the rights of UNHCR's PoCs with specific reference to malaria.
Key Strategies	**Indicators of Achievement**
(1.1) Provide minimal internationally accepted malaria control services to HCR's PoCs during an emergency.	**(1.1.1)** Crude and Under 5 mortality, all causes (by sex). **(1.1.2)** Proportional mortality due to malaria (Crude, Under 5). **(1.1.3)** Proportional morbidity due to malaria (Crude, Under 5). **(1.1.4)** Malaria incidence (suspected and confirmed) (Crude, Under 5).
(1.2) Provide appropriate protection against malaria for vulnerable and at risk populations using globally accepted preventive measures.	**(1.2.1)** % of women receiving LLIN/ITN[4] during pregnancy in emergency phase. **(1.2.2)** % of households with at least one LLIN/ITN in stable phase.
Indicators **1.5.1** and **1.5.2** from HIV Strategic Plan also apply.	

4 Given that 2008/09 is a transitional period for the type of nets that will be distributed, the indicator with LLIN/Insecticide Treated Nets (ITN) should match type of nets that have been distributed. In some cases, you may need separate indicators for both LLINs and ITNs. It would be expected that after 2009, all operations would have made the switch to using only LLINs exclusively.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 2: COORDINATION AND INTEGRATION	To effectively coordinate, advocate for and integrate malaria control policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
Key Strategies	**Indicators of Achievement**
(2.1) Ensure that malaria control policies and programmes for IDPs are coordinated and integrated within humanitarian reform process.	**(2.1.1)** % of HCR country offices that are consistently participating in health cluster meetings among those countries that have been "clusterized".[5]
(2.2) Advocate to ensure inclusion of refugees and IDPs in National Malaria Control Plans.	**(2.2.1)** % of countries with ≥10,000 refugees that have explicitly included refugees in National Malaria Control Plans among those countries that will update their plans between 2008–2012. **(2.2.2)** % of countries with ≥10,000 IDPs that have explicitly included IDPs in National Malaria Control Plans among those countries that will update their plans between 2008–2012.
(2.3) Strengthen HCR health coordination capacity and supervision with relevant stakeholders (e.g. host country authorities, IPs and OPs, and refugee representatives).	**(2.3.1)** Number of HCR Public Health coordinators. **(2.3.2)** Number of health coordination meetings held per year, including ad hoc malaria task force meetings during malaria epidemics.
(2.4) Participate as member in Network for Malaria Control in Emergencies, coordinated by WHO.	**(2.4.1)** % of network conference calls/meeting in which UNHCR headquarters (or appointed representative) participated during past year.
(2.5) Ensure sufficient resources provided to supporting HCR's malaria control activities.	**(2.5.1)** Amount of resources spent by HCR for malaria control (USD/person/yr).
(2.6) Advocate for the inclusion of HCR's PoCs in donor proposals.	Number of countries with HCR's PoCs (≥10,000 persons) benefiting from additional malaria funding sources: **(2.6.1)** US Presidents Malaria Initiative. **(2.6.2)** Global Fund for AIDS, Tuberculosis and Malaria. See also **2.5.1**.
(2.7) Ensure that PoCs are included into participatory assessments and age, gender and diversity analysis as part of HCR's operations management cycle.	**(2.7.1)** % of countries that have conducted participatory assessments as part of the operations management cycle.

5 A cluster is a group of agencies, organisations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, protection, camp coordination and camp management, education, shelter, health and water and sanitation.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 3: ACCESS TO EARLY DIAGNOSIS, PROMPT AND EFFECTIVE TREATMENT, AND PREVENTION	To ensure that UNHCR's PoCs living in the malaria endemic areas have access to early diagnosis, prompt and effective treatment, and prevention according to international standards.
Key Strategies	**Indicators of Achievement**
(3.1) Provide free or highly subsidized diagnosis, treatment, and prevention according to setting.	**(3.1.1)** % of malaria cases confirmed parasitologically.[6] See also **1.1.1-1.1.4**.
(3.2) Support programmes to meet laboratory diagnostic standards set in national policies.	**(3.2.1)** % of camps/programmes meeting national laboratory standards.
(3.3) Ensure provision of appropriate ACTs in areas where *P. falciparum* malaria predominates; in areas in which other species predominate, use internationally accepted guidelines.	**(3.3.1)** % of camps/programmes using ACT as 1st line treatment for uncomplicated malaria by country. **(3.3.2)** % of health facilities with no reported stock-outs of ACTs in emergency phase.[7] **(3.3.3)** % of health facilities with no reported stock out of ACT during the post-emergency/stable phase.[8] **(3.3.4)** % of camps/programmes where community-based malaria management is being implemented.
(3.4) Provide LLIN with priority to most vulnerable populations in emergency phase and expand to full coverage in stable situations.	**(3.4.1)** % households that have >1 distributed LLIN/ITN six months after net distribution. **(3.4.2)** % inpatient facilities that have LLIN/ITN for each bed. See also **1.3.1** and **1.3.2**.
(3.5) Employ Indoor residual spraying (IRS) when appropriate.	**(3.5.1)** % coverage of suitable dwellings when IRS was utilised to control or prevent epidemics.
(3.6) Provide IPTp to all pregnant women at antenatal care (ANC).	**(3.6.1)** % of pregnant women presenting at ANC who receive ≥2 doses of IPTp, when appropriate.
(3.7) Create epidemic preparedness plans that include malaria control activities when appropriate .	**(3.7.1)** % of camps/programmes that have epidemic preparedness plans including malaria when appropriate.
Indicator **3.2.1** from HIV Strategic Plan also applies. Indicator **3.4.6** from Reproductive Health Strategic Plan also applies. Indicators **3.2.4** and **3.2.5** from Nutrition and Food Security Plan also apply. Indicator **3.5.2** from WatSan Strategic Plan also applies.	

6 WHO/GMP formulation is: -Malaria attributed deaths per 100,000 population per year
- Reported malaria cases per 1000 population per year
- Severe malaria cases per 100,000 population per year
- % of malaria cases confirmed parasitologically

7 Stockout is defined as no interruption of supply of ACTs for > 1 week at any time during the last month in the emergency phase.

8 Stockout is defined as no interruption of supply for ACTs for > 1 week during the past year in the post-emergency/stable phase.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 4: DURABLE SOLUTIONS	To develop and incorporate malaria control strategies and interventions into policies and programmes for durable solutions.
Key Strategies	**Indicators of Achievement**
(4.1) Advocate for and establish local integration and repatriation policies and programmes that include appropriate prevention and treatment interventions for malaria.	**(4.1.1)** % of operations where refugees are provided with appropriate returnee packages defined here as ≥1 LLIN/ITN per household and instructions on use, where appropriate. **(4.1.2)** % of operations where malaria control plans have been designed and integrated with health plans in exit strategies (integration areas or areas of return), where appropriate. **(4.1.3)** % of programmes at point of return that offer malaria control services, where appropriate.
(4.2) Coordinate and share malaria control information to governments, UN agencies and other humanitarian organisations during repatriation.	**(4.2.1)** % of countries undertaking major repatriation operations that collect and share malaria control information about refugees and other PoCs in areas of return with government and organisations involved in malaria control policies and programmes.

STRATEGIC OBJECTIVE 5: CAPACITY BUILDING	To build and strengthen specific malaria-related knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
Key Strategies	**Indicators of Achievement**
(5.1) Train HCR and partner health staff on malaria protocols, prevention and treatment.	**(5.1.1)** Number and % of HCR and health partner staff trained on new treatment and screening protocols for uncomplicated malaria, effective prevention of malaria, and clinical management of severe malaria. See also **2.3.2, 2.7.1, 3.7.1**.
(5.2) Provide malaria-focused community education programmes to refugees and other PoCs.	**(5.2.1)** % countries reporting malaria training for HCR's PoCs. See also **2.7.1, 4.1.1**.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 6: ASSESSMENTS, SURVEILLANCE, MONITORING AND EVALUATION, OPERATIONAL RESEARCH	To regularly monitor and report on the status of malaria within PoCs to inform programmatic planning and implementation in a timely manner; To evaluate programme performance and achievements using a results-based management approach; and To develop and carry out operational research on new approaches and technologies in malaria control.
Key Strategies	**Indicators of Achievement**
(6.1) Conduct malaria situation assessments using a standardised checklist.[9]	**(6.1.1)** % of malaria assessments undertaken in endemic settings during initial emergency phase.
(6.2) Collect, analyse, and respond to essential malaria-related data on a routine basis using standard case definitions.	**(6.2.1)** % refugee operation with functioning HIS, as defined by monthly reporting to HCR.
(6.3) Evaluate malaria control programmes on a routine basis.	**(6.3.1)** % of camps/programmes that have evaluated their coverage and quality of malaria control services every 2 yrs in stable settings.
(6.4) Conduct operational research as indicated to guide programme implementation (e.g. antimalarial drug efficacy, new insecticide treated materials, adherence and acceptability of ACT) or to address identified programmatic problems.	**(6.4.1)** Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.

9 Please refer to Technical Guidelines for Malaria, pp. 29, for a sample standardised assessment checklist to use for these assessments.

Table 2: Summary of Indicators of Achievement

INDICATORS OF ACHIEVEMENT	Target[10]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[11]
(1.1.1) Crude and Under 5 mortality, all causes (by sex).	< 1 death/1000/mos < 2 deaths/1000/mos	Monthly, Annually	1,3	HIS	Camp
(1.1.2) Proportional mortality due to malaria (Crude, Under 5).	Variable; based on endemicity	Monthly, Annually	1,3	HIS	Camp
(1.1.3) Proportional morbidity due to malaria (Crude, Under 5).	Variable; based on endemicity	Monthly, Annually	1,3	HIS	Camp Non-camp
(1.1.4) Malaria incidence (suspected and confirmed) (Crude, Under 5).	Variable; based on endemicity	Monthly, Annually	1,3	HIS	Camp
(1.2.1) % of women receiving LLIN/ITN[12] during pregnancy in emergency phase.	>75%	Monthly, Annually	1,3	HIS	Camp
(1.2.2) % of households with at least one LLIN/ITN in stable phase.	>75%	Annually	1,3	Country Offices Malaria survey	Camp
(2.1.1) % of HCR country offices that are consistently participating in health cluster meetings among those countries that have been "clusterized".[13]	>75%	Annually	2	Country Offices	Camp Non-camp
(2.2.1) % of countries with ≥10,000 refugees that have explicitly included refugees in National Malaria Control Plans among those countries that will update their plans between 2008–2012.	>80%	Biannually	2	National Malaria Control Plans	Camp Non-camp
(2.2.2) % of countries with ≥10,000 IDPs that have explicitly included IDPs in National Malaria Control Plans among those countries that will update their plans between 2008–2012.	>80%	Biannually	2	National Malaria Control Plans	Camp Non-camp
(2.3.1) Number of HCR Public Health coordinators country and regional levels.	Variable	Annually	2	Country Offices Regional Offices HQ	Camp Non-camp
(2.3.2) Number of health coordination meetings held per year, including ad hoc malaria task force meetings during malaria epidemics.	12	Annually	2,5	Country Offices Regional Offices HQ	Camp Non-camp
(2.4.1) % of network conference calls/meeting in which HCR HQ (or appointed representative) participated.	>75%	Annually	2	Notes for record of network calls	Camp Non-camp

10 Target refers to the level that UNHCR intends to achieve by the end of 2012. It is based on the current situation and what HCR believes it is feasible to attain.

11 Refers to setting where indicator will ***primarily*** be measured. However, this may vary according to context. All population-based surveys could be undertaken in camp or non-camp settings; however, at this point they are primarily done in camp settings. This may change over time.

12 Given that 2008/09 is a transitional period for the type of nets that will be distributed, the indicator with LLIN/ITN should match type of nets that have been distributed. In some cases, you may need separate indicators for both LLINs and ITNs. It would be expected that after 2009, all operations would have made the switch to using only LLINs exclusively.

13 A cluster is a group of agencies, organisations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, education, shelter, telecommunications, food aid, health and sanitation.

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[8]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[9]
(2.5.1) Amount of resources spent by HCR for malaria control (USD/person/yr).	Variable	Annually	2	MRSP	Camp Non-camp
(2.6.1) Number of countries with HCR's PoCs (≥10,000 persons) benefiting from additional malaria funding sources from US Presidents Malaria Initiative.	Variable	Annually	2	MRSP HQ	Camp Non-camp
(2.6.2) Number of countries with HCR's PoCs (≥10,000 persons) benefiting from additional malaria funding sources from the Global Fund for AIDS, Tuberculosis and Malaria.	Variable	Annually	2	MRSP HQ	Camp Non-camp
(2.7.1) % of countries that have conducted participatory assessments as part of the operations management cycle.	>75%	Annually	2,5	Country Offices	Camp Non-camp
(3.1.1) Proportion of malaria cases confirmed parasitologically.	Variable	Monthly, Annually	1,3	HIS	Camp
(3.2.1) % of camps/programmes meeting national laboratory standards.	100%	Annually	3	Country Offices	Camp Non-camp
(3.3.1) % of camps/programmes using ACT as 1st line treatment for uncomplicated malaria by country.	100%	Annually	3	Country Offices Joint Missions	Camp Non-camp
(3.3.2) % of health facilities with no reported stock-outs of ACTs in emergency phase.	>80%	Annually	3	Country Offices Joint Missions	Camp Non-camp
(3.3.3) % of health facilities with no reported stock outs during the post-emergency/stable phase.	0%	Annually	3	Country Offices Joint Missions	Camp Non-camp
(3.3.4) % of camps/programmes where community-based malaria management is being implemented.	>80%	Annually	3	Country Offices Joint Missions	Camp
(3.4.1) % households that have ≥1 distributed LLIN/ITN six months after net distribution.	>50%	Annually	1,3	Country Offices LLIN survey	Camp
(3.4.2) % inpatient facilities that have for each bed.	100%	Annually	1,3	Country Offices LLIN survey	Camp
(3.5.1) % coverage of suitable dwellings when IRS was utilised to control or prevent epidemics.	>60%	Annually	3	Country Offices LLIN survey	Camp
(3.6.1) % of pregnant women presenting at ANC who receive ≥2 doses of IPTp, when appropriate.	>80%	Monthly, Annually	3	HIS	Camp
(3.7.1) % of camps/programmes that have epidemic preparedness plans including malaria when appropriate.	>80%	Monthly, Annually	3,5	Country Offices	Camp

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[8]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[9]
(4.1.1) % of operations where refugees are provided with appropriate returnee packages defined here as ≥1 LLIN/ITN per household and instructions on use, where appropriate.	100%	Annually	3,5	Country Offices	Camp Non-camp
(4.1.2) % of operations where malaria control plans have been designed and integrated with health plans in exit strategies (integration areas or areas of return), where appropriate.	100%	Annually	4	Country Offices	Camp Non-camp
(4.1.3) % of programmes at point of return that offer malaria control services, where appropriate.	100%	Annually	4	Country Offices	Camp Non-camp
(4.2.1) % of countries undertaking major repatriation operations that collect and share malaria control information about refugees and other PoCs in areas of return with government and organisations involved in malaria control policies and programmes.	Variable	Annually	4	Country Offices	Camp Non-camp
(5.1.1) Number and % of HCR and health partner staff trained on new treatment and screening protocols for uncomplicated malaria, effective prevention of malaria, and clinical management of severe malaria.	>75%	Annually	2,3,5	Country Offices	Camp
(5.2.1) % countries reporting malaria training for HCR's PoCs.	>80%	Annually	2,4,5	Country Offices	Camp Non-camp
(6.1.1) % of malaria assessments undertaken in endemic settings during initial emergency phase.	100%	Annually	6	Country Offices	Camp Non-camp
(6.2.1) % refugee operation with functioning HIS, as defined by monthly reporting to HCR.	100%	Monthly, Annually	6	HIS	Primarily camp with emphasis to include non camp
(6.3.1) % of camps/programmes that have evaluated their coverage and quality of malaria control services every 2 yrs in stable settings.	100%	Biannually	6	Country Offices HQ	Camp
(6.4.1) Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.	Variable	Annually	6	Country Offices Regional Offices HQ	Camp Non-camp

ANNEX 1: TECHNICAL GUIDELINES
UNHCR STRATEGIC PLAN ON MALARIA CONTROL

The purpose of these guidelines is to provide additional technical information on malaria control as it pertains to the operations of UNHCR. This document is not meant to replace more comprehensive malaria publications but to provide rationale, background, and reference information for the objectives and indicators that are specifically introduced in the Strategic Plan. These guidelines include the most recent and relevant recommendations and positions of various scientific authorities. This information may be applicable to many levels of expertise and personnel including country and field office leadership, program officers, and health staff. The guidelines primarily discuss topics such as diagnosis and treatment, prevention, community participation, and monitoring and evaluation, with careful consideration for the special populations for whom UNHCR provides protection and assistance and advocacy. All information and references should be considered in light of the constantly dynamic and emerging scientific information related to the world of malaria control.

DIAGNOSIS AND TREATMENT

Of the eight United Nations' Millennium Development Goals[I] to be achieved by 2015, the sixth pertains to malaria: "Combat HIV/AIDS, malaria, and other diseases." The World Health Organisation (WHO) and Global Malaria Programme (GMP) aim to implement three primary interventions for effective malaria control order to meet the sixth goal:

- Diagnosis of malaria cases and treatment with effective medicines;
- Distribution of insecticide-treated nets (ITNs), more specifically long-lasting insecticidal nets (LLINs), to achieve full coverage of populations at risk of malaria; and
- Indoor residual spraying (IRS) to prevent/contain an outbreak and as for LLINs to reduce malaria transmission.

Rapid Diagnostic Tests (RDTs) and Microscopy

Diagnosis and treatment should be free of charge to the patient. Treatment should be on the basis of laboratory confirmation (with results available within 1 hour), except:

1. During confirmed malaria epidemics when high patient volume precludes individual testing of all febrile patients, OR
2. Among children under 5 years in high transmission settings (Slide Positivity Rate >50%), whereas the Integrated Management of Childhood Illness (IMCI) model (using treatment based on clinical diagnosis) should be followed.[II]

RDT are often used in emergencies. Usually RDTs that detect only *P. falciparum* are used (e.g. Paracheck®), as they are cheaper, easier to use, and more robust than other species- detecting RDTs. Additionally, it is important to specifically exclude *P. falciparum* infection as it is more often potentially

life threatening than other species. However, RDTs should not be used to investigate suspected treatment failures or assess drug efficacy as they remain positive for up to two weeks after successful treatment. In settings where it is known that other species of malaria (such as *P. vivax*) are prevalent, other RDTs may be considered. However, these are generally more expensive and less efficient and reliable in field conditions.

Training, supervision, materials, and supplies for malaria microscopy should eventually replace RDTs for confirmatory diagnosis in stable settings. In all circumstances there should be access to at least one reference laboratory with good malaria microscopy for patient management; and in particular for assessing treatment failures and follow up, severe malaria, and weekly screening of severely malnourished patients. It is also essential for quality control of RDTs that are stored and used under field conditions.

Artemisinin-based Combination Therapy (ACT)

In emergency and non-emergency settings, the mainstay of response is prompt access to effective treatment. First line treatment should be with ACT, following case confirmation using RDTs or microscopy. Stocked in the new Interagency Emergency Health Kits (distributed by WHO), artemether-lumefantrine (Coartem®) is recommended specifically as first line therapy as it remains >95% effective in most African settings. However, depending on any specific country's national malaria treatment guidelines, other ACTs may be recommended for use as first line therapy.

Pregnant Women and Children

For treatment of pregnant women with uncomplicated malaria, artemether-lumefantrine should be used during the 2nd and 3rd trimesters of pregnancy and quinine and clindamycin in the 1st trimester of pregnancy. Artemether-lumefantrine should not be withheld in severe cases or if there is no other option available, and its use in children weighing less than five kilograms is not recommended.[III]

Severe Malaria

Individual cases of severe malaria are marked by hypoglycemia, severe anemia, shock, coma, renal failure, and pulmonary edema. These complications must be urgently addressed and treated in addition to providing appropriate anti-malarial therapy. Guidelines recommend the use of artesunate (intravenous [IV], intramuscular [IM]), artemether (IM), or rectal artemisinin derivatives – which are generally given in situations when the patient is being referred and IV or IM therapies are not available or appropriate. IV quinine is a final alternative, and the goal should be to eventually convert to full course oral ACT therapies when clinically appropriate. In early emergency settings where diagnostics are not yet available, empiric therapy for clinically-suspected severe malaria should not be withheld. Groups at risk for developing severe malaria include pregnant women, young children, those recently displaced, and persons with depressed immunity or severe malnutrition.[III]

Once the emergency phase is over, the approach to treatment and diagnosis should be harmonized with the host country's National Malaria Control Programme, whenever possible. The treatment protocol must always be based on the use of efficacious anti-malarial drugs, which for most *P. falciparum* transmission settings will be ACT. Drug treatment protocols should be based on efficacy data that are less than two years old. Where recent efficacy data are not available, UNHCR and partners may need to engage in efficacy studies with the respective Ministries of Health (MoH) in the affected countries and other partners, such as the WHO. Where the national protocol is based on drug treatment that is no longer effective, then special permission should be obtained from the local authorities to deviate from the national protocol. In situations such as this, the best approach is to use the most efficacious drug to treat all individuals within the refugee-affected area although, in reality, this is difficult to achieve.

Internally Displaced Persons (IDPs) and Returning Refugees

With mass population movements, there is a risk that large numbers of non-immune people may be introduced to regions with high malaria activity. Malaria-partial immunity is thought to wane during stays of 6 months or more in non-endemic areas. It is also possible to transfer different species or different strains with varying drug susceptibilities to new locations – thus posing potential risks for both new arrivals and resident populations.

Therefore, if large population movements are seen or anticipated, the most cost effective measure is to act as close as possible to the time of departure by screening the entire population and subsequently treating positive cases with ACT. Intense information, education, and communication (IEC) efforts are required to ensure that newly arriving populations promptly seek care for fever-related illnesses and receive preventive interventions such as LLINs.

PREVENTION

Preventive measures are generally implemented as the emergency phase shifts into a more stable situation where population flux has diminished. Implementing successful malaria prevention requires available and trained personnel (particularly community health and sanitation workers), sufficient funding, culturally-appropriate and acceptable interventions, and a focus on community-based programming. Factors such as limited access and compromised procurement of supplies due to conflict, security concerns, divergence of preventive efforts to treatment efforts, lack of expertise, and rapid staff turnover may constrain the implementation of preventive measures. Additionally, unstable situations make long-term planning and evaluation of prevention efforts difficult.

During the acute phase, several factors such as risk of infection, characteristics of the population, type of shelter used, and aspects of the local mosquito vector may help determine what preventive measures are appropriate. As the situation becomes more chronic, re-assessment is important as both shelters and population movements may change.

Regardless of the phase of the emergency, culturally-appropriate IEC campaigns should be used in concert with implementation of preventive measures. Community health workers should collaborate closely with staff from water and sanitation teams in order to apply integrated vector control management strategies, including source reduction activities (e.g. draining breeding areas and tap stand maintenance).

Intermittent Preventive Treatment in Pregnancy (IPTp)

The risk of infection with and clinical severity of malaria is higher in pregnant women, particularly with *P. falciparum*. It is also often dependent upon HIV and immune status, previous exposure to malaria, and parity (higher parity being protective). The most common complication of malaria infection for pregnant women is severe anemia, while the most common complication for the infant is low birth weight (LBW), which is further predictive of neonatal demise.

It has been well studied that in moderate to high transmission areas where mothers most often possess at least partial immunity, preventive therapies are beneficial for both the pregnant mother and her child. In reference to pregnant women, in times of emergency, interventions should include good case management, active finding of fever cases, malaria screening, priority of LLIN distribution, and IPTp provided in conjunction with antenatal care (ANC).

Despite high levels of resistance, sulfadoxine-pyrimethamine (SP) remains the staple drug of choice for IPTp, and it should be implemented (even if no national IPTp policy exists) in the following circumstances:

- transmission intensity is moderate to high
- ANC services are established
- SP remains at least moderately efficacious (resistance <50%)

SP is given once during the 2nd and once in the 3rd trimester of pregnancy. For HIV positive mothers or where HIV prevalence is greater than 10% among pregnant women, SP is given monthly from the start of the second trimester. However, SP should not be given to HIV positive women receiving daily cotrimoxizole prophylaxis. In low transmission settings, epidemics, or where SP is inadequate (resistance >50%), the focus of malaria control for pregnant women should be on prompt diagnosis and treatment and other preventive interventions. Ideally, IPTp should be administered using Directly Observed Therapy (DOT) and all doses should be recorded in a register book. A system should be developed using community health care workers to trace women who have failed to show up for their IPTp doses.

Indoor Residual Spraying (IRS)

IRS can be effective in emergency settings but its success depends on several conditions: presence of an endophilic (indoor resting) vector, use of an efficacious insecticide, a well-trained staff, and housing structures that have walls suitable for spraying. It is essential, prior to any spraying campaign, that all equipment to be used is tested and repaired, if necessary.

Experiences from many UNHCR and other programmes show that spraying usually commences after the start of the rainy season, too late to have an impact on malaria transmission. This is a considerable waste of resources and risks possible negative consequences for the environment and human health. Even with all the required operational factors in place, IRS is not always completed effectively. Insecticides must be selected on the basis of known efficacy and sensitivity data; and, because of historically tenuous public acceptance, IRS is a strategy in which it is critical to implement strong information, education and communication (IEC) in advance of the spray campaign to maximize public participation and adherence. Timing of spray campaigns should also take into account cultural patterns of mud plastering walls in accordance with holidays or other traditional practices.[IV]

At least 85% of all dwellings must be covered for effective community protection.[V] IRS should only be implemented in emergency and stable settings where the following elements are in place:

- Availability and adequacy of equipment and logistics
- Trained and expert staff
- Well organized implementation plan, with adequate levels of supervision and monitoring
- Ability to implement spraying prior to the rainy season

Suggested indicators include:[V]

- Coverage = number of dwellings sprayed/number of dwellings in targeted area (%).
- Insecticide used per dwelling = quantity of insecticide used/number of dwellings sprayed (a measure of efficiency and correct use of insecticide)
- User acceptability pre-spray = % of households agreeing to be sprayed
- User acceptability post-spray = % of dwellings re-plastered or washed, or % of householders complaining about IRS (to be assessed one month after spraying)

Long Lasting Insecticidal Nets and Insecticide-Treated Nets

WHO currently recommends full coverage of populations at risk of malaria, preferably with that malaria control programs should specifically purchase only LLINs in order to provide 100% coverage of all people at risk of malaria. However, nets have been shown to provide a community protective effect when as little as 60% of the population are using the nets.[VI, VII] At lower rates of coverage, they have only an individual effect on those sleeping under the net.

During the initial emergency phase, net distribution should target those most at risk, such as pregnant women and children under five years of age. As soon as it is feasible, free distribution of nets should be provided to the entire population at risk. All infants at their first immunization visit and pregnant women visiting antenatal clinics should receive an LLIN in endemic areas.[VIII] All UNHCR programs should have full coverage with LLINs for all inpatient beds (clinics, hospitals, and therapeutic feeding centres). Additional general campaigns for net distribution can be developed targeting distribution at primary health facilities, HIV/AIDS programmes, feeding centres, and through the use of community health care workers. This will help to ensure that all at-risk populations are targeted and covered.

Distribution should be accompanied by effective community education strategies, monitoring, and follow up. Net misuse and resale is a problem in refugee settings where adequate community engagement and education is not conducted, and where there are competing survival priorities. For example, some programmes have noted that nets are sold when food rations have been cut or when distribution of non-food items is limited.

There are many other insecticide-treated materials which have been used in attempt to prevent spread of malaria, such as insecticide treated blankets, clothing, and plastic sheeting. Although many show promising study results, none are currently approved and/or recommended by WHO or the WHO Pesticide Evaluation Scheme. Insecticide-treated hammocks may be a valuable asset for displaced populations to use to prevent forest malaria.

LLINs are expected to last for three years under field conditions, if used as recommended. Given the stark living conditions in which the displaced often reside, expectations may need to be decreased regarding expected length of usefulness of LLINs in these settings. Programmes should ensure that a system is in place to record when LLINs were purchased and distributed, and budget accordingly for cyclic replacements as needed.

Monitoring of net retention and utilisation should occur on a regular basis, such as at time of distribution, one and six months post-distribution, and annually thereafter. It is important to distinguish between net retention and proper net usage. Sample indicators include:[V]

- Coverage = number of LLIN/ITNs distributed/target population size (%).
- Utilization rate = number of Under 5s/pregnant women who slept under the net on the previous night/number of Under 5s/pregnant women given LLIN/ITNs (%).
- Retention rate = number of people retaining LLIN/ITNs / number of people originally given LLINs/ITNs (%).
- Deterioration rate = average number of holes per LLIN/ITN.

As LLINs are a relatively new intervention, many programmes are still using ITNs. If so, a regular programme of re-treatment should be established within the community, as well as for all nets used inpatient facilities.

Information, Education, and Communication and Community Participation

For malaria in particular, community investment and participation are absolutely essential for a successful prevention and treatment operation. Preventive interventions, such as the use of LLINs, require that individuals not only accept and retain the net but also use the net correctly. As well, the positive effects of IRS can be negated if the target population fears the insecticide or does not understand that walls should not be washed or re-plastered following a spray application. Delays in treatment seeking from health care facilities may be improved if culturally sensitive and appropriate IEC messages are developed through participatory methods that include input from community representatives.

When establishing messages and priorities, several key issues should be included: the link between the mosquito and the disease, identification of those most-at-risk, need for prompt treatment seeking with febrile illnesses, distinction between uncomplicated and severe malaria, and preventive methods and how best to access health facilities. Whenever possible, IEC activities should complement planned social events and link to other health campaigns. Health education messages should be widely distributed and visible in all health care facilities, as well as areas within camps or settlements where people meet, such as community halls, religious institutions or other gathering areas.

It simply cannot be overstated that IEC must be linguistically, socially, and culturally appropriate. In designing successful health education messages, several steps should be followed:[v]

- Define the objectives of health education
- Identify the target audience
- Define the desired behaviours and develop clear messages
- Provide information about what people can do
- Use methods that are culturally acceptable
- Deliver messages through trusted and respected individuals
- Provide training and materials

To help achieve these objectives, it is useful to establish multi-sectoral working groups consisting of representatives from implementing partners and coordination agencies (such as representatives from health, water/sanitation, education, and cultural enrichment programmes), as well as community leaders from the refugee and refugee-affected populations. Participation can be strengthened by meeting on a regular basis during which feedback and concerns can be discussed from all perspectives. An added benefit of these working groups is that those attending will receive routine updates and informal training in issues relevant to malaria control as well as learn ways to improve collaboration with other sectors.

Epidemic Preparedness and Response

Declaring a malaria epidemic can be somewhat difficult to do because often baseline malaria-related rates of morbidity and mortality and levels of endemicity are often unknown – especially in emergencies and in displaced populations. Additionally, malaria outbreaks can be sub-acute and be multi-factorial in causality. However, when baseline or seasonal data are lacking (stable situations often require five years data for comparison), the weekly incidence rate, case fatality rate, slide positivity rate (SPR), and malaria-proportional mortality may be helpful. In such cases, it is recommended that the alert threshold for a suspected malaria outbreak should be defined as a 1.5 times increase in the number of cases above the baseline (baseline defined as average rates over the previous three weeks).

Suspected malaria outbreaks should be investigated immediately with the purpose of attempting to achieve two objectives:

1. Confirm the cause of the outbreak with rapid prevalence surveys (high SPR or RDT positivity rate among fever cases)
2. Describe the characteristics of the outbreak (age groups, time and geographical distributions, epidemic curve)[v]

Proper preparedness measures should include several elements:

a. Stockpiling appropriate amounts of medications and supplies
b. Developing epidemic plans that include resource mobilisation
c. Identifying staff to serve as points of contact during an emergency
d. Adequate staff and transport if mobile teams are necessary
e. Training of all staff in emergency measures

Given the short half-life of some of the newer ACTs, attention must be placed on the shelf life of the drug when determining how long anti-malarials can be stored before they expire. As well, RDTs are heat sensitive so stocks of RDTs should be stored in a cool area whenever possible.

Once it has been determined that an outbreak has commenced, the first priority is to provide for prompt and effective diagnosis and treatment per the above mentioned guidelines. Vector control strategies may be considered, although these are primarily preventive measures, and should not drain resources from diagnosis and treatment efforts. Ideally, vector control strategies would be implemented prior to the epidemic peak.

With respect to treatment, it is important that enough clinical access points are available and that vulnerable populations are targeted. These settings are also amenable to empiric treatment based on clinical case definitions, once testing have confirmed that a malaria-related outbreak is occurring. RDT or microscopy may be continued on a small percentage of patients to provide a surrogate marker for malaria activity.

Follow-up evaluation of outbreak coverage of prevention efforts can be tracked using the above-mentioned malaria-related morbidity and mortality indicators and case fatality rates. Systematic prevalence and demographic assessments also help to further characterize malaria and population activities in relation to the outbreak.[V]

Health Information System (HIS) and Monitoring and Evaluation

The use of a health information system is essential to ensure that standardised data are available for routine programme monitoring and evaluation. An HIS uses a set of mutually-agreed upon common core variables and standard indicators, with associated tools for data collection and analysis. All agencies involved in malaria control activities should use the same tools and HIS. When applicable, the UNHCR HIS should be employed. It is important to be aware of the host country's HIS, if available, to assist national staff in transitioning from the national HIS to that of UNCHR's HIS, as there may be slight differences in terminology and case definitions.

The UNHCR HIS uses the following case definitions for malaria:[IX]

Suspected Malaria:

UNCOMPLICATED
Any person with fever or history of fever within the past 48 hours (with or without other symptoms such as nausea, vomiting and diarrhoea, headache, back pain, chills, myalgia) in whom other obvious causes of fever have been excluded.

SEVERE
Any person with symptoms as for uncomplicated malaria, as well as drowsiness with extreme weakness and associated signs and symptoms related to organ failure such as disorientation, loss of consciousness, convulsions, severe anaemia, jaundice, haemoglobinuria, spontaneous bleeding, pulmonary oedema and shock.

TO CONFIRM A CASE
Demonstration of malaria parasites in blood film by examining thick or thin smears, or by RDT for *Plasmodium falciparum*.

At a very minimum, as in all settings, crude mortality and under 5 mortality should be ascertained. Ideally, as soon as feasible, additional indicators should include:

- Proportional mortality due to malaria
- Proportional morbidity due to malaria
- Incidence of malaria
- Case fatality rate (confirmed cases)
- Blood-slide positivity rate
- Rapid-diagnostic test (RDT) positivity rate.

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III WHO (2006). *Guidelines for the Treatment of Malaria*. Geneva, World Health Organisation (WHO/HTM/MAL/2006.1108).

IV WHO (2006). *Indoor Residual Spraying*, Geneva, Global Malaria Programme/ World Health Organisation (WHO/HTM/MAL/2006.1112).

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VI Killeen GF et al. (2007). Preventing childhood malaria in Africa by protecting adults from mosquitoes with insecticide-treated nets. *PLoS Medicine* 4: e229.

VII Hawley WA et al. (2003). Community-wide effects of permethrin-treated bed nets on child mortality and malaria morbidity in western Kenya. *Am. J. Trop. Med. Hyg. 68 (Suppl 4)*: 121-127.

VIII WHO (2007). *Insecticide-treated mosquito nets: a WHO position paper*. Geneva, World Health Organisation.

IX UNHCR (2007). Health Information System Toolkit, Case Definitions (HISNBI0307). (www.unhcr.org/protect/PROTECTION/4614aa682.pdf).

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- Malaria Consortium (1999). Partnerships for change and communication: guidelines for malaria control. London, London School of Hygiene and Tropical Medicine and WHO. (sara.aed.org/sara_pubs_list_usaid_1.htm).

DIAGNOSIS

- Laboratory identification: www.dpd.cdc.gov/dpdx. (Companion CD-ROM available by request: dpdx@cdc.gov).
- Rapid diagnosis: www.wpro.who.int/rdt.
- WHO (1991). Basic Malaria Microscopy (part I and II). Geneva, World Health Organisation.

DRUG SELECTION AND SUPPLY

- Information on WHO/UNICEF prequalified drugs: mednet3.who.int/prequal.
- Standard efficacy study protocol: www.who.int/malaria/resistance.html.
- Interagency Emergency Health Kit 2006: http://www.who.int/medicinedocs/index.fcgi?a=d&d=Js13486e.

EPIDEMICS

- Nájera, J.A., Kouznetsov, R.L., Delacollette, C. (1998). Malaria Epidemics, Detection and Control Forecasting and Prevention. Geneva, World Health Organisation. (www.rbm.who.int/docs/najera_epidemics/naj_toc.htm).
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HIV

- WHO (2004). Malaria and HIV interactions and their implications for public health policy: report of a technical consultation Geneva, Switzerland 23-25 June 2004. Geneva, World Health Organisation. (www.who.int/hiv/pub/prev_care/malaria/en/index.html).

IRS

- Insecticide selection: www.who.int/malaria/cmc_upload/0/000/012/604/IRSInsecticides.html.
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- WHO (2006). Guidelines for the Treatment of Malaria. Geneva, World Health Organisation (WHO/HTM/MAL/2006.1108).

GENERAL

- forum.actmalaria.net/YaBB.pl
- www.malariaconsortium.org
- www.wellcome.ac.uk/node5816.html
- www.who.int/malaria
- www.who.int/whopes

ANNEX 2: MALARIA SITUATION ASSESSMENT CHECKLIST

Sources of information

- UNHCR/NGO/MOH/WHO data and reports
- Interviews with health staff and other key informants
- Focus group discussions with beneficiaries
- Direct observation of health facilities (record review, pharmacy, treatment practices)
- Surveys as necessary (eg household - parasite or fever prevalence, health seeking behaviour, ITN usage; health facility exit surveys; entomological data)

Policy framework

- National Malaria Control Programme – treatment protocol, efficacy data, drug delivery systems, prevention activities, surveillance system
- Population of concern addressed by National Malaria Control Programme

Coordination mechanisms

- Annual expenditure per capita on health, on malaria control specifically for population of concern
- UNHCR and partner capacity for planning, monitoring and evaluating malaria control programme
- Malaria task force or other interagency coordination mechanism
- Malaria planning, implementation, monitoring and evaluation included in annual programme cycle
- Standardisation of data collection, analysis and dissemination

Epidemiological situation

- Target population and demographics (including % women, % children <5)
- Epidemiology of place of origin, transit (if recently arrived) and asylum
    - Vector and insecticide resistance
    - Parasite species and drug resistance
    - Seasonality, stability of transmission
    - Climate
- Health data
    - Malaria incidence and proportional morbidity due to malaria (by age, over time)
    - Malaria specific mortality rate and proportional mortality due to malaria (by age, over time)
    - Proportion of admissions to hospital due to malaria, case fatality rate (by age)
    - Main diseases of public health importance.
    - HIV prevalence

Infrastructure and personnel

- Primary health facility
  - Condition, including water, latrines
  - Distance, opening hours, catchment population
  - Materials for universal precautions
  - Supplies, drugs and equipment
  - Pre-referral treatment protocol (eg artesunate suppositories, intramuscular artemether)
- Referral facility
  - Condition, including water, latrines, mosquito nets
  - Supplies, drugs, equipment
  - Capacity for safe blood transfusion; caesarian section.
  - Transport, communication, travel time
  - Distance, opening hours, catchment population
- Personnel
  - Number and type
  - Training
  - Supervisory mechanisms

Malaria service provision

- Partners / service providers
- Treatment
  - Protocols available in health centres
  - Drugs supply management system in place
  - Supervisory system
- Preventive activities (describe)
  - Date of last activity
  - Estimated coverage
  - Supervisory system
- Health education and community mobilisation activities (describe)
  - Frequency
  - Coverage
  - Supervisory system

Behavioural, socio-cultural and systemic barriers to successful implementation of malaria control activities

- Utilisation of formal health facilities
- Accessibility of formal health care to all population sub-groups
- Preference for traditional practices
- Presence of harmful traditional practices
- Attitudes to fever, convulsions, anaemia
- Attitudes to formal health care

Surveillance, monitoring and evaluation

- Clinic and hospital data – morbidity and mortality time trends (by age)
- Community coverage data – prevention, promotion
- Health service provider – use of standard treatment protocols, attitudes to malaria treatment
- Community surveys - attitudes and use of prevention and treatment services
- Periodic evaluations

Notes

UNHCR
The UN Refugee Agency

UNHCR's Strategic Plan for Nutrition and Food Security

2008 - 2012

UNHCR
The UN Refugee Agency

Table of contents

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APR	Annual Protection Report
GAM	Global Acute Malnutrition
GSO	Global Strategic Objective
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IDPs	Internally Displaced Person
IP	Implementing Partner
IYCF	Infant and Young Child Feeding
JAMs	Joint Assessment Missions
MSRP	Management Systems Renewal Project
OP	Operational Partner
PoCs	Persons of Concern
SAM	Severe Acute Malnutrition
S&I	Standards and Indicators
SFP	Supplementary Feeding Programme
TFP	Therapeutic Feeding Programme
UNHCR	United Nations High Commissioner for Refugees
WFP	World Food Program

EXECUTIVE SUMMARY

This United Nations High Commissioner for Refugees' (UNHCR) Strategic Plan for Nutrition and Food Security outlines the vision, strategic objectives and main strategies of UNHCR as well as the indicators to measure their implementation. It aims to fully integrate nutrition and food security into UNHCR's overall mandate of protection of refugees and other persons of concern (PoCs), and to meet internal and international standards in UNHCR's nutrition and food security-related policies and programmes. The Strategic Plan supports and is compatible with existing initiatives such as the Millennium Development Goals, the United Nations humanitarian reform process, the Reinforcing Efforts to Address Child Hunger, and the internationally recognised right to adequate food.

This Strategic Plan was developed in coordination with those of other sectors in the Public Health and HIV Section in the Division of Operational Services including HIV/AIDS, malaria, reproductive health, and water/sanitation. This approach will help to ensure a comprehensive and integrated approach across these technical sectors. The Strategic Plan aims to guide operations in camp, urban and other non-camp settings according to all stages of an emergency, as well as for local integration and returnee situations, during the period of 2008-2012 (see 2008-12 guiding principles). This Strategic Plan was developed in consultation with Operational Partner (OPs) including UN agencies, NGOs and academic institutions.

OVERALL STRATEGIC OBJECTIVE:

To support and promote nutrition and food security policies and programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, internally displaced persons (IDPs), returnees and other PoCs to UNHCR.

NUTRITION AND FOOD SECURITY STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection:** To protect the right of UNHCR's PoCs to sufficient food which relies upon access to adequate nutrition and food security.

2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate nutrition and food security policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Prevention:** To prevent malnutrition and food insecurity by supporting implementation of and scaling up effective preventative interventions to UNHCR's PoCs with an emphasis on community participation, especially among women, children and people with special needs.

4. **Care, Support and Treatment:** To ensure that PoCs have access to timely, quality and effective supportive and curative nutrition services.

5. **Durable Solutions:** To develop and incorporate nutrition and food security strategies and interventions into policies and programmes for durable solutions.

6. **Capacity Building:** To build and strengthen specific nutrition and food security knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

7. **Assessments, Surveillance, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on PoCs' nutrition and food security status to inform programme planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches and technologies in nutrition and food security.

INTRODUCTION

Ensuring adequate nutrition and eliminating malnutrition have long been recognised as integral to fulfilling UNHCR's protection mandate.[1] Improved programme monitoring during the last several years documenting high rates of acute and micronutrient malnutrition in protracted refugee settings has fueled a debate about the adequacy of humanitarian assistance for refugees and other PoCs to UNHCR as a basic human right.[2,3] UNHCR is working to ensure that the strategies the agency uses to ensure adequate nutrition build upon the most current epidemiological data on nutrition and health available, and capitalise upon the many advances in nutritional approaches (e.g. community-level management of severe acute malnutrition) and technologies (e.g., new ready to use therapeutic foods and community level fortification) of the last decade. This UNHCR Strategic Plan for Nutrition and Food Security documents the vision, strategic objectives and main strategies of UNHCR to fully integrate nutrition and food security into UNHCR's overall mandate of protection of refugees and other PoCs. It also provides core indicators by which progress against these strategic objectives will be measured to ensure that UNHCR meets internal and international standards.

The foundation for the UNHCR Strategic Plan for Nutrition and Food Security was laid by:

- Recent work on nutrition as a programme priority and part of UNHCR's Global Strategic Objectives of 2006, 2007, and 2008-2009.
- UNHCR Executive Committee Conclusions (No. 107 (LVIII) - 2007).
- "Health, Nutrition and HIV/AIDS – New Strategies" (Standing Committee paper, June 2007).
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- Policy of the UNHCR Related to the Acceptance, Distribution and Use of Milk Products in Refugee Settings (August 2006).
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- UNHCR Executive Committee conclusion 74(XLV),1994.
- UNHCR Executive Committee Conclusion 59(XL), para (e), 1989.
- UNHCR Executive Committee Conclusions (No. 47 (XXXVIII), 1987.

Nutrition is now explicitly highlighted in UNHCR's Global Strategic Objectives for 2008-2009 (Box 1).[4] For the purpose of this Strategic Plan, the terms "nutrition" and "food security" are defined consistently

1 See the International Covenant on Economic, Social and Cultural Rights (1966) and the United Nations Convention on the Rights of the Child (1989).

2 See guiding principles 2008 - 2012 for UNHCR's definition of the term "Persons of Concern".

3 UNHCR Standing Committee Paper, EC/57/SC/CRP.17 (June 2006).

4 UNHCR, "Biennial Programme Budget 2008-2009 of the Office of the United Nations High Commissioner for Refugees." A/AC.96/1040, 12 September 2007, Fifty-eighth session.

with these other key documents and with sister UN agencies (Box 2). Unless otherwise specified, the term "malnutrition" refers to the various forms of malnutrition typically present in low-income settings (i.e. wasting, nutritional oedema, underweight, stunting, and micronutrient deficiencies). The concurrent and indeed interrelated problems of undernutrition and overweight in the same population, should not be overlooked and strategies to address this phenomenon continue to gain importance.

BOX 1: Nutrition and Food Security in UNHCR's Global Strategic Objectives

Global Strategic Objective 3 - Realizing the social and economic well-being of persons of concern, with priority given to:

3.1. Reducing malnutrition, and major risks to the health of populations of concern, notably malaria, HIV/AIDS and inadequate reproductive health services.

Performance Targets:

3.1.1. The percentage of stable refugee operations receiving food aid, in collaboration with WFP, and recording reduced acute malnutrition prevalence of < 5% (z-score) is increased.

Global Strategic Objective 4 - Responding to emergencies in a timely and effective manner, with priority given to:

4.2. Meeting the needs of women, children and groups with specific needs in emergency situations.

Performance Targets:

4.2.2. Emergency protection and assistance interventions in the first three months of an emergency increasingly respond to age, gender and diversity considerations including specific interventions for women, children and groups with special needs.

BOX 2: Key Terms

Malnutrition: The term "malnutrition" will be used broadly in this Strategic Plan to encompass nutritional imbalances. Most commonly it includes "the various forms of malnutrition: notably global acute malnutrition (GAM), i.e. wasting plus nutritional oedema, expressed in Z-scores; chronic malnutrition (stunting); and micronutrient deficiencies (hidden hunger) that are the focus of the UNHCR Nutrition paper (2006). However, it also includes forms of overnutrition such as excess caloric or micronutrient consumption, which are a public health problem in selected refugee settings.

Food Security: The term "food security" in this paper is, adapted, somewhat from the World Food Summit (1996) and will be defined as follows: when all people at all times have sustainable physical and economic access to sufficient, safe and nutritious food, to meet their dietary needs and food preferences, for a healthy and productive life.

An interim assessment of all indicators and targets in this plan will be undertaken after the end of 2009.

GOALS AND OBJECTIVES

OVERALL NUTRITION AND FOOD SECURITY FOR 2008-12:

To support and promote nutrition and food security policies and programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

Nutrition and Food Security Strategic Objectives for UNHCR:

1. **Protection:** To protect the right of UNHCR's PoCs to sufficient food which relies upon access to adequate nutrition and food security.

2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate nutrition and food security policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Prevention:** To prevent malnutrition and food insecurity by supporting implementation of and scaling up effective preventative interventions to UNHCR's PoCs with an emphasis on community participation, especially among women, children and people with special needs.

4. **Care, Support and Treatment:** To ensure that PoCs have access to timely, quality and effective supportive and curative nutrition services.

5. **Durable Solutions:** To develop and incorporate nutrition and food security strategies and interventions into policies and programmes for durable solutions.

6. **Capacity Building:** To build and strengthen specific nutrition and food security knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

7. **Assessments, Surveillance, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on PoCs' nutrition and food security status to inform programme planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches and technologies in nutrition and food security.

STRATEGIES AND INDICATORS OF ACHIEVEMENT

UNHCR will monitor its progress against these strategic objectives over the 2008-2012 period through a rigorous monitoring and evaluation system at global, regional and country levels. The data will be aggregated and reported regularly at the global level. The following core set of **41 indicators** will be tracked as a measure of progress against the strategic objectives. For each of these indicators many others could be suggested, particularly programme performance monitoring indicators, which are not detailed here but many of which will be collected and used at country level. Realisation of these strategic objectives will require a certain level of accountability at various levels of management. This accountability will be most important at the country and field levels through the processes of the programme planning cycle and ongoing reporting.

Table 1 summarises the strategies and indicators of achievement. It provides explicit definitions for and essential information on how the indicators will be measured at the global, regional and country operational levels.

Table 2 provides summaries of how the indicators of achievement will be reported. This includes information on targets, periodicity, applicable strategic objectives, and sources of measurement.

UNHCR will obtain data on nutrition and food security from the following main sources:

1. Joint Assessment Missions (JAMs) conducted with WFP.
2. UNHCR's Health Information System (HIS)
3. UNHCR's Standards and Indicators (S&I)
4. UNHCR's Global Strategic Objectives (GSOs)
5. Population-based surveys conducted by UNHCR in coordination with other agencies.
6. The United Nations Standing Committee on Nutrition/Nutrition Information in Crisis Situations database supported in part by UNHCR.
7. UNHCR's Financial Systems using Management Systems Renewal Project (MSRP)

Table 1. Key Strategies and Indicators of Achievement

STRATEGIC OBJECTIVE 1: PROTECTION	To protect the right of UNHCR's PoCs to sufficient food which relies upon access to adequate nutrition and food security.
Key Strategies	**Indicators of Achievement**
(1.1) Policies, guidelines and programmes to improve nutrition (including micronutrients), infant and young child feeding and food security.	**(1.1.1)** Prevalence of global acute malnutrition (GAM) for children 6-59 months of age. **(1.1.2)** Prevalence of severe acute malnutrition (SAM) for children 6-59 months of age.
(1.2) Ensure provision of a general ration where required, which is sufficient in terms of quantity, quality, regularity and equity.	**(1.2.1)** Amount of food distributed through general food ration, as % of planned amount, as measured by: kilocalories, fat/energy percentage, protein/energy percentage, and selected micronutrients.
(1.3) Support to food security through strategies to enhance self reliance.	**(1.3.1)** % operations where projects are being implemented with a specific focus on reducing food insecurity in the population.[5]
(1.4) Provide essential non food items where required.	**(1.4.1)** Amount of non-food items distributed as a % of planned amount.[6]
Indicators **1.5.1** and **1.5.2** from HIV Strategic Plan apply.	

5 Examples of such programs include advocacy to establish policy frameworks to expand access to capital, land and markets and freedom of mobility; provision of inputs, tools or other production support; support to income generating activities; and microcredit programmes.

6 Essential non food items frequently include firewood, shelter materials, clothes, and essential cooking and household items. For example soap is 250grams/per person/per month, firewood: 1kg per person varying according to wood availability cooking pot: 4 units per family depending on the quality of pots , types of stoves and food.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 2: COORDINATION AND INTEGRATION	To effectively coordinate, advocate for and integrate nutrition and food security policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
Key Strategies	**Indicators of Achievement**
(2.1) Expand and strengthen partnership with World Food Programme.	**(2.1.1)** % operations concerned with joint projects with WFP that have an updated Joint Plan of Action to address malnutrition including joint appeals.
(2.2) Ensure that nutrition and food security policies and programmes for IDPs are coordinated and integrated within humanitarian reform process.	**(2.2.1)** % of HCR country offices that are consistently participating in nutrition cluster meetings among those countries that have been "clusterized".[7]
(2.3) Advocate to ensure integration of refugees and other PoCs into national and regional programmes and systems.	**(2.3.1)** % countries with ≥10,000 refugees that have been explicitly included in national plans of action on nutrition and/or food security among those countries that will update their plans between 2008–2012.
(2.4) Strengthen HCR nutrition/food security coordination capacity and supervision with relevant stakeholders (e.g. host country authorities, IPs and OPs, and refugee representatives).	**(2.4.1)** Number of HCR Public Health and/or Nutrition/Food Security Coordinators. **(2.4.2)** Number of nutrition/food security coordination meetings held per year. **(2.4.3)** Number of public health coordination meetings with integrated nutrition and food security component held per year.
(2.5) Ensure sufficient resources provided to supporting HCR's nutrition and food security activities.	**(2.5.1)** Amount of resources spent by HCR for nutrition and food security activities (USD/person/yr).
(2.6) Ensure that PoCs are included into participatory assessments and age, gender and diversity analysis as part of HCR's operations management cycle.	**(2.6.1)** % of countries that have conducted participatory assessments as part of the operations management cycle.

7 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, protection, camp coordination and camp management, education, shelter, health and water and sanitation.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 3: PREVENTION	To prevent malnutrition and food insecurity by supporting implementation of and scaling up effective preventative interventions to UNHCR's PoCs with an emphasis on community participation, especially among women, children and people with special needs.
Key Strategies	**Indicators of Achievement**
(3.1) Advocate for provision of general food ration and supplementary feeding, when required, that is sufficient in terms of quantity, quality, regularity and equity.	**(3.1.1)** Prevalence of stunting for children 6-23 months of age. **(3.1.2)** % of newborns born with <2500g of weight. **(3.1.3)** % of pregnant and lactating women provided supplementary feeding. See also **1.1.1, 1.1.2** and **1.2.1**.
(3.2) Ensure provision of micronutrients, when required, through provision of fortified foods or micronutrient supplements.	**(3.2.1)** Amount of fortified blended foods distributed as part of general food ration, as a % of planned amount. **(3.2.2)** Coverage rate of vitamin A supplementation for children 6-59 months of age. **(3.2.3)** Coverage rate of vitamin A supplementation for lactating women. **(3.2.4)** Prevalence of anaemia in children 6-59 months of age. **(3.2.5)** Prevalence of anaemia in women 15-49 years of age. See also **1.3.1, 3.1.3**.
(3.3) Establish infant and young child feeding (IYCF) policies and programmes.	**(3.3.1)** % operations reporting compliance with HCR's policy on the acceptance and distribution of milk products. **(3.3.2)** % of infants (0-<6 months of age) exclusively breastfed for the first six months of life. **(3.3.3)** % of non-breastfed infants with access to necessary quantity of breast milk substitute, resources and follow-up.
Indicator **1.3.1** from WatSan Strategic Plan also applies. Indicators **1.2.1, 1.2.2, 3.4.1** and **3.4.2** from Malaria Strategic Plan also apply. Indicators **3.1.1** and **3.8.1** from HIV Strategic Plan also apply.	

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 4: CARE, SUPPORT AND TREATMENT	To ensure that PoCs have access to timely, quality and effective supportive and curative nutrition services.
Key Strategies	**Indicators of Achievement**
(4.1) Improve management of moderate acute malnutrition in supplementary feeding programmes (SFPs).	**(4.1.1)** % of SFPs that meet SPHERE standards for performance: recovery >75%, case fatality <3%, defaulter rate <15%, and coverage >50% for rural areas, >70% for urban areas and >90% for camps. **(4.1.2)** % of SFPs that adhere to standard treatment protocols. See also **1.1.1**.
(4.2) Improve management of severe acute malnutrition in 'therapeutic care' (facility and community-based).	**(4.2.1)** % operations where community-based management SAM is being implemented where HCR determined it is appropriate and necessary. **(4.2.2)** % of programmes for management of SAM that meet SPHERE standards for performance: recovery >75%, case fatality <10%, defaulter rate <15%, and coverage >50% for rural areas, >70% for urban areas and >90% for camps regardless of whether facility-based or community-based. **(4.2.3)** % of therapeutic feeding programmes (TFPs) that adhere to standard treatment protocols. See also **1.1.2**.
Indicator **4.1.1** from Malaria Strategic Plan also applies.	

STRATEGIC OBJECTIVE 5: DURABLE SOLUTIONS	To develop and incorporate nutrition and food security strategies and interventions into policies and programmes for durable solutions.
Key Strategies	**Indicators of Achievement**
(5.1) Advocate for and establish local integration and repatriation policies and programmes that include appropriate food and food security support.	**(5.1.1)** % of operations where refugees are provided with appropriate returnee food package. **(5.1.2)** % of operations where nutrition and food security have been designed and integrated in exit strategies (integration areas or areas of return).
(5.2) Coordinate and share nutrition and food security information to governments, UN agencies and other humanitarian organisations during repatriation.	**(5.2.1)** % of countries undertaking major repatriation operations that collect and share nutrition and food security about refugees and other PoCs in areas of return with government and organisations involved in nutrition and food security policies and programmes.
Indicator **4.2.1** from HIV Strategic Plan also applies. Indicator **4.1.1** from WatSan Strategic Plan also applies. Indicator **3.1.1** from Malaria Strategic Plan also applies.	

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 6: CAPACITY BUILDING	To build and strengthen specific nutrition and food security knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
Key Strategies	**Indicators of Achievement**
(6.1) Train HCR and partner health staff on nutrition and food security.	**(6.1.1)** Number and % of HCR and partner staff trained on new nutrition and food security issues. See also **1.3.1, 2.1.1, 2.2.1, 2.4.2, 2.4.3**.
(6.2) Provide nutrition and food security focused community education programmes to refugees and other PoCs.	**(6.2.1)** % of countries reporting nutrition and food security trainings for HCR's PoCs See also **1.3.1, 2.6.1**.

STRATEGIC OBJECTIVE 7: ASSESSMENTS, SURVEILLANCE, MONITORING AND EVALUATION, OPERATIONAL RESEARCH	To regularly monitor and report on PoCs' nutrition and food security to inform programmatic planning and implementation in a timely manner; To evaluate programme performance and achievements using a results-based management approach; and To develop and carry out operational research on new approaches and technologies.
Key Strategies	**Indicators of Achievement**
(7.1) Collect, analyse and respond to essential nutrition and food security data (facility and population –based) on a routine basis using standard case definitions.	**(7.1.1)** % refugee operations with functioning HIS, including nutrition component, as defined by monthly reporting to HCR. **(7.1.2)** % refugee operations where population-based nutrition survey undertaken (minimum on annual basis). **(7.1.3)** % of stable refugee situations where growth monitoring programmes are being implemented – by camp and country.
(7.2) Monitor distribution, acceptability, milling, consumption and sale of food rations.	**(7.2.1)** % operations where monthly food basket monitoring is being implemented. **(7.2.2)** % operations where monthly post-distribution monitoring (i.e. household/community level) is being implemented.
(7.3) Improve nutrition and food security programmes through Joint Assessment (and monitoring) Missions (JAMs) with WFP and other partners.	**(7.3.1)** Number of countries undertaking JAMs. See also **2.1.1**.
(7.4) Conduct operational research as indicated to guide programme implementation (e.g. micronutrients, anaemia) or to address identified programmatic problems.	**(7.4.1)** Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.

Table 2: Summary of Indicators of Achievement

INDICATORS OF ACHIEVEMENT	Target[8]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[9]
(1.1.1) Prevalence of global acute malnutrition (GAM) for children 6-59 months of age.	<5%	Every 6 mos for acute situations or Annually	1,3,4	Pop-based surveys	Camp
(1.1.2) Prevalence of severe acute malnutrition (SAM) for children 6-59 months of age.	<1%	Every 6 mos for acute situations or Annually	1,3,4	Pop-based surveys	Camp
(1.2.1) Amount of food distributed through general food ration, as % of planned amount, as measured by: kilocalories, fat/energy percentage, protein/energy percentage, and selected micronutrients.	>80%	Monthly, Annually	1,3	Country Offices (HCR and WFP)	Camp
(1.3.1) % operations where projects are being implemented with a specific focus on reducing food insecurity in the population.[10]	>75%	Annually	1,3,6	Country Offices	Camp Non-camp
(1.4.1) Amount of non-food items distributed as a % of planned amount.[11]	100%	Monthly, Annually	1	Country Offices	Camp
(2.1.1) % operations concerned with joint activities with WFP that have an updated Joint Plan of Action to address malnutrition.	100%	Annually	2,6,7	Country Offices (HCR and WFP) HQ	Camp
(2.2.1) % of HCR country offices that are consistently participating in nutrition cluster meetings among those countries that have been "clusterized". [12]	>75%	Annually	2,6	Country Offices	Camp Non-camp
(2.3.1) % countries with ≥10,000 refugees that have been explicitly included in national plans of action on nutrition and/or food security among those countries that will update their plans between 2008–2012.	>75%	Biannually	2	National Plans of Action	Camp Non-camp
(2.4.1) Number of HCR Public Health and Nutrition/ Food Security coordinators.	Variable	Annually	2	Country Offices Regional Offices HQ	Camp Non-camp
(2.4.2) Number of nutrition/food security coordination meetings held per year.	100%	Annually	2,6	Country Offices Regional Offices HQ	Camp Non-camp
(2.4.3) Number of public health coordination meetings with integrated nutrition and food security component held per year.	100%	Annually	2,6	Country Offices Regional Offices HQ	Camp Non-camp

8 Target refers to the level that UNHCR intends to achieve by the end of 2012. It is based on the current situation and what HCR believes it is feasible to attain.

9 Refers to setting where indicator will ***primarily*** be measured. However, this may vary according to context. All population-based surveys could be undertaken in camp or non-camp settings; however, at this point they are primarily done in camp settings. This may change over time.

10 Examples of such programs include advocacy to establish policy frameworks to expand access to capital, land and markets and freedom of mobility; provision of inputs, tools or other production support; support to income generating activities; and microcredit programmes.

11 Essential non food items frequently include firewood, shelter materials, clothes, and essential cooking and household items. For example soap is 250grams/per person/per month, firewood: 1kg per person varying according to wood availability cooking pot: 4 units per family depending on the quality of pots , types of stoves and food.

12 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, education, shelter, telecommunications, food aid, health and sanitation.

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[8]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[9]
(2.5.1) Amount of resources spent by HCR for nutrition and food security activities (USD/person/yr).	Variable	Annually	2	MSRP	Camp Non-camp
(2.6.1) % of countries that have conducted participatory assessments as part of the operations management cycle.	>75%	Annually	2,6	Country Offices	Camp Non-camp
(3.1.1) Prevalence of stunting for children 6-23 months of age.	<20%	Annually	1,3	Pop-based surveys	Camp
(3.1.2) % of newborns born with less than 2500g of weight.	<15%	Monthly, Annually	1,3	HIS	Camp
(3.1.3) % of pregnant and lactating women provided supplementary feeding.	100%	Monthly, Annually	1,3	HIS	Camp
(3.2.1) Amount of fortified blended foods distributed as part of general food ration, as a % of planned amount.	100%	Monthly, Annually	1,3	Country Offices (HCR and WFP)	Camp
(3.2.2) Coverage rate of vitamin A supplementation for children 6-59 months of age.	>90%	Annually	1,3	Pop-based surveys	Camp
(3.2.3) Coverage rate of vitamin A supplementation for lactating women.	>90%	Monthly, Annually	1,3	HIS	Camp
(3.2.4) Prevalence of anaemia in children 6-59 months of age.	<20%	Annually	1,3	Pop-based surveys	Camp
(3.2.5) Prevalence of anaemia in women 15-49 years of age.	<20%	Annually	1,3	Pop-based surveys	Camp
(3.3.1) % operations reporting compliance with HCR's policy on the acceptance and distribution of milk products.	100%	Annually	3	Country Offices JAMs	Camp Non-camp
(3.3.2) % of infants (0-<6 months of age) exclusively breastfed for the first six months of life.	>80%	Annually	3	Country Offices	Camp
(3.3.3) % of non-breastfed infants with access to necessary quantity of breast milk substitute, resources and follow-up.	100%	Annually	3	Country Offices	Camp
(4.1.1) % of SFPs that meet SPHERE standards for performance: recovery >75%, case fatality <3%, defaulter rate <15%, and coverage >50% for rural areas, >70% for urban areas and >90% for camps.	>90%	Monthly, Annually	1,4	HIS	Camp
(4.1.2) % of SFPs that adhere to standard treatment protocols.	100%	Annually	1,4	JAMs Country Offices	Camp
(4.2.1) % operations where community-based management SAM is being implemented where HCR determined it is appropriate and necessary.	100%	Annually	1,4	JAMs Country Offices HIS	Camp

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[8]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[9]
(4.2.2) % of programmes for management of SAM that meet SPHERE standards for performance and adhere to standard treatment protocols: recovery >75%, case fatality <10%, defaulter rate <15%, and coverage >50% for rural areas, >70% for urban areas and >90% for camps regardless of whether facility-based or community-based.	>90%	Monthly, Annually	1,4	HIS	Camp
(4.2.3) % of TFPs that adhere to standard treatment protocols.	100%	Annually	1,4	JAMs Country Offices	Camp Non-camp
(5.1.1) % of operations where refugees are provided with appropriate returnee food package.	100%	Annually	5	Country Offices	Camp Non-camp
(5.1.2) % of operations where nutrition and food security have been designed and integrated in exit strategies (integration areas or areas of return).	100%	Annually	5	Country Offices	Camp Non-camp
(5.2.1) % of countries undertaking major repatriation operations that collect and share nutrition and food security about refugees and other PoCs in areas of return with government and organisations involved in nutrition and food security programmes.	100%	Annually	2,5	Country Offices	Camp Non-camp
(6.1.1) Number and % of HCR and partner staff trained on new nutrition and food security issues.	>75%	Annually	1,2,6	Country Offices	Camp
(6.2.1) % of countries reporting nutrition and food security trainings for HCR's PoCs.	>75%	Annually	1,2,6	Country Offices	Camp
(7.1.1) % refugee operations with functioning HIS, including nutrition component, as defined by monthly reporting to HCR.	100%	Monthly, Annually	7	HIS	Primarily camp with emphasis to include non camp
(7.1.2) % refugee operations where population-based nutrition survey undertaken (minimum on annual basis).	100%	Annually	7	Pop-based surveys	Camp
(7.1.3) % of stable refugee situations where growth monitoring programmes are being implemented.	100%	Monthly, Annually	7	HIS	Camp Non-camp
(7.2.1) % operations where monthly food basket monitoring is being implemented.	>80%	Monthly, Annually	7	Food basket monitoring	Camp
(7.2.2) % operations where monthly post-distribution monitoring (i.e., household/community level) is being implemented.	>75%	Monthly, Annually	7	Post distribution monitoring	Camp
(7.3.1) Number of countries undertaking JAMs.	>75%	Annually	2,7	JAMs	Camp
(7.4.1) Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.	Variable	Annually	7	Country Offices Regional Offices HQ	Camp Non-camp

Notes

Notes

UNHCR
The UN Refugee Agency

UNHCR's Strategic Plan for Reproductive Health

2008 - 2012

UNHCR
The UN Refugee Agency

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
APR	Annual Protection Reports
COPs	Country Operation Plans
EmONC	Emergency Obstetric and Neonatal Care
FGM	Female Genital Mutilation
GBV	Gender Based Violence
HIS	Health Information System
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group on Reproductive Health in Crisis
IDP	Internally Displaced Person
IP	Implementing Partner
MISP	Minimum Initial Service Package
MSRP	Management Systems Renewal Project
NGO	Non-Governmental Organization
OP	Operational Partner
PEP	Post-Exposure Prophylaxis
PoCs	Persons of Concern
S&I	Standards and Indicators
UBW	Unified Budget and Workplan for UNAIDS
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Funds
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organisation

EXECUTIVE SUMMARY

The United Nations High Commissioner for Refugees' (UNHCR) Reproductive Health Strategic Plan for 2008-12 outlines the vision, strategic objectives, and main strategies of UNHCR as well as indicators to measure their implementation. It aims to fully integrate reproductive health into UNHCR's overall mandate of protection of refugees and other persons of concern (PoCs), and to meet internal and international standards in UNHCR's reproductive health-related policies and programmes. The Strategic Plan supports the existing initiatives such as the Millennium Development Goals, the United Nations (UN) humanitarian reform process, and the Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) decisions.

This Strategic Plan was developed in coordination with those of other sectors in the Public Health and HIV Section in the Division of Operational Services at UNHCR as well as with other groups in and outside of UNHCR including other UN agencies, Non-Governmental Organisations (NGOs) and academic institutions. This approach will help to ensure a comprehensive and integrated approach across sectors. The Strategic Plan aims to guide operations in camp, urban and other non-camp settings according to all stages of an emergency, as well as for local integration and returnee situations, during the period of 2008-2012 (see also 2008-12 Guiding Principles).

The first action plan targets PoCs in camps and urban settings as well as major repatriation operations for progressive achievements of the objectives over the period 2008-2012. New emergencies will be supported and monitored using the Minimum Initial Package of Services (MISP). However, each operation should aim to significantly improve reproductive health deliverables and in particular safe-motherhood interventions within the coming 5 years.

OVERALL STRATEGIC OBJECTIVE:

To support and promote reproductive health policies and programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, Internally Displaced Persons (IDPs), returnees and other PoCs to UNHCR.

REPRODUCTIVE HEALTH STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection:** To protect the reproductive health rights of UNHCR's PoCs while respecting their dignity and physical and mental integrity, with special attention to vulnerable groups.

2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate reproductive health policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Access to Early Diagnosis, Prompt and Effective Prevention and Treatment:** To ensure that PoCs have access to timely, quality, culturally adapted and effective preventive and curative services delivered by trained personnel working in a professional and respectful manner, with the necessary material and equipment in in structures that respect the need for privacy and security.

4. **Durable Solutions:** To develop and incorporate reproductive health strategies and interventions into policies and programmes for durable solutions.

5. **Capacity Building and Training:** To build and strengthen specific reproductive health knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

6. **Assessment, Surveillance, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on the reproductive health status of PoCs to inform programmatic planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches in reproductive health.

INTRODUCTION

Reproductive health is a right as well as a psychological and health need. It is defined by the World Health Organisation (WHO) as "a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes."

The International Conference on Population and Development which took place in Cairo, Egypt in 1994, first defined in its plan of action for reproductive health care services and strategies to ensure that people :

- Have the capability to reproduce and the freedom to decide if, when and how often to do so.
- Have the ability to control their sexual and reproductive health behaviour in agreement with social and personal ethics, resulting in a satisfying and safe sex life, free of feelings such as fear, shame, guilt or prejudice.
- Be free from organic injuries, mutilations, and diseases, which disturb their sexual and reproductive functions.

"Reproductive Health is not just a major health issue; it is a development issue, a human rights issue."[1] Determinants of sexual and reproductive health and well-being include health services but also behaviour, socio-economical conditions and living conditions and standards. Reproductive health differs from other health issues because it affects major societal, religious and cultural structures and systems. In fact many sexual and reproductive health and legal systems have been designed and set-up much more on the basis of beliefs, values and taboos than on medical needs and individual rights. Successful programmes increase people's knowledge and enhance healthy behaviours in good harmony and respect of community values.

Reproductive health needs continue and are generally exacerbated during crisis. For example, malnutrition, stress and epidemics increases the risk of of reproductive health complications. Childbirth can occur on the wayside during population movement, risk of gender and sexual violence increases due to social instability, and harmful traditional practices such as genital mutilation continue to be perpetrated.

Though the situation has improved greatly over the past few years, numerous reproductive health gaps for UNHCR's PoCs still exist, particularly during crisis and conflicts:

- Delayed implementation of the Minimum Initial Service Package (MISP)[2] at onset of emergencies.
- Inadequate capacity of health facilities to address basic reproductive health services including emergency obstetric care.

1 Reproductive Health and Human rights, R.J. Cook, B.M. Dickens, M.F, Fathalla, 2003

2 MISP represents the minimum standard of services in UNHCR operations. It is implemented during the early phase of emergency situations and during repatriation. It is a package of priority interventions with high impact on mortality and morbidity. The MISP is a set of activities (not a kit of supplies and equipment), specially designed for the initial stage of a crisis. Documented evidence of its efficiency justifies its use without prior needs assessment. Comprehensive services should be provided as soon as the situation stabilizes.

- Access difficulties to friendly, confidential, quality, comprehensive services.
- Limited capacities of women and adolescents to take control over key moments and events of their sexual and reproductive life.[3]

In order to provide adequate protection and assistance to women and girls and men and boys, UNHCR commits to support all components of reproductive health, prioritizing high impact interventions that affect mortality and morbidity at the onset of a crisis, while moving rapidly to more comprehensive services to cover the needs and rights of women and girls and men and boys.

The foundation of UNHCR's Reproductive Health Strategic Plan for 2008-2012 is supported by the following documents and policy statements:

- Inter Agency Standing Committee (IASC), Guidelines for Gender-based Violence Interventions in humanitarian settings, 2005.
- International Conference on Population and Development Programme of Action, Cairo, Egypt in 1994 and follow-up conferences of Beijing and Geneva.
- Report of the Inter-Agency Global Evaluation, Reproductive Health Services for Refugees and Internally Displaced Persons, 2004.
- R.J. Cook, B.M. Dickens, M.F, Fathalla. Reproductive Health and Human rights, 2003.
- UNHCR Executive Committee A/AC.96/1032, 1996.
- UNHCR/WHO, Clinical Management of Rape Survivors, 2005.
- UNHCR, High Commissioner's Special Project related to public health priority areas (2007 and 2008).
- Women's Commission, Emergency Obstetric Care in Humanitarian Programs, 2005.
- WHO/UNHCR/UNFPA, Reproductive Health in Refugee Situations, an Inter-Agency Field Manual, 1999 and corrigendum 2007.
- WHO, Managing Complications in Pregnancy and Childbirth: a guide for midwives and doctors, 2007.
- WHO, Reproductive Health during conflict and displacement, a guide for programme managers, 2000.

3 Reproductive Health Services for Refugees and Internally Displaced Persons, report of the Inter-Agency Global Evaluation 2004

BOX 1: Reproductive health in UNHCR's Global Strategic Objectives

Reproductive Health is also highlighted in UNHCR's Global Strategic Objectives[4]

Global Strategic Objective 3 - Realizing the social and economic well-being of person of concern, with priority given to:

3.1. Reducing malnutrition, and major risks to the health of populations of concern, notably malaria, HIV/AIDS and inadequate reproductive health services.

Performance Targets:

3.1.6. The percentage of live births attended by midwife, nurse or doctor (excluding Traditional Birth Attendants) is increased.

Global Strategic Objective 4 - Responding to emergencies in a timely and effective manner, with priority given to:

4.2. Meeting the needs of women, children and groups with specific needs in emergency situations.

Performance Targets:

4.2.2. Emergency protection and assistance interventions in the first three months of an emergency increasingly respond to age, gender and diversity considerations including specific interventions for women, children and groups with special needs.

An interim assessment of all indicators and targets in this plan will be undertaken after 2009.

4 UNHCR Global Appeal 2007 *UNHCR's global strategic objectives*

GOALS AND OBJECTIVES

OVERALL REPRODUCTIVE HEALTH GOAL FOR 2008-12:

To support and promote reproductive health policies and programmes in order to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

REPRODUCTIVE HEALTH STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection:** To protect the reproductive health rights of UNHCR's PoCs while respecting their dignity and physical and mental integrity, with special attention to vulnerable groups.
2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate reproductive health policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
3. **Access to Early Diagnosis, Prompt and Effective Prevention and Treatment:** To ensure that PoCs have access to timely, quality, culturally adapted and effective preventive and curative services delivered by trained personnel working in a professional and respectful manner, with the necessary material and equipment in structures that respect the need for privacy and security.
4. **Durable Solutions:** To develop and incorporate reproductive health strategies and interventions into policies and programmes for durable solutions.
5. **Capacity Building and Training:** To build and strengthen specific reproductive health knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
6. **Assessment, Surveillance, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on the reproductive health status of PoCs to inform programmatic planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches in reproductive health.

STRATEGIES AND INDICATORS OF ACHIEVEMENT

UNHCR will monitor its progress against these strategic objectives over the 2008-2012 period through a rigorous monitoring and evaluation system at global, regional and country levels. The data will be aggregated and reported regularly at the global level. The following core set of **50 indicators** will be tracked as a measure of progress against the strategic objectives. For each of these indicators, many others could be suggested, particularly programme performance monitoring indicators, which are not detailed here but many of which will be collected and used at country level. Realisation of these strategic objectives will require a certain level of accountability at various levels of management. This accountability will be most important at the country and field level, through the processes of the programme planning cycle and ongoing reporting.

Table 1 summarises the strategies and indicators of achievement. It provides explicit definitions for and essential information on how the indicators will be measured at the global, regional and country operational levels.

Table 2 provides summaries of how the indicators of achievement will be reported. This includes information on targets, periodicity, applicable strategic objectives, and sources of measurement.

UNHCR will obtain data on reproductive health from the following main sources:

1. UNHCR's Health Information System (HIS).
2. UNHCR's HIV Information System (HIVIS).
3. UNHCR's Standards and Indicators (S&I).
4. UNHCR's Global Strategic Objectives.
5. Population-based surveys conducted by national authorities, UNHCR and other humanitarian agencies in coordination with Implementing or Operational Partners.
6. Joint Assessment Missions conducted with other UN agencies and Non-Governmental Organizations (NGOs).
7. UNHCR's Financial Systems using Management Systems Renewal Project (MSRP).

Table 1. Key Strategies and Indicators of Achievement

STRATEGIC OBJECTIVE 1: PROTECTION	To protect the reproductive health rights of UNHCR's PoCs while respecting their dignity and physical and mental integrity, with special attention to vulnerable groups.
Key Strategies	**Indicators of Achievement**
(1.1) Ensure implementation of life-saving MISP strategies from onset of an emergency.	**(1.1.1)** % of children dying under 28 days of age (neonatal). **(1.1.2)** % of HCR operations where clean delivery kits are available for women obviously pregnant, in the absence or difficult access to quality institutional deliveries. **(1.1.3)** Number of reported cases of Gender-Based Violence (GBV), segregated per type, age and sex.
(1.2) Establish policies, guidelines and programmes to prevent and respond to gender-based violence.	**(1.2.1)** % of operations supporting health clinics with treatment and case management protocols for rape survivors in place. See also **(1.1.3)**.
(1.3) Establish policies, guidelines and programmes to protect women's body integrity and reduce harmful practices.	**(1.3.1)** % of operations where female genital mutilation (FGM) is practiced, where reduction strategies are adopted. **(1.3.2)** % of operations with obstetric fistula detection and referral programmes. See also **(1.1.2)** and **(1.2.1)**.
(1.4) Ensure that every pregnant women, new mother and newborn child is cared for by a skilled health professional in a continuum of services.	**(1.4.1)** % of all birth that take place in Emergency Obstetric and Neonatal Care (EmONC) facilities. **(1.4.2)** % of women who had at least 4 antenatal care (ANC) visits to a health professional with midwifery skills by time of delivery. **(1.4.3)** % of mothers having 3 postnatal visits within 6 weeks after birth. See also **(1.1.1)**.
(1.5) Establish programmes protecting the girls and contributing to reduce the number of teenage mothers.	**(1.5.1)** % of women who delivered before age of 18 years (teenage pregnancies).
Indicator **1.2.1** from Nutrition/Food Security Strategic Plan also applies. Indicators **1.4.1**, **1.5.1** and **1.5.2** from HIV Strategic Plan also apply.	

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 2: COORDINATION AND INTEGRATION	To effectively coordinate, advocate for and integrate reproductive health policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
Key Strategies	**Indicators of Achievement**
(2.1) Ensure that reproductive health policies and programmes for IDPs are coordinated and integrated within humanitarian reform process.	**(2.1.1)** % of HCR country offices that are consistently participating in health cluster meetings among those countries that have been "clusterized".[5]
(2.2) Establish mechanisms to ensure that policies and programmes are coordinated and integrated with best practices and standards implemented.	**(2.2.1)** % of HCR operations systematically investigating every maternal death. **(2.2.2)** Proportion of operation involving men in reproductive health activities, including family planning.
(2.3) Strengthen HCR health coordination capacity and supervision with relevant stakeholders (e.g. host country authorities, IPs and OPs, and refugee representatives).	**(2.3.1)** Number of HCR Public Health Coordinators. **(2.3.2)** Number of health coordination meetings held per year.
(2.4) Actively participate in international and regional reproductive health fora.	**(2.4.1)** % of HCR attendance at the Inter Agency Working Group (IAWG) on Reproductive Health in Crisis meetings.
(2.5) Ensure sufficient resources provided to supporting HCR's reproductive health activities.	**(2.5.1)** Reproductive health services mainstreamed in all country operation plans (COPs). **(2.5.2)** Amount of resources spent by HCR for reproductive health (USD/person/yr).
(2.6) Ensure that PoCs are included into participatory assessments and age, gender and diversity analysis as part of HCR's operations management cycle.	**(2.6.1)** % of countries that have conducted participatory assessments as part of the operations management cycle. See also **(2.2.2)**.

5 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, protection, camp coordination and camp management, education, shelter, health and water and sanitation.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 3 **ACCESS TO EARLY DIAGNOSIS, PROMPT AND EFFECTIVE PREVENTION AND TREATMENT**	To ensure that PoCs have access to timely, quality, culturally adapted and effective preventive and curative services delivered by trained personnel working in a professional and respectful manner, with the necessary material and equipment in structures that respect the need for privacy and security.
Key Strategies	**Indicators of Achievement**
(3.1) Ensure access to appropriate maternal and newborn health preventive services.	**(3.1.1)** % of pregnant women screened for syphilis during the antenatal period. **(3.1.2)** % of antenatal care mothers that tested positive for syphilis. **(3.1.3)** % countries, when indicated, where pregnant women and the infant received antiretroviral medication to reduce the risk of mother to child transmission of HIV. **(3.1.4)** % of pregnant women presenting at ANC who receive at least 2 doses of Intermittent Preventive Treatment for malaria in pregnancy, when appropriate. **(3.1.5)** % stillbirths. See also **(1.1.1), (1.1.2), (1.3.1), (1.4.1), (1.4.2), (1.4.3), (1.5.1)**.
(3.2) Improve women delivery and child birth services with emphasis on EmONC.	**(3.2.1)** % of all birth through Caesarean section. **(3.2.3)** % of camps with access to EmONC, 24 hours per day, 7 days per week. **(3.2.3)** % of newborns born with less than 2500g of weight. **(3.2.4)** % of infants (0-<6 months of age) exclusively breastfed for the first six months of life. See also **(1.1.1), (1.3.2), (1.4.1), (3.1.5)**.
(3.3) Establish effective and supportive family planning programmes.	**(3.3.1)** % of women who use (or whose partner uses) a modern family planning method. See also **(1.5.1), (2.2.2)**.
(3.4) Reduce sexually transmitted infections (STIs) and HIV infections and increase access to STI management.	**(3.4.1)** Incidence of male urethral discharge by age. **(3.4.2)** Incidence of genital ulcer disease – by age and sex. **(3.4.3)** % of clients tested for syphilis with a positive result – by age and sex. **(3.4.4)** % of partners/contacts of STI patients that were notified and treated –by age and sex. **(3.4.5)** % of refugee operations where universal precautions are satisfactorily applied.[6] **(3.4.6)** % of refugee operations that provide blood transfusions which screen blood for HIV in a quality-assured manner. **(3.4.7)** % of refugee operations where sufficient number of male and female condoms are distributed.[7] **(3.4.8)** % of refugee operations where standard STI case management protocols are in place.
(3.5) Ensure appropriate care and treatment for all rape survivors.[8]	**(3.5.1)** % of countries reporting provision of emergency contraception to non pregnant rape survivors within 120 hours of rape. **(3.5.2)** % of countries reporting provision of PEP to survivors of rape within 72 hours of rape. **(3.5.3)** % of UNHCR operations enusring access and availability of emergency contraception See also **(1.1.3), (1.2.1)**.
Indicators **1.2.1** and **1.2.2** from Malaria Strategic Plan also apply. Indicator **3.1.3** and **3.2.5** from Nutrition/Food Security Strategic Plan also apply.	

6 Satisfactory universal precautions refers to a set of procedures to minimize the risk of infection and includes for this indicator a sufficient supply of stock of needles, syringes, and gloves defined as no stock out of >1 week at anytime during the past year

7 Sufficient number of male and female condoms = 0.5/per person/per month

8 Consistent with Reproductive Health in Refugee Situations, an Interagency Field Manual, 1999 and corrigendum 2007.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 4 **DURABLE SOLUTIONS**	To develop and incorporate reproductive health strategies and interventions into policies and programmes for durable solutions.
Key Strategies	**Indicators of Achievement**
(4.1) Advocate for and establish local integration and repatriation policies and programmes that include appropriate prevention and treatment interventions for reproductive health with an emphasis on MISP.	**(4.1.1)** % of operations where refugees are provided with appropriate returnee packages for reproductive health.[9] **(4.1.2)** % of operations where reproductive health plans have been designed and integrated with health plans in exit strategies (integration areas or areas of return). **(4.1.3)** % of programmes at point of return that offer EmONC services. See also **(1.1.2)**.
(4.2) Coordinate and share reproductive health information to governments, UN agencies and other humanitarian organisations during repatriation.	**(4.2.1)** % of countries undertaking major repatriation operations that collect and share reproductive health information about refugees and other PoCs in areas of return with government and organisations involved in reproductive health policies and programmes
Indicator **4.1.1** from Malaria Strategic Plan also applies.	

STRATEGIC OBJECTIVE 5: **CAPACITY BUILDING AND TRAINING**	To build and strengthen specific reproductive health knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
Key Strategies	**Indicators of Achievement**
(5.1) Improve reproductive and sexual health and rights knowledge and capacities among HCR and partners, at global, regional and country level.	**(5.1.1)** Number of reproductive health workshops and training events –by subject. See also **(1.2.1), (1.3.2), (2.1.1), (2.2.1), (2.3.2), (2.4.1), (2.6.1)**.
(5.2) Improve reproductive and sexual health and rights knowledge and capacities among HCR's PoCs.	**(5.2.1)** % of countries reporting reproductive health training for HCR's PoCs. See also **(1.4.2), (2.2.2), (2.6.1), (3.1.3), (4.1.1)**.

9 Defined here as sanitary towels and family planning materials.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 6 **ASSESSMENT, SURVEILLANCE, MONITORING AND EVALUATION AND OPERATIONAL RESEARCH**	To regularly monitor and report on the reproductive health status of PoCs to inform programmatic planning and implementation in a timely manner; To evaluate programme performance and achievements using a results-based management approach; and To develop and carry out operational research on new approaches in reproductive.
Key Strategies	**Indicators of Achievement**
(6.1) Conduct reproductive health situation assessments using a standardised checklist.	**(6.1.1)** % of reproductive health assessments undertaken during initial emergency phase based on standard checklist.
(6.2) Collect, analyse, and respond to reproductive health data on a routine basis using standard case definitions.	**(6.2.1)** % of refugee operation with functioning HIS, as defined by monthly reporting to HCR.
(6.3) Monitor and investigate all maternal deaths.	See indicator **(2.2.1)**.
(6.4) Evaluate reproductive health programmes on a routine basis.	**(6.4.1)** % of camps/programmes that have evaluated their coverage and quality of reproductive health services every 2 years in stable settings.
(6.5) Conduct operational research as indicated to guide programme implementation or to address identified programmatic problems.	**(6.5.1)** Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.

Table 2: Summary of Indicators of Achievement

INDICATORS OF ACHIEVEMENT	Target[9]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[10]
Minimum Initial Services Package						
(1.1.1) % of children dying under 28 days of age (neonatal).	<53/1000 SS Africa <36/1000 SE Asia	Monthly, Annually	1, 3	HIS		Camp
(1.1.2) % of HCR operations where clean delivery kits are available for women obviously pregnant, in the absence or difficult access to quality institutional deliveries.	100%	Annually	1, 3, 4	Country Offices		Camp Non-camp
(1.1.3) Number of reported cases of GBV, segregated per type, age and sex.	100%	Monthly, Annually	1, 3	Country Offices HIS APR		Camp Non-camp
(3.4.5) % of refugee operations where universal precautions are satisfactorily applied.[11]	100%	Annual	3	Country Offices HIVIS	UBW PO[12] 7	Camp
(3.4.6) % of refugee operations that provide blood transfusions which screen blood for HIV in a quality-assured.	100%	Monthly, Annually	3	HIVIS HIS	UNGASS[13] 3 UBW PO 7	Camp
(3.4.7) % of refugee operations where sufficient[14] number of male and female condoms are distributed.	>75%	Monthly, Annually	3	HIS	UNGASS 17, 18, 19, 20	Camp

9 Target refers to the level that UNHCR intends to achieve by the end of 2012. It is based on the current situation and what HCR believes it is feasible to attain.

10 Refers to setting where indicator will primarily be measured. However, this may vary according to context. All population-based surveys could be undertaken in camp or non-camp settings; however, at this point they are primarily done in camp settings. This may change over time.

11 Satisfactory universal precautions refers to a set of procedures to minimize the risk of infection and includes for this indicator a sufficient supply of stock of needles, syringes, and gloves defined as no stock out of >1 week at anytime during the past year

12 UBW PO = Principle Outcome of the Joint UNAIDS Budget and Workplan for 2008 and 2009

13 UNGASS = United Nations General Assembly Special Session on HIV/AIDS and provides international set of standard core indicators that measure the effectiveness of the national HIV response

14 Sufficient number of male and female condoms = 0.5/per person/per month

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[9]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[10]
Maternal and Newborn Health (+ MISP indicators)						
(1.4.2) % of women who had at least 4 antenatal care visits to a health professional with midwifery skills by time of delivery.	100%	Monthly, Annually	1, 3, 5	HIS		Camp
(3.1.1) % of pregnant women screened for syphilis during the antenatal period.	>90%	Monthly, Annually	1,3	HIS		Camp
(3.1.2) % of antenatal care mothers that tested positive for syphilis.	Variable	Monthly, Annually	1,3	HIS		Camp
(1.4.3) % of mothers having 3 postnatal consultations within 6 weeks after birth.	>75%	Monthly, Annually	1, 3	HIS		Camp
(3.1.3) % countries, when indicated, where pregnant women and the infant received antiretroviral medication to reduce the risk of mother to child transmission of HIV.	>90% in generalized epidemics	Monthly, Annually	1, 3, 5	HIVIS HIS	UNGASS 5 UBW PO 7	Camp
(3.1.4) % of pregnant women presenting at ANC who receive at least 2 doses of Intermittent Preventive Treatment in pregnancy for malaria, when appropriate.	>80%	Monthly, Annually	1,3	HIS		Camp
(3.1.5) % stillbirths.	20/1000 birth (max. 32/1000)	Monthly, Annually	1,3	HIS		Camp
(3.2.2) % of camps with access to EmONC, 24 hours per day, 7 days per week.	100%	Annually	1,3	Country Offices	UN process indicator 1	Camp
(1.4.1) % of all birth that take place in EmONC facilities.	Min 15%; 100% in protracted situations	Monthly, Annually	1, 3	HIS	UN process indicator 3	Camp
(4.1.3) % of programmes at point of return that offer EmONC services.	100%	Annually	1,4	Country Offices		Camp Non-camp
(3.2.1) % of all birth through Caesarean section.	5 %< CS < 15%	Monthly, Annually	1,3	HIS	UN process indicator 5	Camp
(3.2.3) % of newborns born with less than 2500g of weight.	<15%	Monthly, Annually	1,3	HIS		Camp
(3.2.4) % of infants (0-<6 months of age) exclusively breastfed for the first six months of life.	>80%	Annually	1,3	Country Offices		Camp
(1.3.2) % of operations with obstetric fistula detection and referral programmes.	Variable	Annually	1, 3, 5	Country Offices		Camp Non-camp
(2.2.1) % HCR operations systematically investigating every maternal death.	100%	Immediate reporting, Monhtly, Annually	2, 5, 6	HIS		Camp

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[9]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[10]
Family Planning						
(3.3.1) % of women who use (or whose partner uses) a modern family planning method.	Variable	Monthly, Annually	1,2,3	HIS		Camp
(1.5.1) % of women who delivered before age of 18 years (teenage pregnancies).	Variable	Monthly, Annually	1, 3	HIS		Camp
(2.2.2) % of operation involving men in reproductive health activities, including family planning.	100%	Annually	2, 3, 5	Country Offices		Camp Non-camp
(4.1.1) % of operations where refugees are provided with appropriate returnee packages for reproductive health (defined here as sanitary towels and family planning material).	Variable	Annually	1,4, 5	Country Offices		Camp Non-camp
Prevention and Management of Gender Based Violence (+ MISP indicators)						
(1.2.1) % of operations supporting health clinics with treatment and case management protocols for rape survivors in place.	100%	Annually	1, 3, 5	Country Offices		Camp Non-camp
(3.5.1) % of countries reporting provision of emergency contraception to non pregnant rape survivors within 120 hours of rape.	100%	Monthly, Annually	1,3	HIS		Camp
(3.5.2) % of countries reporting provision of PEP to survivors of rape within 72 hours of rape.	100%	Monthly, Annually	1,3	HIS		Camp
(3.5.3) % of HCR operation ensuring access and availability of emergency contraception.	100%	Annually	1,2,3	Country Offices		Camp Non-camp
(1.3.1) % of operations where FGM is practiced, where reduction strategies are adopted.	100%	Annually	1, 3	Country Offices		Camp Non-camp

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[9]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[10]
Prevention and Management of Sexually Transmitted Infections (+ MISP indicators)						
(3.4.1) Incidence of male urethral discharge by age.	Variable	Monthly, Annually	3	HIS		Camp
(3.4.2) Incidence of genital ulcer disease – by age and sex.	Variable	Monthly, Annually	3	HIS		Camp
(3.4.3) % of clients tested for syphilis with a positive result – by age and sex.	Variable	Monthly, Annually	3	HIS		Camp
(3.4.4) % of partners/contacts of STI patients that were notified and treated –by age and sex.	Variable	Monthly, Annually	3	HIS		Camp
(3.4.8) % of refugee operations where standard case management protocols are in place.	100%	Annually	3	Country Offices		Camp Non-camp
Support Services						
(2.1.1) % of HCR country offices that are consistently participating in health cluster meetings among those countries that have been "clusterized".[14]	>75%	Annually	2, 5	Country Offices		Camp Non-camp
(2.3.1) Number of HCR Public Health Coordinators.	Variable	Annually	2	Country Offices Regional Offices HQ		Camp Non-camp
(2.3.2) Number of health coordination meetings held per year.	Variable	Annually	2, 5	Country Offices Regional Offices HQ		Camp Non-camp
(2.4.1) % of HCR attendance at the InterAgency Working Group on Reproductive Health in Crisis meetings.	100%	Annually	2, 5	Country Offices Regional Offices HQ		Not applicable
(2.5.1) Reproductive health services mainstreamed in all COPs.	100%	Annually	2	MSRP COPs		Camp Non-camp

14 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, protection, camp coordination and camp management, education, shelter, health and water and sanitation.

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[9]	Periodicity	Strategic Objectives	Source of Measure-ment	Relation to Global Indicators	Setting: Camp, Non-camp[10]
Support Services (cont.)						
(2.5.2) Amount of resources spent by HCR for reproductive health (USD/person/yr).	Variable	Annually	2	MSRP		Camp Non-camp
(2.6.1) % of countries that have conducted participatory assessments as part of the operations management cycle.	>75%	Annually	2, 5	Country Offices		Camp Non-camp
(4.1.2) % of operations where reproductive health plans have been designed and integrated with health plans in exit strategies (integration areas or areas of return).	100%	Annually	1,4	Country Offices		Camp Non-camp
(4.2.1) % of countries undertaking major repatria-tion operations that collect and share reproductive health information about refugees and other PoCs in areas of return with government and organisations involved in reproductive health policies and programmes.	100%	Annually	4	Country Offices		Camp Non-camp
(5.1.1) Number of reproductive health workshops and training events –by subject.	Variable	Annually	1,2,5	Country Offices Regional Offices HQ		Camp Non-camp
(5.2.1) % of countries reporting reproductive health training for HCR's PoCs.	100%	Annually	1,2,3,4,5	Country Offices		Camp Non-camp
(6.1.1) % of reproductive health assessments undertaken during initial emergency phase based on standard checklist.	100%	Annually	6	Country Offices		Camp Non-camp
(6.2.1) % of refugee operation with functioning HIS, as defined by monthly reporting to HCR.	100%	Annually	6	HIS		Primarily camp with emphasis to include non camp
(6.4.1) % of camps/programmes that have evaluated their coverage and quality of reproductive health services every 2 yrs in stable settings.	100%	Biannually	6	Country Regional Offices		Camp
(6.5.1) Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.	Variable	Annually	6	Country Offices Regional Offices HQ		Camp Non-camp


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UNHCR's Strategic Plan for Water and Sanitation

2008 - 2012

UNHCR
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List of Acronyms

APR	Annual Protection Reports
CDC	Centers for Disease Control and Prevention
DOS	Division of Operational Services
GBV	Gender Based Violence
HIS	Health Information System
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
HQ	Headquarters
HRI	Humanitarian Reform Initiative
IDP	Internally Displaced Person
IP	Implementing Partner
M&E	Monitoring and
MSRP	Management Systems Renewal Project
NFI	Non Food Item
OP	Operational Partner
PA	Participatory Assessment
PoCs	Persons of Concern
S&I	Standards and Indicators
UN	United Nations
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
WatSan	Water and Sanitation
WHO	World Health Organisation

EXECUTIVE SUMMARY

UNHCR's Strategic Plan for Water and Sanitation (2008-2012) outlines the overall objectives and main strategies to address Water and Sanitation (WatSan) within the context of UNHCR's mandate to protect refugees, internally displaced persons (IDPs) and other persons of concern (PoCs). The Strategic Plan aims to complement the UNHCR Standards and Indicators specific to the WatSan sectors (UNHCR's Standard and Indicators[S&I] Handbook, 2006), the Millennium Development Goals, the United Nations Humanitarian Reform Initiative (HRI), the internationally recognised right to adequate water, and other global commitments and processes in the WatSan sectors.

This Strategic Plan takes into account the need for close coordination among the essential service sectors of UNHCR including protection, community services, health, nutrition, food security, shelter, HIV/AIDS, environment and education. These linkages will ensure a comprehensive and integrated approach across technical sectors covered by UNHCR's Public Health and HIV Section as well as other divisions within UNHCR. The Strategic Plan aims to guide operations in camp, urban and other non-camp settings as well as in local integration and returnee situations during the period of 2008-2012 (see 2008-12 guiding principles).

OVERALL STRATEGIC OBJECTIVE:

To support and promote WatSan policies and programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

WATER AND SANITATION STRATEGIC OBJECTIVES FOR UNHCR:

1. **Protection:** To ensure the human rights of UNHCR's PoCs to equitable access to safe and adequate WatSan services.

2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate WatSan policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Prevention:** To reduce transmission of diseases associated with insufficient WatSan services through provision of appropriate, reliable, accessible and adequate WatSan policies and programmes with an emphasis on community participation.

4. **Operations Management:** To effectively respond, maintain and operate WatSan systems in collaboration with PoCs and other stakeholders directly benefiting from the services

5. **Durable Solutions:** To ensure that WatSan components are integrated in local integration or reintegration operations so as to guarantee sustainability of durable solutions.

6. **Capacity Building and Training:** To build and strengthen specific WatSan-related knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

7. **Assessments, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on the status of WatSan programmes to inform programmatic planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches and technologies in WatSan sectors.

INTRODUCTION

Access to clean water and improved sanitation are essential to life, health and dignity. They are, therefore, basic human rights. The Universal Declaration of Human Rights, 1948, Article 25 states that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family". The *General Comment No. 15, 'The Right to Water'*, UN Committee on Economic, Social and Cultural Rights, 2002, Article 2, further elaborates on this point, draws specific attention to UNHCR's PoCs and urges state parties to ensure that: "Refugees, asylum-seekers, internally displaced persons and returnees have access to adequate drinking water whether they stay in camps or in urban area. … should be granted the right to water in the same conditions as nationals."

Timely and adequate provision of clean water to PoCs is of special importance because they often face discrimination, difficulties in fully exercising their rights, and are prone to exploitation. Of equal importance is the provision of adequate sanitation including the management of human excreta disposal, solid waste, medical waste, and waste water and drainage as well as control of vectors of communicable diseases (e.g. mosquitoes, rats, mice and flies). Water and sanitation programmes must be implemented together with proper hygiene promotion and implementation activities to ensure effective prevention of diseases and death.

This UNHCR Strategic Plan for WatSan documents the vision, strategic objectives, and main strategies of UNHCR to fully integrate effective WatSan policies and programmes into UNHCR's overall mandate to protect refugees and other PoCs. It also provides core indicators by which progress against these strategic objectives will be measured to ensure that UNHCR meets its internal standards and indicators and complies with international standards.

The foundation for the UNHCR Strategic Plan for WatSan 2008 – 2012 was laid by:

- UNHCR, Water Manual for Refugee Situations, 1992
- UNHCR Handbook for Emergencies (Section 14 and 15), Third Edition, UNHCR, 2007
- UNHCR, Standard and Indicators in UNHCR, 2006
- WHO, Guidelines for Drinking-water Quality, Third Edition, 2004
- UNHCR, Vector and Pest Control in Refugee Situations, 1997
- Loughborough University, UK, Emergency Sanitation, WEDC, 2002
- Loughborough University, UK, Excreta Disposal in Emergencies, WEDC, 2007
- United Nations, ECOSOC General Comment No. 15, the Human Rights to Water, 2002
- UNESCO World Water Assessment Programme, Water a Shared Responsibility, The UN World Water Development Report 2, 2006

WatSan is also explicitly highlighted in UNHCR's Global Strategic Objectives for 2008-2009 (See Box 1).[1]

BOX 1: Water and Sanitation in the UNHCR Global Strategic Objectives

Global Strategic Objective 3 - Realising the social and economic well being of persons of concern, with priority given to:

3.1 Reducing malnutrition, and major risks to the health of populations of concern, notably malaria, HIV/AIDS and inadequate reproductive health services.

3.2 Reducing vulnerability and improving standards of living, especially in relation to water, shelter, and sanitation service.

3.5 Creating opportunities for self-reliance through a community-based approach.

Global Strategic Objective 4 - Responding to emergencies in a timely and effective manner, with priority given to:

4.2 Meeting the needs of women, children and groups with specific needs in emergency situations.

Performance Targets:

4.2.2. Emergency protection and assistance interventions in the first three months of an emergency increasingly respond to age, gender and diversity considerations including specific interventions for women, children and groups with special needs.

An interim assessment of all indicators and targets in this plan will be undertaken after the end of 2009.

GOALS AND OBJECTIVES

OVERALL STRATEGIC OBJECTIVE:

To support and promote WatSan policies and control programmes to reduce morbidity and mortality and to enhance the quality of life among refugees, IDPs, returnees and other PoCs to UNHCR.

Water and Sanitation Strategic Objectives for UNHCR:

1. **Protection:** To ensure the human rights of UNHCR's PoCs to equitable access to safe and adequate WatSan services.

2. **Coordination and Integration:** To effectively coordinate, advocate for and integrate WatSan policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.

3. **Prevention:** To reduce transmission of diseases associated with insufficient WatSan services through provision of appropriate, reliable, accessible and adequate WatSan policies and programmes with an emphasis on community participation.

1 UNHCR, "Biennial Programme Budget 2008-2009 of the Office of the United Nations High Commissioner for Refugees." A/AC.96/1040, 12 September 2007, Fifty-eighth session.

4. **Operations Management:** To effectively respond, maintain and operate WatSan systems in collaboration with PoCs and other stakeholders directly benefiting from the services

5. **Durable Solutions:** To ensure that WatSan components are integrated in the local integration or reintegration operations so as to guarantee sustainability of durable solutions.

6. **Capacity Building and Training:** To build and strengthen specific WatSan-related knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.

7. **Assessments, Monitoring and Evaluation and Operational Research:** To regularly monitor and report on the status of WatSan programmes to inform programmatic planning and implementation in a timely manner; to evaluate programme performance and achievements using a results-based management approach; and to develop and carry out operational research on new approaches and technologies in WatSan sectors.

STRATEGIES AND INDICATORS OF ACHIEVEMENT

UNHCR will monitor its progress against these strategic objectives over the 2008-2012 period through a rigorous monitoring and evaluation system at regional and country levels. The data will be aggregated and reported regularly at the global level. The following core of **36 indicators** will be tracked as a measure of progress against the strategic objectives. For each of these indicators, many others could be suggested, particularly programme performance monitoring indicators, which are not detailed here but many of which will be collected and used at country level. Realisation of these strategic objectives will require a certain level of accountability at various levels of management. This accountability will be most important at the country and field level through the processes of the programme planning cycle and on-going reporting.

Table 1 summarises the strategies and indicators of achievement. It provides explicit definitions for and essential information on how the indicators will be measured at the global, regional and country operational levels.

Table 2 provides summaries of how the indicators of achievement will be reported. This includes information on targets, periodicity, applicable strategic objectives, and sources of measurement.
UNHCR will obtain data on WatSan from following main sources:

1. UNHCR's Health Information System (HIS)
2. UNHCR's Standards and Indicators (S&Is)
3. UNHCR's Annual Protection (APRs)
4. UNHCR's Global Strategic Objectives
5. Joint Assessment Missions conducted with other UN agencies and non-governmental organisations and WatSan surveys.
6. UNHCR's Financial Systems using Management Systems Renewal Project (MSRP)

Table 1. Key Strategies and Indicators of Achievement

STRATEGIC OBJECTIVE 1: PROTECTION	To ensure the human rights of UNHCR's PoCs to equitable access to safe and adequate WatSan services.
Key Strategies	**Indicators of Achievement**
(1.1) Reduce diseases associate with poor WatSan services through effective WatSan policies and programmes.	**(1.1.1)** Proportional mortality due to watery diarrhoea (Crude, Under 5). **(1.1.2)** Proportional morbidity due to watery diarrhoea (Crude, Under 5). **(1.1.3)** Watery diarrhoea incidence (Crude, Under 5).
(1.2) Reduce incidence of gender-based violence (GBV) related to WatSan programmes.	**(1.2.1)** Use of toilets is arranged by household(s) and/or segregated by sex. **(1.2.2)** Number of reported cases of GBV, segregated per type, age and sex. **(1.2.3)** Where communal bathing facilities are necessary, there are sufficient bathing cubicles available with separate cubicles for males and females, and they are used appropriately and equitably.
(1.3) Ensure access to equitable water and sanitation services.	**(1.3.1)** % of camps having > 20L of water per person per day. **(1.3.2)** % of camps having ≤ 80 persons per useable taps, or ≤ 200 persons per hand pump or well. **(1.3.3)** % of camps with access to > 80% family latrines (stable phase).
Indicators **1.5.1** and **1.5.2** from HIV Strategic Plan also apply.	

STRATEGIC OBJECTIVE 2: COORDINATION AND INTEGRATION	To effectively coordinate, advocate for and integrate WatSan policies and programmes in a multi-sectoral approach for PoCs by strengthening and expanding strategic partnerships with key stakeholders.
Key Strategies	**Indicators of Achievement**
(2.1) Ensure WatSan policies and programmes for IDPs are coordinated and integrated within humanitarian reform process.	**(2.1.1)** % of HCR country offices that are consistently participating in WASH cluster meetings among those countries that have been "clusterized".[2] **(2.1.2)** % HCR participation in WASH cluster meetings/events at global level.
(2.2) Strengthen HCR WatSan coordination capacity and supervision with relevant stakeholders (e.g. host country authorities, IPs and OPs, and PoCs representatives).	**(2.2.1)** Number of HCR public health coordinators and /or WatSan Officers. **(2.2.2)** Number of public health coordination meetings with integrated WatSan components held per year. **(2.2.3)** % of WatSan experts deployed by our partners compared with number of HC requests.
(2.3) Ensure sufficient resources provided to supporting HCR's WatSan activities.	**(2.3.1)** Amount of resources spent by HCR for WatSan (USD/person/yr).
(2.4) Ensure that PoCs are included into participatory assessments and age, gender and diversity analysis as part of HCR's operations management cycle.	**(2.4.1)** % of countries that have conducted participatory assessments as part of the operations management cycle.

2 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, protection, camp coordination and camp management, education, shelter, health and water and sanitation.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 3: PREVENTION	To reduce transmission of diseases associated with insufficient WatSan services through provision of appropriate, reliable, accessible and adequate WatSan policies and programmes with an emphasis on community participation.
Key Strategies	**Indicators of Achievement**
(3.1) Provide minimal internationally accepted WatSan services to HCR's PoCs during an emergency.	**(3.1.1)** % of families receiving > 250 g of soap per person per month. **(3.1.2)** % of camps with ≤ 20 persons per latrine or drop hole. **(3.1.3)** % of camps reporting no faecal coliforms per 100ml at point of delivery. See also **1.3.1-1.3.3**.
(3.2) Ensure participation of and access by vulnerable groups in establishing and maintaining WatSan services.	**(3.2.1)** % of population living within 200 m from water points. **(3.2.2)** % of population living within 5 to 50 m from the latrines. Also see **1.2.1-1.2.3**.
(3.3) Create epidemic preparedness plans that include water-borne diseases.	**(3.3.1)** % of camps/programmes that have epidemic preparedness plans including water-borne disease.
(3.4) Improve hygiene promotion.	**(3.4.1)** % of HCR operations with WatSan committees in operations with equal participation of female members. **(3.4.2)** % of camps with one hygiene promoter per 500 persons. See also **1.1.1-1.1.3, 3.1.1, 3.1.3, 3.2.1, 3.2.2**.
(3.5) Control disease vectors through environmentally friendly measures and improved waste management practices.	**(3.5.1)** % coverage of suitable dwellings when IRS was utilized to control or prevent epidemics. **(3.5.2)** % of camps with ≤ 500 persons per communal refuse pit.
Indicators **1.2.1** and **1.2.2** from Malaria Strategic Plan also apply.	

STRATEGIC OBJECTIVE 4: OPERATIONS MANAGEMENT	To effectively respond, maintain and operate WatSan systems in collaboration with PoCs and other stakeholders directly benefiting from the services.
Key Strategies	**Indicators of Achievement**
(4.1) Improve and implement operation management plans for WatSan facilities in HCR operations.	**(4.1.1)** % of water systems with a total of ≥ 3 days of downtime in a month and/or more than one consecutive day of supply interruption. See also **1.1.1-1.1.3, 1.3.1-1.3.3, 3.1.1-3.1.3**.
(4.2) Functioning WatSan committees and support staff to oversee and improve performance of WatSan services.	**(4.2.1)** % of priority operations with trained and dedicated WatSan staff to ensure technical integrity in these sectors. See also **3.4.1, 3.4.2**.
(4.3) Respond effectively and timely to an emergency.	See **(2.2.3)**.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 5: DURABLE SOLUTIONS	To ensure that WatSan components are integrated in the local integration or reintegration operations so as to guarantee sustainability of durable solutions.
Key Strategies	**Indicators of Achievement**
(5.1) Advocate for and establish local integration and repatriation policies and programmes that include appropriate prevention and treatment interventions for WatSan.	**(5.1.1)** % of operations where WatSan plans have been designed and integrated in exit strategies (integration areas or areas of return).
(5.2) Coordinate and share WatSan information with governments, UN agencies and other humanitarian organisations during repatriation.	**(5.2.1)** % of major repatriation operations that collect and share WatSan information about PoCs in areas of return with government and organisations involved in programmes.

STRATEGIC OBJECTIVE 6: CAPACITY BUILDING AND TRAINING	To build and strengthen specific WatSan-related knowledge and skills as well as to provide necessary technical tools to PoCs and those staff working with them.
Key Strategies	**Indicators of Achievement**
(6.1) Train HCR and partner health staff on essentials of improved WatSan services and provide necessary tools and guidance.	**(6.1.1)** % of training activities in which WatSan modules integrated and delivered according to number planned. See also **2.1.1, 2.1.2, 2.2.2, 2.4.1**.
(6.2) Improve capacity of HCR's PoCs to participate in the design, implementation, monitoring and evaluation of WatSan programmes.	**(6.2.1)** % of countries reporting WatSan training for UNHCR's PoCs. See also **2.4.1, 3.3.1, 3.4.1, 3.4.2, 4.2.1**.

Table 1. Key Strategies and Indicators of Achievement (cont.)

STRATEGIC OBJECTIVE 7: ASSESSMENTS, SURVEILLANCE, MONITORING AND EVALUATION AND OPERATIONAL RESEARCH	To regularly monitor and report on the status of WatSan programmes within PoCs to inform programmatic planning and implementation in a timely manner; To evaluate programme performance and achievements using a results-based management approach; and To develop and carry out operational research on new approaches and technologies in WatSan sectors.
Key Strategies	**Indicators of Achievement**
(7.1) Conduct WatSan situational assessments using a standardised checklist.	**(7.1.1)** % of WatSan assessments undertaken during initial emergency phase.
(7.2) Collect and analyse essential WatSan-related data on performance and impacts on a routine basis.	**(7.2.1)** % refugee operations with functioning HIS, as defined by monthly reporting to HCR.
(7.3) Evaluate WatSan programmes on a routine basis.	**(7.3.1)** % of camps/programmes that have evaluated their coverage and quality of WatSan services every 2 yrs in stable settings.
(7.4) Conduct WatSan operational research to guide programme implementation or to address identified programmatic problems.	**(7.4.1)** Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.

Table 2: Summary of Indicators of Achievement

INDICATORS OF ACHIEVEMENT	Target[3]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[4]
(1.1.1) Proportional mortality due to watery diarrhoea (Crude, Under 5).	Variable	Monthly, Annually	1,3,4	HIS	Camp
(1.1.2) Proportional morbidity due to watery diarrhoea (Crude, Under 5).	Variable	Monthly, Annually	1,3,4	HIS	Camp Non-camp
(1.1.3) Watery diarrhoea incidence (Crude, Under 5).	Variable	Monthly, Annually	1,3,4	HIS	Camp
(1.2.1) Use of toilets is arranged by household(s) and/or segregated by sex.	100%	Annually	1,3	WatSan Survey	Camp
(1.2.2) Number of reported cases of GBV, segregated per type, age and sex.	Variable	Monthly, Annually	1,3	Country Offices HIS APR	Camp Non-camp
(1.2.3) Where communal bathing facilities are necessary, there are sufficient bathing cubicles available with separate cubicles for males and females.	100%	Annually	1,3	WatSan Survey	Camp
(1.3.1) % of camps having > 20L of water per person per day.	>80%	Annually	1,3,4	WatSan Survey S&I	Camp
(1.3.2) % of camps having ≤ 80 persons per useable taps, or ≤ 200 persons per hand pump or well.	>75%	Annually	1,3,4	WatSan Survey	Camp
(1.3.3) % of camps with access to 80% family latrines (stable phase).	>90%	Annually	1,3,4	S&I	Camp
(2.1.1) % of HCR country offices that are consistently participating in WASH cluster meetings among those countries that have been "clusterized".[5]	>75%	Annually	2,6	Country Offices	Camp Non-camp
(2.1.2) % HCR participation in WASH cluster meetings/events at global level.	>90%	Annually	2,6	HQ Reports	Not applicable

3 Target refers to the level that UNHCR intends to achieve by the end of 2012. It is based on the current situation and what HCR believes it is feasible to attain.

4 Refers to setting where indicator will ***primarily*** be measured. However, this may vary according to context. All population-based surveys could be undertaken in camp or non-camp settings; however, at this point they are primarily done in camp settings. This may change over time.

5 A cluster is a group of agencies, organizations and/or institutions unified by their particular mandates, working towards common objectives. The purpose of the clusters is to promote effective and predictable outcomes in a timely manner, while also improving accountability and leadership. Globally, 11 clusters have been identified, each with a lead agency, covering areas such as, education, shelter, telecommunications, food aid, health and sanitation.

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[3]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[4]
(2.2.1) Number of HCR public health coordinators and/or WatSan Officers.	Variable	Annually	2	Country Offices Regional Offices HQ	Camp Non-camp
(2.2.2) Number of public health coordination meetings with integrated WatSan components held per year.	100%	Annually	2,6	Country Offices Regional Offices HQ	Camp Non-camp
(2.2.3) % of WatSan experts deployed by our partners compared with number of HCR requests.	>75%	Annually	2,4	HQ	Camp Non-camp
(2.3.1) Amount of resources spent by HCR for WatSan (USD/person/yr).	Variable	Annually	2	MSRP	Camp Non-camp
(2.4.1) % of countries that have conducted participatory assessments as part of the operations management cycle.	>80%	Annually	2,6	Country Offices	Camp Non-camp
(3.1.1) % of families receiving > 250 g of soap per person per month.	>90%	Annually	1,3,4	WatSan Survey	Camp
(3.1.2) % of camps with ≤ 20 persons per latrine or drop hole.	>90%	Annually	1,3,4	WatSan Survey S&I	Camp
(3.1.3) % of camps reporting no faecal coliforms per 100ml at point of delivery.	>75%	Annually	1,3,4	WatSan Survey S&I	Camp
(3.2.1) % of population living within 200 m from water points.	>80%	Annually	1, 3	WatSan Survey S&I	Camp
(3.2.2) % of population living within 5 to 50 m from the latrines.	>80%	Annually	1, 3	WatSan Survey	Camp
(3.3.1) % of camps/programmes that have epidemic preparedness plans including water-borne disease.	>80%	Annually	1,6	Country Offices	Camp
(3.4.1) % of UNHCR operations with WatSan committees in operations with equal participation of female members.	>90%	Annually	1,3,4,6	WatSan Survey	Camp
(3.4.2) % of camps with one hygiene promoter per 500 persons.	>75%	Annually	1,3,4,6	WatSan Survey	Camp
(3.5.1) % coverage of suitable dwellings when IRS was utilized to control or prevent epidemics.	>80%	Annually	3	Country Offices LLIN survey	Camp
(3.5.2) % of camps with ≤ 500 persons per communal refuse pit.	>90%	Annually	3	WatSan Survey S&I	Camp

Table 2: Summary of Indicators of Achievement (cont.)

INDICATORS OF ACHIEVEMENT	Target[3]	Periodicity	Strategic Objectives	Source of Measurement	Setting: Camp, Non-camp[4]
(4.1.1) % of water systems with a total of ≥ 3 days of downtime in a month and/or more than one consecutive day of supply interruption.	<15%	Annually	1, 3, 4	WatSan Survey	Camp
(4.2.1) % of priority operations with trained and dedicated WatSan staff to ensure technical integrity in these sectors.	100%	Annually	3, 4, 6	Country Offices HQ	Camp Non-camp
(5.1.1) % of operations where WatSan plans have been designed and integrated in exit strategies (integration areas or areas of return).	100%	Annually	5, 2	Country Offices	Camp Non-camp
(5.2.1) % of major repatriation operations that collect and share WatSan information about PoCs in areas of return with government and organisations involved in programmes.	100%	Annually	5, 2	Country Offices	Camp Non-camp
(6.1.1) % of training activities in which WatSan modules integrated and delivered according to number planned.	90 %	Annually	2,6	Country Offices HQ	Camp Non-camp
(6.2.1) % of countries reporting WatSan training for UNHCR's PoCs.	>75%	Annually	2,3,4,6	Country Offices	Camp Non-camp
(7.1.1) % of WatSan assessments undertaken during initial emergency phase.	100 %	Annually	7	Country Offices	Camp Non-camp
(7.2.1) % refugee operations with functioning HIS, as defined by monthly reporting to HCR.	100%	Monthly, Annually	7	Country Offices HQ	Primarily camp with emphasis to include non camp
(7.3.1) % of camps/programmes that have evaluated their coverage and quality of WatSan services every 2 yrs in stable settings.	100 %	Biannually	7	Country Offices	Camp
(7.4.1) Number of programmes that have conducted operational research defined as any investigation that is not routine and undertaken to inform programmatic planning or to address identified programmatic problems.	Variable	Annually	7	Country Offices Regional Offices HQ	Camp Non-camp

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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

Appendix: Cross-Reference of Indicators

2008-2012

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APPENDIX: CROSS-REFERENCE OF INDICATORS[1]

Table 1: Identically Worded Indicators in More than One Strategic Plan

INDICATORS	Cross-references by indicator numbering				
	HIV/AIDS	Malaria	Nutrition and Food Security	Reproductive Health	Water and Sanitation
Number of reported cases of GBV, segregated by type, age and sex.				1.1.3	1.2.2
% of pregnant women presenting to ANC receiving ≥ 2 doses of Intermittent Preventative Treatment in pregnancy.		3.6.1		3.1.4	3.5.1
% coverage of suitable dwellings when IRS was utilized to control or prevent epidemics.		3.5.1			
% of refugee operations that provide blood transfusions which screen blood for HIV in a quality-assured manner.	3.2.1			3.4.6	
% refugee operations where universal precautions are satisfactorily applied.	3.3.1			3.4.5	
% countries, when indicated, where pregnant women received antiretroviral medication to reduce the risk of mother to child transmission of HIV.	3.8.1			3.1.3	
% countries reporting provision of PEP to survivors of rape within 72 hours of rape.	3.9.1			3.5.2	
Incidence of male urethral discharge – by age.	3.4.1			3.4.1	
Incidence of genital ulcer disease – by age and sex.	3.4.2			3.4.2	
% of clients tested for syphilis with a positive result –by age and sex.	3.4.3			3.4.3	
% of partners/contacts of STI patients that were notified and treated –by age and sex.	3.4.4			3.4.4	
% of refugee operations where sufficient number of male and female condoms are distributed.	3.10.1			3.4.7	
% of newborns born with <2500g of weight.			3.1.2	3.2.3	
% of infants (<6 months of age) exclusively breastfed for the first six months of life.			3.3.2	3.2.4	

1 These indicators are relevant to the monitoring of cross-cutting objectives that are shared between the Malaria, HIV/AIDS, Reproductive Health, Nutrition/Food Security and Water and Sanitation strategic plans.

Table 2: Indicators referred to in More than One Strategic Plan[2]

INDICATORS	Cross-references by indicator numbering				
	HIV/AIDS	Malaria	Nutrition and Food Security	Reproductive Health	Water and Sanitation
Nut/FS (1.1.1) Prevalence of global acute malnutrition (GAM) for children 6-59 months of age.	X				
Malaria (1.2.1) % of women receiving LLIN/ITN during pregnancy in emergency phase.	X		X	X	X
Malaria (1.2.2) % of households with ≥ LLIN/ITN in stable phase.	X		X	X	X
WatSan (1.3.1) % of camps having ≥ 20L of water per person per day.			X		
HIV (1.5.1) % of refugee children by sex enrolled in grades 1-6.		X	X	X	X
HIV (1.5.2) % of refugee children enrolled by sex in grades 7 -12.		X	X	X	X
HIV (1.4.1) % of countries that have integrated GBV prevention and response activities into HIV activities.				X	
Nut/FS (1.2.1) Amount of food distributed through general food ration, as % of planned amount, as measured by: kilocalories, fat/energy percentage, protein/energy percentage, and selected micronutrients.				X	
RH (1.1.3) Number of reported cases of GBV, segregated per type, age and sex.	X				X
RH (1.2.1) % of operations supporting health clinics with treatment and case management protocols for rape survivors in place.	X				
RH (1.4.1) % of all birth that take place in EmONC facilities.	X				
RH (1.4.2) % of women who had at least 4 antenatal care visits to a health professional with midwifery skills by time of delivery.	X				
RH (1.5.1) % of women who delivered before age of 18 years (teenage pregnancies).	X				

2 Unlike in Table 1, the indicators in Table 2 are only written in one strategic plan but are referenced as being applicable in one or more other strategic plans.

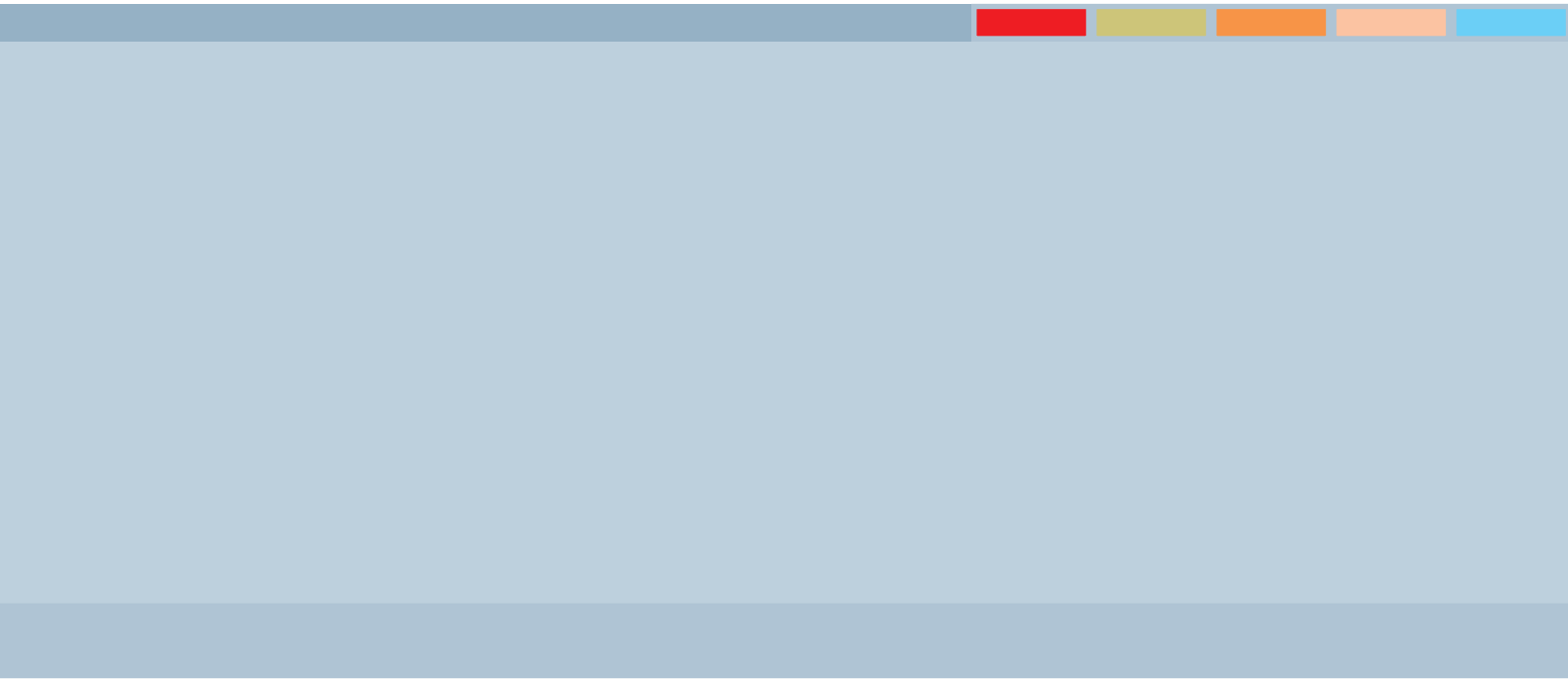
Table 2: Indicators referred to in More than One Strategic Plan[2] (cont.)

INDICATORS	Cross-references by indicator numbering				
	HIV/AIDS	Malaria	Nutrition and Food Security	Reproductive Health	Water and Sanitation
RH (2.2.1) % of UNHCR operations systematically investigating every maternal death.	X				
HIV (3.2.1)/RH (3.4.6) % of refugee operations that provide blood transfusions which screen blood for HIV in a quality-assured manner.		X			
Nut/FS (3.2.4) Prevalence of anaemia in children 6-59 months of age.		X			
Nut/FS (3.2.5) Prevalence of anaemia in women 15-49 years of age.		X		X	
WatSan (3.5.2) % of camps with ≤ 500 persons per communal refuse pit.		X			
Nut/FS (3.1.3) % of pregnant and lactating women provided supplementary feeding.				X	
HIV (3.1.1) % countries that have access to culturally appropriate HIV and AIDS information, education, communication materials.			X	X	
Malaria (3.6.1)/RH (3.1.4) % of pregnant women presenting at ANC who receive ≥2 doses of IPTp, when appropriate.	X				
RH (3.1.1) % of pregnant women screened for syphilis during the antenatal period.	X				
RH (3.1.2) % of antenatal care mothers that tested positive for syphilis.	X				
RH (3.2.1) % of all birth through Caesarean section.	X				
RH (3.2.2) % of camps with access to EmONC, 24 hours per day, 7 days per week.	X				
RH (3.2.4)/Nut/FS (3.3.2) % of infants (0-<6 months of age) exclusively breastfed for the first six months of life.	X				
RH (3.3.1) % of women who use (or whose partner uses) a modern family planning method.	X				
RH (3.5.2) % of UNHCR operation ensuring access and availability of emergency contraception.	X				

Table 2: Indicators referred to in More than One Strategic Plan[2] (cont.)

INDICATORS	Cross-references by indicator numbering				
	HIV/AIDS	Malaria	Nutrition and Food Security	Reproductive Health	Water and Sanitation
RH (3.5.1) % of countries reporting provision of emergency contraception to non pregnant rape survivors within 120 hours of rape.	X				
Nut/FS (3.3.3) % of non-breastfed infants with access to necessary quantity of breast milk substitute, resources and follow-up.	X				
Malaria (3.4.1) % households that have ≥1 distributed net six months after net distribution.			X		
Malaria (3.4.2) % inpatient facilities that have LLIN/ITN for each bed.			X		
HIV (3.8.1) % countries, when indicated, where pregnant women and the infant received antiretroviral medication to reduce the risk of mother to child transmission of HIV.			X		
Nut/FS (4.1.2) % of SFPs that adhere to standard treatment protocols.	X				
Nut/FS (4.2.1) % operations where community-based management SAM is being implemented where HCR determined it is appropriate and necessary.	X				
Nut/FS (4.2.3) % of TFPs that adhere to standard treatment protocols.	X				
Malaria (4.1.1) % of operations where refugees are provided with appropriate returnee packages defined here as ≥1 LLIN/ITN per household and instructions on use, where appropriate.	X		X	X	
RH (4.1.1) % of operations where refugees are provided with appropriate returnee packages for reproductive health (defined here as sanitary towels and family planning material).	X				
RH (4.1.3) % of programmes at point of return that offer EmONC services.	X				
Nut/FS (5.1.1) % of operations where refugees are provided with appropriate returnee food package.	X				
Nut/FS (5.1.2) % of operations where nutrition and food security have been designed or integrated in exit strategies (integration areas or areas of return).	X				
RH (6.1.1) % of reproductive health assessments undertaken during initial emergency phase based on standard checklist.	X				

Notes



UNHCR
The UN Refugee Agency